Directivas Anticipadas para Personas con Demencia

(Advance Directive for Living with Dementia)

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Una Directiva Anticipada para Personas con Demencia puede ayudarle a usted, a sus seres queridos y a quienes le atienden y cuidan a comprender sus deseos y preferencias sobre su atención durante el largo curso de la enfermedad y cuando no puede hablar por sí mismo. Incluye información sobre quién le gustaría que le proporcione su cuidado personal, dónde le gustaría vivir si no puede quedarse en casa de forma segura, cómo pagar la atención, qué hacer si se pone agresivo, las relaciones futuras para usted y su cónyuge/pareja y cuándo dejar de conducir. (Formulario e instrucciones)

Form attached:
Advance Directive for Living with Dementia (NJP Planning 512)

¿Qué se incluye en esta Directiva Anticipada?

Puede incluir cualquier cosa que pueda ayudar a los demás a saber cómo darle la atención y el cuidado que necesita y a tomar decisiones por usted cuando no pueda tomarlas por sí mismo. Esto podría ser:

- Quién quiere que cuide de usted en su hogar.
- Dónde quiere vivir si ya no puede vivir en casa.
- Sus preferencias culturales, religiosas y de género sobre su atención y cuidado.
- Qué hacer si se pone agresivo o abusivo debido a la demencia.
- Preferencias para financiar su atención.
- Preferencias sobre futuras relaciones íntimas para usted y/o su cónyuge o pareja.
- Cuándo debe dejar de conducir.

¿Qué no incluye?

Esta Directiva Anticipada **no incluye sus preferencias para la atención y cuidado al fin de la vida**. Para eso, usted necesita preparar una Directiva de Atención de Salud (Testamento en Vida) para documentar sus deseos y un Poder Notarial que nombre a alguien que tome decisiones por usted cuando usted no pueda tomarlas por sí mismo.

¿Es legal?

Es una directiva anticipada legal bajo la ley estatal de Washington. Los proveedores médicos, de atención prolongada y otros proveedores generalmente están obligados por ley a seguir sus directivas anticipadas. Hay excepciones.

Incluso si usted vive fuera del estado de Washington, esta Directiva Anticipada proporciona una orientación valiosa a sus seres queridos y a quienes cuidan de usted.

¿Necesita estar notarizada?

Lo mejor es firmar su directiva ante un notario.

Si no puede encontrar un notario, puede firmar ante 2 testigos calificados. El formulario dice quién califica.

¿Qué debo hacer después de firmar?

Dé copias a todos los proveedores médicos, seres queridos y personas involucradas en su atención y cuidado o en tomar decisiones por usted. Si tiene algún Poder Notarial, deles copias a sus representantes.

La mejor manera de asegurarse de que se respetarán sus deseos es hablar de esta Directiva Anticipada con su equipo médico, su establecimiento asistencial, sus cuidadores y sus seres queridos. Pídales que respeten sus preferencias y decisiones.

¿Qué más puedo hacer para planificar con anticipación?

Esta Directiva Anticipada es para personas con demencia, pero tenemos otras directivas que puede usar para planificar su atención y cuidado al fin de la vida. (Ver enlaces relacionados abajo.)

El kit de herramientas para la planificación legal de personas con demencia (https://www.dshs.wa.gov/altsa/dac/individualsandfamilies) puede ayudarle a tomar decisiones financieras y de atención médica importantes y darle un lugar

para escribirlas.

¿Quién puede ayudarme a planificar cómo pagar la atención por un periodo prolongado?

La atención por un periodo prolongado es cara. Puede pagarla con sus propios ahorros, con un seguro de atención por un periodo prolongado y/o con la asistencia pública de Medicaid. **Recomendamos encarecidamente** que busque la ayuda de un abogado especializado en leyes de la tercera edad para planificar cómo financiar su atención y cuidado. La Academia de Abogados especializados en Derecho de la Vejez de Washington (https://waela.org/) tiene un directorio.

Advance Directive for Living with Dementia

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

I am a person with decision-making capacity. I voluntarily sign this mental health directive under RCW 71.32.260. If I cannot make decisions for myself, my relatives, friends, agents, and medical providers should fully honor every part of this directive. If any part of this directive is invalid, the rest should be honored. I revoke any Advance Directive for Living with Dementia that I have signed in the past.

This directive instructs my health care agent or other legal decision-maker ("decision-maker") and all caregivers how to act on my behalf.

1. **I have written this advance directive because:**
   - ☐ Skip this section.
   - ☐ I have a current diagnosis of dementia and want to plan ahead.
   - ☐ I have **no** current diagnosis, but want to plan ahead.
   - ☐ Other (*Example: I've seen others with dementia and know what I would want*):

     _____
2. **Start date.** This directive is effective (*check one*):
   - ☐ Now.
   - ☐ Only if I can't make decisions for myself (if I'm incapacitated).
   - ☐ When my decision-maker determines that any of these circumstances, symptoms, or behaviors have occurred (*check all that apply*):
     - ☐ I can no longer communicate verbally.
     - ☐ I can no longer recognize people who are important to me.
     - ☐ I put myself or others in danger because of my actions or behaviors.
     - ☐ Other (*describe*): _____

       _____
3. **End date.** I want this directive to remain in effect until revoked.
4. **Revocation.**

   As your dementia progresses, you may worry you'll reject the decisions and preferences you've made in this directive. If so, select the first option below. This means you **can't cancel** this directive unless you're able to make decisions for yourself (you have **capacity**).

   I can cancel (revoke) this directive (*check one*):
   - ☐ **Only when I can make decisions for myself (when I have capacity).** I understand this means I can't cancel this directive unless I have capacity. It means I may receive the medical and personal care listed in this directive even if I object at the time.
   - ☐ **Even if I cannot make decisions for myself (if I'm incapacitated).** I understand this means I can cancel this directive at any time. This means I may not get the medical and personal care listed in this directive when I am incapacitated.

5. Health care decisions

I want whoever makes dementia care decisions for me to do as I would want in the circumstances, based on the choices I express in this directive. If my wishes are not known, then I want decisions to be made in my best interest, based on my values, this directive, and information provided by my health care providers.

6. Personal history and care values statement

☐ None.

☐ Attached.

➢ Preferences and instructions about my care and treatment

7. Care in my home

☐ Skip this section.

☐ If I need personal care and assistance in my home, I want these people to provide it: (*Check all that apply*)

☐ Volunteer caregivers who are friends or family.

☐ Volunteer caregivers who are **not** friends or family.

☐ Paid caregivers who are friends or family.

☐ Paid caregivers who are **not** friends or family.

Other details about who I want to provide care in my home (*Example: Specific people you do or **don't** want involved. It's okay to leave this blank.*)

_____

_____

8. Out-of-home placements

☐ Skip this section.

☐ If I can't receive care in my home, I want to receive care in the following place/s, if possible: (*Check all that apply.*)

☐ A friend or family member's home.

Name (*optional*): _____

☐ Adult family home.

Name and/or location (*optional*): _____

☐ Assisted living facility.

Name and/or location (*optional*): _____

☐ Nursing home.

Name and/or location (*optional*): _____

☐ I know that it may not be possible for me to receive care where I want, given my needs and circumstances at the time. I trust my healthcare decision-maker/s and know that they will make the best decisions for me after considering my values, and consulting with my loved ones and care providers.

Other details about where I want to receive care (*Examples: If one of these options is your first or last choice, if there's anywhere you **don't** want to live, or if you prefer a memory care facility. It's okay to leave this blank.*)

_____

_____

9. Cultural, religious, and/or gender preferences about my care and assistance

☐ Skip this section.

☐ (*Describe*) _____

_____

_____

_____

_____

10. Assessment. If someone needs to do an assessment or make recommendations about my ability to remain in my home, I prefer this be done by the following person/s or agencies:

☐ No preference.

☐ (*Name/s*) _____

11. Psychiatric Hospitalization

Sometimes people with Alzheimer's or dementia become aggressive, assaultive, or combative, despite good care. If this happens, emergency or other treatment may be necessary. You can consent to psychiatric hospitalization in advance. If you don't consent, someone would have to get a court order for your involuntary commitment to a psychiatric hospital.

Important! By consenting to inpatient mental health treatment now, while you are well, you may get treatment sooner if you decompensate.

☐ Skip this section.

☐ Check one *(sign if consenting):*

☐ **I consent** to voluntary admission to inpatient mental health treatment for (*up to 14*) _____ days if my mental health care agent and treating medical providers decide it is appropriate. I prefer to receive treatment in a facility specializing in Alzheimer's/dementia care to reduce my behavioral symptoms and stabilize my condition.

▶ _____

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

☐ **I don't consent** to inpatient mental health treatment.

12. Psychiatric hospital or other facility preferences

☐ Skip this section.

☐ If I need hospitalization, I prefer to go to a specialized dementia care unit at:

_____

☐ If I need hospitalization, I **don't consent** to these hospitals or facilities:

_____

☐ I want treatment from trained caregivers who know me and my history, and who know how to handle the situation.

13. Financing my care

☐ Skip this section.

☐ I know that the cost of my care could become high over the course of my illness. I have the following preferences about financing my care (*check one*):

☐ Please use my income, assets, and savings to buy the highest quality private care forme, even if this requires selling my home and other property.

☐ I want to preserve my income, assets, and savings for my partner/spouse, children, and heirs, if possible. Please use all available planning options to meet this goal, including, but not limited to (*check all that apply*):

☐ Medicaid planning

☐ Gifting

☐ Divorce or legal separation

☐ Changing estate planning documents

☐ Tax planning

☐ Other: _____

_____

14. Future intimate relationships – partner or spouse

☐ Skip this section.

☐ My partner or spouse is (*name*):_____.

a. Preferences about continuing our intimate relationship (c*heck all that apply*):

☐ My intimate relationship with my partner/spouse is important to us.

☐ We want to maintain our sexual relationship for as long as possible.

☐ I completely trust my partner/spouse to make any judgments about continuing our intimate relationship, including when to stop if they're no longer comfortable.

☐ I want to maintain our sexual relationship even if we divorce or end our legal domestic partnership for financial reasons.

☐ If I need nursing home care, I request the privacy needed for us to continue our relationship, as required by law.

☐ I know that I may forget my partner/spouse as my Alzheimer's or dementia progresses. If this happens (*check one*):

☐ I want to continue to be intimate for as long as my partner/spouse wants to and feels comfortable doing so.

☐ I **don't** want to continue to be intimate with my partner/spouse.

☐ Other preference/s: _____

_____

b. Preferences about my partner/spouse having relationships with someone else (c*heck one*):

☐ I want my partner/spouse to seek companionship and intimacy when I can no longer provide that in our relationship if they wish to do so. I would not consider this a violation of our vows or commitment to each other. I understand that my illness may last a long time, and that I may no longer recognize or be able to function emotionally or sexually with my partner/spouse.

☐ I **don't** want my partner/spouse to pursue a relationship outside our partnership/marriage or other committed relationship.

Other preference/s, if any: _____

_____

15. My future intimate relationships

☐ Skip this section.

☐ Whether or not I have a current partner or spouse (c*heck one*):

☐ I know that residents at long-term care facilities sometimes develop intimate or romantic relationships with each other. I am not opposed to having such a relationship if my caregivers or medical providers believe the relationship improves my mental health and I am not coerced in any way.

☐ I **don't consent** to any intimate relationships, even if the relationship improves my mental health, except as stated in section 14 if I have a spouse or partner.

Other preference/s, if any: _____

_____

16. Driving

☐ Skip this section.

☐ If it's unsafe for me to drive, I agree that people can take steps to stop me from driving including hiding my keys, disabling my car, and denying me access to my car.

The decision about whether I'm safe to drive can be made by (*check all that apply*):

☐ My legal decision-maker/s.

☐ A qualified professional who can test my visual and mental acuity.

17. Pets

☐ Skip this section.

☐ I don't have any pets.

☐ When I can no longer care for my pets, I prefer (*describe who you want to care for them or if someone has agreed to adopt them*):

_____

_____

18. Participation in experimental Alzheimer's or dementia drug trials (*check one*):

☐ Skip this section.

☐ **I consent** to participation in any clinical drug trials for drugs that might improve the symptoms of Alzheimer's/dementia or prevent the full onset of the disease. I am willing to participate in the trial even if it could lead to my earlier death. I would rather die sooner but with my memory more intact.

☐ **I don't consent** to participation in any drug trials.

19. Durable Power of Attorney for Mental Health Care

> ***Important!*** *A general power of attorney for health care can't authorize mental health hospitalization. If you want your power of attorney to be able to consent to this (in section 10, above), you must complete the power of attorney for mental health care section below. You should appoint the same person as your agent for mental health care as for general health care to avoid confusion.*

☐ I am **not** appointing a power of attorney **for mental health care**.

☐ I am appointing a power of attorney for mental health care as follows. I revoke (cancel) any other power of attorney **for mental health care** documents I signed in the past.

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

b. Spouse or partner.

☐ Does not apply. I didn't name my spouse or partner as an agent or alternate.

☐ One of the agents or alternates named above is my spouse or domestic partner. If we divorce or legally separate (*check one*):

☐ Their authority to act as my agent is revoked.

☐ They will continue to have authority to act as my agent.

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

d. 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.

e. Revocation. I understand that I may revoke this power of attorney at any time by giving written notice of revocation to my agent.

f. Powers. My agent shall have full power and authority to make mental health treatment decisions on my behalf, consistent with any instructions and/or limitations in this directive. If my agent does not know my wishes, I authorize my agent to make the decision that my agent determines is in my best interest.

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

h. **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.

20. Other documents

In planning for my health care, estate, and potential incapacity, I have signed the following documents (*check all that apply and attach copies, if possible*):

☐ Durable Power of Attorney for Health Care (**not** mental health)

☐ Durable Power of Attorney for Finances

☐ Health Care Directive ("Living Will")

☐ Other (*Examples: POLST, Advance Directive for Voluntary Stopping of Eating and Drinking (VSED)*):

_____

_____

I understand the purpose and effect of this Advance Directive for Living with Dementia. I understand consent to treatment or admission in this directive constitutes my informed consent. 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 _____.

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

On (*date*): _____, (*name*): _____ signed this Advance Directive for Living with Dementia in my presence. This person is personally known to me or provided proof of identity. I believe they are able to make health care decisions, to understand this document, and to have signed it voluntarily. They don't appear to be acting under duress, undue influence, or fraud.

I am **not**:

- A person designated to make medical decisions for them
- A health care provider or professional directly involved in their care at the time the directive is made
- An owner, operator, employee, or relative of an owner or operator of a health care facility or long-term care facility where they are a patient or resident
- A person related by blood, marriage, or adoption to them
- In a dating relationship with them (see RCW 7.105.010)
- A minor or incapacitated person
- A person who would benefit financially if they undergo mental health treatment

Witness 1

▶ _____
Signature

Print Name: _____

Address: _____

_____

Phone: _____

Witness 2

▶ _____
Signature

Print Name: _____

Address: _____

_____

Phone: _____

Advance Directive for Living with Dementia
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 for Health Care** that let someone else (an "agent") make health care decisions for me if I'm not able.

My health care agent (if any)

Name _____

Relationship to me (*Examples: friend, partner, spouse, sister, etc.*)

_____

Phone _____

Email _____

My alternate health care agent (if any)

Name _____

Relationship to me (*Examples: friend, partner, spouse, sister, etc.*)

_____

Phone _____

Email _____

My 2nd alternate health care agent (if any)

Name _____

Relationship to me (*Examples: friend, partner, spouse, sister, etc.*)

_____

Phone _____

Email _____

Record of Directive

I've given a copy of this directive to the following people:

Advance Directive for Living with Dementia
Optional Attachment:
Personal History and Care Values

I want my caregivers, family, and friends to know and remember who I am and what is important to me for when I may not be able to remember or fully express this.

Important people in my life:

My education, work history, skills, accomplishments:

Things I love to do or to experience:

Important events in my life:

How I would like caregivers, family, and friends to treat and care for me if I can no longer say (*Examples: Treat me as an adult, not a child; allow me privacy when dressing, bathing, and toileting; help me maintain my personal hygiene and appearance.*):