DISCLAIMER: This model form is for informational purposes only, and does not constitute legal advice. Laws relating to powers of attorney are state specific. We recommend you speak to an attorney before completing any form to make sure that your form meets all legal requirements.

DISTRICT OF COLUMBIA DURABLE POWER OF ATTORNEY FOR HEALTH CARE WITH SPECIAL PROVISIONS FOR SUPPORTED DECISION-MAKING

INFORMATION ABOUT THIS DOCUMENT

This is an important legal document, which is governed by D.C. Code §§ 21-2205 to 21-2209, as amended. Before signing this document, it is vital for you to know and understand these facts:

- This document gives the person you name as your attorney-in-fact the power to make health-care decisions for you if you cannot make the decisions for yourself.
- After you have signed this document, you have the right to make health-care decisions for yourself if you have not been certified to be incapacitated to do so. In addition, after you have signed this document, no treatment may be given to you or stopped over your objection if you have not been certified to be incapacitated to make that decision.
- You may state in this document any type of treatment that you do not desire and any that you want to make sure you receive.
- You have the right to take away the authority of your attorney-in-fact, unless you have been adjudicated incapacitated, by notifying your attorney-in-fact or health-care provider either orally or in writing. Should you revoke the authority of your attorney-in-fact, it is advisable to revoke in writing and to place copies of this revocation wherever this document is located. 3
- You should keep a copy of this document after you have signed it. Give a copy to the person(s) you name as your attorney(s)-in-fact. If you are in a health-care facility, a copy of this document should be included in your medical record.

POWER OF ATTORNEY FOR HEALTH CARE

I, _____, currently residing at _____, hereby appoint _____, who currently resides at _____, and whose current telephone number is _____, as my attorney-in-fact to make health-care decisions for me, in the event I am certified to be incapacitated to make my own decisions, even with support (see "Special Provisions and Limitations" below).

In the event I am certified to be incapacitated, my attorney-in-fact shall have all the rights, powers and authority related to health-care decisions that I would have under state, District of Columbia, and federal law. This authority shall include, at a minimum:

1) The authority to grant, refuse or withdraw consent to the provision of any health-care service, treatment, or procedure;

2) The right to review my health care records, talk to health-care personnel, be provided with all information necessary to make informed health-care decisions (see Section B.1 of the "Special Provisions and Limitations" below);

3) The authority to select and discharge health-care professionals; and

4) The authority to make decisions regarding admission to or discharge from health-care facilities and to take any lawful actions that may be necessary to carry out these decisions.

If the person named above as my attorney-in-fact is not available or is unable to act as my attorney-in-fact, I appoint the following persons to serve in the order listed below.

1) _____
Name

_____
Home Address

_____
Telephone Number

2) _____
Name

_____
Home Address

_____
Telephone Number

With this document, I intend to create a power of attorney for health care, which shall allow my attorney-in-fact to act for me if I am certified to be incapacitated to make my own health-care decisions and shall continue during that incapacity.

My attorney-in-fact shall make health-care decisions and act as I direct below or as I make known to my attorney-in-fact in some other way.

(A) STATEMENT OF DIRECTIVES CONCERNING LIFE-PROLONGING CARE, TREATMENT, SERVICES, AND PROCEDURES:

_____
_____
_____
_____
_____

(B) SPECIAL PROVISIONS AND LIMITATIONS:

1) Effective immediately after I sign this Power of Attorney, I authorize all health care providers to release, and I give consent to the use and disclosure of, health information about me to my attorney-in-fact for treatment and advocacy purposes, pursuant to the District of Columbia Mental Health Information Act of 1978, as amended (D.C. Code §§ 7-1201.01 et seq., specifically § 7-1202.01); the D.C. Citizens with Intellectual Disabilities Act, as amended (D.C. Code § § 7-1301.01 et seq., specifically § 7-1305.12);

the Health Insurance Portability and Accountability Act of 1996 as amended (Pub. L. 104-191), and other local and federal privacy laws and regulations. I specifically authorize my attorney-in fact to request, receive, and review any information regarding my physical and/or mental health, including my medical records from physicians, hospitals, or outpatient clinics, and/or any records relating to the services and/or care provided by or through the DC Department of Health Care Finance (DHCF), the DC Department on Disability Services (DDS), and the DC Department of Behavioral Health (DBH), and any successor agencies.

2) Except as described in Section B.1 above, my attorney-in-fact will have the authority to act for me with respect to health care only in the event I am certified to be incapacitated to make my own decisions, even with support, either temporarily or permanently. Such mental incapacity must be certified, in writing, in accordance with D.C. Code § 21-2204, by both a physician and either a qualified psychologist or psychiatrist, who also are required to state the cause and nature of the mental incapacity and its extent and probably duration.

3) Until such time as the certifications in Section B.2 are made, my attorney-in-fact will give me the support I need and want to make my own decisions. This means my attorney-in-fact will help me understand the situations I face and the decisions I have to make. Therefore, at times when my attorney-in-fact does not have full power to make any decision(s) for me, s/he will provide support to make sure I am able to make decisions to the maximum of my ability, with me being the final decision-maker.

4) In the event the certifications in B.2 are made, my attorney-in-fact will follow my expressed or known wishes regarding health care services, service providers, and activities that I want or need. I am able to communicate what I like and dislike about the activities and service providers that work with me. I prefer to receive services and supports in my own home.

In the event that I become incapacitated for a prolonged time period and this Power of Attorney and my Advance Directive are not sufficient to address all my needs, it may become necessary for a court to appoint a guardian or a conservator for me. If that is the case, I nominate my current attorney-in-fact to serve as my guardian or conservator, only with respect to my needs that are <u>not</u> addressed in this Durable Power of Attorney for Health Care.

My attorney(s) in fact will serve without any compensation, except for reimbursement for out-of-pocket expenses spent while acting on my behalf.

EVEN IF I BECOME INCAPACITATED OR DEEMED INCOMPETENT BY A COURT OF LAW THIS POWER OF ATTORNEY WILL CONTINUE TO BE EFFECTIVE.

I agree that any third party who receives a copy of this document may act under it. Revocation of the power of attorney is not effective as to a third party until the third party learns of the revocation either orally or in writing. i agree to indemnify the third party for any claims that arise against the third party because of reliance on this power of attorney.

DISCLAIMER: This model form is for informational purposes only, and does not constitute legal advice. Laws relating to powers of attorney are state specific. We recommend you speak to an attorney before completing any form to make sure that your form meets all legal requirements.

BY MY SIGNATURE I INDICATE THAT I UNDERSTAND THE PURPOSE AND EFFECT OF THIS DOCUMENT.

I sign my name to this form on this __ day of_____, 2016 at _____. This same day, I have delivered to my attorney-in-fact and my alternative attorney-in-fact this power of attorney.

_____
(Signed Name)

_____
(Printed Name)

_____
(Social Security Number)

_____
(Date of Birth)

_____
(Address)

_____
(Home Phone Number)

WITNESSES:

I declare that the person who signed or acknowledged this document is personally known to me, that the person signed or acknowledged this power of attorney for health care in my presence, and that the person appears to be of sound mind and under no pressure, duress, fraud, or undue influence. I am not related to the person who signed this document by blood, marriage, or adoption, nor, to the best of my knowledge, am I entitled to any part of his estate by a current will or operation of law. I am not the person appointed in this document. I am not a health care provider or an employee of a health care provider who is now, or has been in the past, responsible for the care of the person signing the document.

First Witness

_____
(Signed Name)

_____
(Printed Name)

_____
(Address)

Second Witness

_____
(Signed Name)

_____
(Printed Name)

_____
(Address)

DISCLAIMER: This model form is for informational purposes only, and does not constitute legal advice. Laws relating to powers of attorney are state specific. We recommend you speak to an attorney before completing any form to make sure that your form meets all legal requirements.

DISTRICT OF COLUMBIA) SS:

I, _____, a Notary Public within and for the District of Columbia, do hereby certify that the foregoing Power of Attorney for Health Care was brought to me in the District of Columbia by _____ and was executed and acknowledged by him to be a free and voluntary act.

Subscribed and sworn to before me this_____day of_____2015.

_____
Notary Public

My Commission Expires: _____

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