

DIY Estate Plan Checklist:

- Last Will and Testament**
- Directions for Disposition of Remains and Funeral Instructions**
- Healthcare Directive**
- Physician Orders for Life Sustaining Treatment (POLST)**
- Mental Health Care Advance Directive**
- Durable Power of Attorney (POA) for Healthcare**
- Durable Financial Power of Attorney**

Lavender Rights Project

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Tips for Using Your Estate Plan:

Some tips about the future use of your Estate plan:

- Keep your Estate plan docs in a safe place, ideally a safe or safe deposit box
- Make digital copies if you are able to as well
- Make sure that all your agents/executors know where in your house/safe/safe deposit box that your documents are kept. Or just give them copies to have themselves
- WA state no longer has a Will or POA registry, but there are national registry systems if you want to use one of those
- Your POAs are the most likely to be used with more regularity or will have more occasion for use. Most of the time the copies of these will be fine-it is very rare that you will need to provide an original signed POA
- For the Wills- You will really only need this in the event of your death. However if that does happen, it is very important that the executors be able to access the original signed Will as soon as possible in the days immediately following your death
- **WA state requires that your executors must produce the Will copy to the Court Clerk within 45 days of your death.** All Estates must go through basic Will notice/filing upon death in WA. WA requires that after a person dies, the Courts officially must be notified so that a Judge can officially say that the estate was pre-determined by Will or Trust and to decide if Probate proceedings are needed to decide distribution or validity
- **Give a copy of your Healthcare Directive or POLST to your Doctor**
- If you own real property, you may have to record your power of attorney at the County Recorder's office
- If you would like to, write a letter explaining your Will decisions or Healthcare Decisions to your executors/agents to better inform them of your desires and to make your decisions very clear to those who will be performing them. Keep a letter copy with each of the documents
- Make sure your Healthcare Directives and POLSTs are readily available in case of medical emergency
- POLST copies should be on bright green paper

Resource Source List for DIY Estate Planning:

- The sample documents provided are from different non profit organizations which support folks with estate planning. Each type will offer a different style and different approach to estate language.
- Use the documents as they are or check out the websites for each organization to get additional sample forms.
- These forms have not been shared for profit and can not be shared or reproduced for profit or commercial use. Use these forms for personal use only.
- ***And DIY estate forms and instructions are not a substitute for professional personal legal advice.*** If you need in depth help, be sure to reach out to a qualified licensed estate attorney.
- You can print this entire packet and fill it out by hand or on a computer. You can also just print the individual documents that you may need.

1- Tips for Using Your Estate Plan from Lavender Rights Project (LRP)

2- Tips for Witnessing Issues from LRP

3- Suggestions for Power of Attorney agent issues from LRP

4- Last Will and Testament fill in the blank sample will- Adapted from the King County Bar Association sample Will at

<http://www.kcba.org/pbs/pdf/NLClinks/BasicWill.pdf>

2- Disposition of Remains and Funeral Instructions Form- made by Lavender Rights Project

3- Washington Durable Financial Power of Attorney Form - from Northwest Justice Project

https://www.washingtonlawhelp.org/files/C9D2EA3F-0350-D9AF-ACAE-BF37E9BC9FFA/attachments/392A5117-D581-FCE9-5EF2-E382E46B92AC/9608en_power-of-attorney-documents.pdf

4- Physician Orders for Life Sustaining Treatment (POLST) aka DNR- Should be printed on double sided green paper if possible.

<https://wsma.org/polst>

5- Durable Power of Attorney for Healthcare- from Northwest Justice Project

https://www.washingtonlawhelp.org/files/C9D2EA3F-0350-D9AF-ACAE-BF37E9BC9FFA/attachments/392A5117-D581-FCE9-5EF2-E382E46B92AC/9608en_power-of-attorney-documents.pdf

6- Health Care Directive (aka Living Will)- from Northwest Justice Project:

https://www.washingtonlawhelp.org/files/C9D2EA3F-0350-D9AF-ACAE-BF37E9BC9FFA/attachments/10774FF5-F531-4E8B-9F81-F384410CB53A/9607en_health-care-directive.pdf

7- Mental Health Care Directive- for those at risk of or with a history of institutionalization
<https://www.hca.wa.gov/assets/free-or-low-cost/mental-health-advance-directive-form.doc>

8- Values Worksheet for Living Wills from End of Life Washington-
<https://endoflifewa.org/wp-content/uploads/2012/10/Values.Worksheet.fillable.11.15.pdf>

9- Quick Info List for Executors, Survivors and Funeral Planners- from LRP

10- Notification List- from LRP

11-Important Info for my care and end of life- from LRP

12- After a Death Occurs Checklist from Legal Voice
<https://www.legalvoice.org/after-death-occurs-checklist>

Other good helpful resources for Life Planning:

- NOLO.com- Self help legal support
<https://www.nolo.com/>
- EndofLifeWa.org- DIY end of life document support for WA
<https://endoflifewa.org/>
- Recompose- alternative burial and body disposition options
<https://www.recompose.life/>

Make Sure Your DIY Estate Documents are Properly Witnessed:

LRP encourages all trans folks to make their estate documents as secure as possible by using both two uninterested witnesses for each document AND by having the documents witnessed and signed by all parties before a notary public.

Who is a good witness? A good witness is someone that you trust but whom is not mentioned in the documents that are being witnessed (meaning they are “uninterested”). Often this may be a friend, neighbor or coworker. Witnesses should never be people who will benefit if you were to die or receive healthcare treatment. Witnesses should not be your spouse, lover, partner or anyone related to you through dating, marriage, blood or adoption.

For your Will and/or Disposition of Remains (Funeral Instructions):

- WA requires two witnesses who meet the following requirements:
 1. Be of sound mind (not under duress, able to consent to be witness)
 2. Be of sound age (must be 18+)
 3. Must NOT have any interest in the claims of your Estate- which means they should not be beneficiaries of your Estate and if possible they should not be your Executor either. The witnesses should not be entitled to any portion of your estate upon your death under any Will or Codicil or by operation of existing law
 4. Must NOT be a person who is related by blood, marriage, or adoption to you, or with whom you have a dating relationship.
- Yourself and both witnesses should sign the document in front of a notary public who will then notarize the document.

For your Healthcare Directive and Mental Health Care Directive:

- WA requires two witnesses who meet the following requirements:
 1. Be of sound mind (not under duress, able to consent to be witness)
 2. Be of sound age (must be 18+)

6. Must NOT be a person designated to make medical decisions on your behalf
7. Must NOT be a health care provider or professional person directly involved with the provision of care to you at the time the directive is executed
8. Must NOT be an owner, operator, employee, or relative of an owner or operator of a health care facility or long-term care facility in which the you are a patient or resident
9. Must NOT be a person who would benefit financially if you were to undergo health treatment

What to do if you lack anyone to assign as your POA:

Use of a professional guardian is ok! But will involve fees.

<http://www.wa-pg.org/guardian-directory/>

That is the link for the WA Association of Professional Guardians directory.

A Court can also appoint you a POA/guardian when it is required.

Creating a POA that in the least requires that state appointed guardians must have cultural competency training as required under WA law.

**It may be "safer" though more costly to use a professional service in lieu of a casual acquaintance/
casual friend.**

Non Family Possible Ideas:

Social group members, Church members or church leaders if you have a personal relationship, social workers or therapists (there will be dual relationship conflicts of interest however to address), lawyers, professional trustees, any person who is connected to you with some other kind of group oversight. The most risky POA's are those who have no shared social overlap with you-this means that they have more power to abuse the relationship and go un-noticed.

LAST WILL AND TESTAMENT
OF

I, _____, being domiciled in the State of Washington, hereby revoke all previous Wills and Codicils and declare this to be my Will.

Article I

Family

My immediate family consists of the following persons:

Name	Relationship
_____	_____
_____	_____
_____	_____
_____	_____

Article II

Tangible Personal Property

I dispose of my tangible personal property as follows:

Initials: _____

Page __ of __

- A. If I leave written instructions concerning the disposition of nonbusiness tangible personal property, I give my interests in that property according to those instructions. I intend the instructions to be the "separate writing" permitted by RCW 11.12.260. The instructions may be amended at any time by notations in my handwriting or by subsequent instructions, and may be dated. However, the instructions shall have no effect unless they are known to my Executor at the time of distribution of the property.

Article III

Specific Gifts

- B. I leave the following Specific Gifts:

Article VI

Gift of Residue

- A. I leave the rest, residue and remainder of my estate as follows:

Initials: _____

Page __ of __

Article V

Limitation On Distributions To Minors

If any distributee under this Will is under age 25 at the time for the distribution of any benefits hereunder, and if such distribution would otherwise be made free of trust to said distributee, then the executor or trustee responsible for making the distribution shall have the discretion to deliver the distributee's share of the distribution to a suitable person selected by said executor or trustee (including such executor or trustee) as custodian for the distributee under the Washington Uniform Transfer to Minors Act (or a similar act in the state of the distributee's domicile).

Article VI

Personal Representatives

I make the following nominations and appointments:

A. Personal Representative of this Will: I name _____ as my personal representative. If for any reason he or she fails or ceases to act, I name _____ as his or her successor.

Article VII

Exclusions

A. I explicitly request that the following persons, which may include my biological family, be barred from exercising any power, control or decision making authority over my estate, my real property, my pets, my body, my remains, my healthcare, my end of life decisions, my burial, my funeral directions, my guardianship and my Will:

1. _____ (Name) _____ (Relation)
2. _____ (Name) _____ (Relation)
3. _____ (Name) _____ (Relation)
4. _____ (Name) _____ (Relation)
5. _____ (Name) _____ (Relation)

Initials: _____ Page __ of __

Article VIII

Name and Identifiers for Estate Matters

A. I explicitly request that the name used for all of my estate matters, including my funeral, my obituary and my headstone, is to be the following name:

B. I explicitly request that the gender and gender marker used for all of my estate matters, including my certificate of death, my funeral, my obituary and my headstone, is to be the following gender:

C. I explicitly request that the pronoun used for all of my estate matters, including my funeral, my obituary and my headstone, is to be the following pronoun:

Article IX:

Probate Administration

A. My Executor shall serve without bond and without the intervention of any court, except as may be required under the laws of the State of Washington in the case of nonintervention wills. Without limiting the generality of the foregoing, I grant to my Executor the full power, as I would have if living, to hold in its existing form, manage, sell, convey, exchange, mortgage, encumber, lease, invest, reinvest, or otherwise deal in and with, or dispose of my estate or any part thereof or interest therein, at such times and on such terms as in the sole judgment of my Executor shall be deemed to be in the best interests of my estate. My Executor shall have full power to lend money and to borrow money, secured or unsecured, from any source, including from the Executor; and to select any part of the estate in satisfaction of any partition or distribution hereunder, in kind, in money, or both. In addition, during the administration of my estate, my Executor shall have the authority and protection provided the Trustee with respect to administration of a trust established by this Will. Such powers may be exercised whether or not necessary for the administration of my estate.

B. All references to children and descendants shall include adopted persons. In the event any person not named or provided for herein claims to be an heir of mine and entitled to participate in my estate, I bequeath to such person the sum of One Dollar (\$1.00).

C. Unless some other meaning and intent is apparent from the context, the plural shall include the singular and vice versa, and masculine, feminine and neuter words shall be used interchangeably.

D. This Will shall be governed by the laws of the State of Washington. Any provision hereof which is prohibited by law or is unenforceable shall be inoperative, and all of the remaining provisions thereof, nevertheless, shall be given full force and effect.

IN WITNESS WHEREOF, I have signed this page and have initialed all pages hereof this _____ day of _____,

Initials: _____ Page ___ of ___

Declaration

We, the attesting witnesses to the Will of _____, under oath and subject to the penalty for perjury in the State of Washington, state that each of us was present and saw (him/her) _____ sign and declare this as (his/her) _____ Will, consisting of ___ pages and being the instrument of which this declaration is a part. Each of us believe (him/her) _____ to be of sound mind and memory and not under duress or constraint of any kind; and that each of us attested to the Will at his/her _____ request, and in (his/her) _____ presence, and in the presence of each other.

Date	Place of Signing	Signature
Print Name and Residence:		_____

Date	Place of Signing	Signature
Print Name and Residence:		_____

Initials: _____

STATE OF WASHINGTON)
) ss.
COUNTY OF _____)

Each of us whose signature appears below, being sworn, says that, on the day last above written, in the presence of each of us, _____ signed and declared the foregoing instrument, consisting of ___ pages, including this page, to be (his/her) _____ Will, and we have signed below as attesting witnesses, remaining in (his/her) _____ presence and in the presence of each other; and that we know _____, and (he/she) _____ appears to be of full age and sound and disposing mind and memory and competent in every respect to make a Will and not under any restraint, and we make this attestation and affidavit at (his/her) _____ request.

Witnesses:

_____	_____
Signature	Signature
_____	_____
Print Name	Print Name

SUBSCRIBED AND SWORN to before me this ____ day of _____, _____.

Print Name: _____
Notary Public in and for the State of
Washington
Residing at: _____

Commission expires: _____

Initials: _____

Page ___ of ___

**DIRECTIONS REGARDING DISPOSITION OF REMAINS AND
FUNERAL INSTRUCTIONS OF**

I, _____ being of sound mind,
voluntarily make known my wishes regarding the place and method of disposition of my
remains following my death as set forth below.

1. Disposition of Body

In the event of my death, I ask that my body be:

___ buried according to the following instructions:

___ cremated according to the following instructions:

___ or otherwise disposed of according to the following instructions:

In the event of my death, I request that my remains be given to the following people to do
with as requested by the direction I provide to them during my lifetime.

Name: _____ Relationship to Me: _____

Address: _____

Name: _____ Relationship to Me: _____

Address: _____

I exclude the following people from having any rights to the disposition of my remains:

2. Funeral Instructions

I ask that my funeral occur at a place and date as determined by the recipient of my remains. I request to be buried according to the instructions of whomever my remains are given to and according to the instructions of this instrument. I ask that at any funeral or memorial service for me, I be referred to as my this name: “_____” and with the pronouns, “_____” and as my correct gender, “_____” by all officiants and all speakers. If I have already arranged for a place of funeral and burial or cremation and inurnment, please find the instructions below:

_____.

I prefer:

____ A gravestone

____ An urn.

I trust whomever receives my remains to decide their resting place according to what they know of my desires and according to the instructions of this instrument. All obituary references related to my death shall name me only as “_____” and must use the correct gender and pronouns in reference to me, “_____.” I request that my obituary be written by _____ or _____ if possible.

My body is to be dressed for burial as instructed by the recipient of my remains and is to be dressed with clothing of my appropriate lived gender, which is _____.

Directions Regarding Disposition of Remains and Funeral Instructions
for _____

I prefer to be buried in the following outfit:

_____ If initialed here, I request that my funeral services not include any religious matter or anything of a religious nature from any religion at all whatsoever.

_____ If initialed here, I request that my funeral services include the following religious matter:

_____ If initialed here, is my express wish that under no circumstances are my biological family members allowed to plan my funeral or memorial services.

_____ If initialed here, it is my express wish that under no circumstances are my biological family members allowed to attend or speak at my funeral or memorial services unless said biological family members expressly agree to refer to me using only the name, pronoun and gender references as described in this document.

_____ If initialed here, _____ or _____ may ask my biological family members to leave my funeral for any reason at any time.

I direct that all of my family and survivors shall honor this authorization. I direct that no funeral home, cemetery, cremation authority, or memorial society shall be liable for arranging or for undertaking the disposition of my remains, if done in reliance on this authorization.

Signed this _____ day of _____ in the year of _____.

Signature of Declarant:

Printed Name and Date of Birth of Declarant:

DOB: _____

**AFFIDAVIT OF ATTESTING WITNESSES TO
THE DIRECTIONS REGARDING DISPOSITION OF REMAINS AND FUNERAL
INSTRUCTIONS OF _____**

WITNESSED ON _____ day of _____ in the year of _____.

I declare under penalty of perjury under the laws of the State of Washington that on the date set forth below in _____, Washington the person who executed the above Directions on the date set forth above has been and is personally known to me. I believe such person to be of sound mind, and that such person signed the foregoing Directions Regarding Disposition of Remains and Funeral Instructions willfully and voluntarily. I further declare that I am not:

1. A person who is related by blood, marriage, or adoption to the person, or with whom the principal has a dating relationship as defined in RCW 26.50.010;
2. entitled, to the best of my knowledge, to any portion of the person's estate upon Their death under any Will or Codicil or by operation of existing law;
3. An incapacitated person; or
4. A minor.

Witness:

Witness:

Signature of Witness

Signature of Witness

Print Name

Print Name

Address

Address

City, State ZIP

City, State ZIP

CERTIFICATE OF ACKNOWLEDGMENT OF NOTARY PUBLIC

I certify that I know or have satisfactory evidence that _____ is the person who appeared before me, and said person signed this instrument before me and acknowledged it to be their free and voluntary act for the uses and purposes mentioned in the instrument.

SUBSCRIBED AND SWORN to before me on this _____ day of _____, 20__.

NOTARY PUBLIC in and for the State of Washington,

residing _____, Washington. _____

My commission expires

on: _____

Directions Regarding Disposition of Remains and Funeral Instructions
for _____

Page __ of __



Durable Power of Attorney Documents

What is a power of attorney document?

A power of attorney document lets you choose a trusted friend or relative to help you with your finances and/or health care decisions. After you sign it, the person you choose will take the power of attorney document to your medical providers, bank, school, and other places to make decisions and sign contracts just as if he or she were you.

The trusted friend or relative you choose to help you with your finances and/or health care decisions is called your “agent.”

Do I need to sign my documents in front of a notary?

You must sign your Durable Power of Attorney document in front of either a notary or two witnesses. The two witnesses cannot be a health care provider in your home or long-term care facility nor can they be related to you by blood, marriage or state registered domestic partnership.

It is a good idea to sign your Durable Power of Attorney for Finances in front of a notary because some banks and government agencies require these documents to be notarized.

After you sign your documents, make two copies. Give the original document to your agent, give one copy to your alternate agent, and keep the second copy for yourself.

Can I change my Power of Attorney documents and choose a new agent?

You can revoke (cancel) your power of attorney document at any time with a written notice to your agent. A sample “Notice of Revocation” is included in this packet. You can also give a copy of this written notice to your medical providers, bank, school, and other places that might accept the old power of attorney document.

What if I need legal help?

If you live outside King County, call the CLEAR hotline Monday-Friday from 9:15 am to 12:15 pm at 1-888-201-1014. You can also apply online at <http://nwjustice.org/get-legal-help>.

If you live in King County, call 211 for information and referral to a legal services provider Monday-Friday from 8:00 am to 6:00 pm. You can find more information online at www.resourcehouse.com/win211/.

Deaf, hard of hearing or speech impaired callers can call CLEAR or 211 (or toll-free 1-877-211-9274) using the relay service of their choice.

This publication provides general information concerning your rights and responsibilities. It is not intended as a substitute for specific legal advice. This information is current as of August 2018.

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Durable Power of Attorney for Finances for

_____ [My Name]

1. **Agent.** I choose _____ as my Agent with full authority to manage my finances.
2. **Alternate.** If _____ is unable or unwilling to act, I choose _____ as my Agent with full authority to manage my finances.
3. **My Rights.** I keep the right to make financial decisions for myself as long as I am capable.
4. **Durable.** My Agent can use this power of attorney document to manage my finances even if I become sick or injured and cannot make decisions for myself. This power of attorney document shall not be affected by my disability.
5. **Start Date.** This power of attorney document is effective: (check one)
 - Immediately.
 - Only if my medical provider signs a letter saying I cannot make decisions for myself.
6. **End Date.** This power of attorney document will end if I revoke it or when I die. If my spouse or domestic partner is my Agent, this power of attorney document will end if either of us files for divorce in court.
7. **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 document at any time by giving written notice of revocation to my Agent.
8. **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, to open and remove items from any safe deposit box in my name, to sell, exchange or transfer title to stocks, bonds or other securities, and to sell, convey or encumber any real or personal property. My agent shall also have the following **special powers**: (check all that apply)

- create, amend, revoke, or terminate a living trust
- make gifts of my money or property
- create or change my rights of survivorship
- create or change my beneficiary designation(s)
- delegate some authority granted in this document to someone else
- waive my right to be the beneficiary of an annuity or retirement plan
- create, amend, revoke, or terminate my community property agreement
- tell a trustee to make distributions from a trust just as I could

9. **No Power to Agree to Binding Pre-Dispute Arbitration.** I recognize that some long-term-care providers will ask me or my Agent to sign a binding pre-dispute arbitration agreement. These agreements limit my right to sue the provider before any injury or dispute occurs. I think these agreements are unfair and unacceptable. Therefore, my agent does not have the power to agree to pre-dispute binding arbitration or any other process involving my person or property that limits my right to a jury, to sue for money, or to join a class action.

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

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

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/

/

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.

My Signature

Date

Notarization (optional, but recommended)

State of Washington

County of _____

I certify that I know or have satisfactory evidence that _____, is the person who appeared before me, signed above, and acknowledged that the signing was done freely and voluntarily for the purposes mentioned in this instrument.

SUBSCRIBED and SWORN to before me on _____.

SIGNATURE OF NOTARY

PRINT NAME OF NOTARY

NOTARY PUBLIC for the State of Washington.

My commission expires _____.

Witness 1

Signature

Name

Address

Witness 2

Signature

Name

Address

Revocation of Durable Power of Attorney
for

Finances

Health Care

I, _____, hereby revoke the Durable Power of Attorney I gave to

_____.

Signature

Date

Notarization (optional)

State of Washington

County of _____

I certify that I know or have satisfactory evidence that _____, is the person who appeared before me, signed above, and acknowledged that the signing was done freely and voluntarily for the purposes mentioned in this instrument.

SUBSCRIBED and SWORN to before me on _____.

SIGNATURE OF NOTARY

PRINT NAME OF NOTARY

NOTARY PUBLIC for the State of Washington.

My commission expires _____.

Glossary

Here are some terms you may find helpful when reading a power of attorney document:

- **Agent:** the trusted person you choose to help you with your finances or health care.
- **Beneficiary:** the person who gets money or property. For example, if you have life insurance and you die, the person who gets the insurance money is called a beneficiary. The person who gets money or property from a trust is also called a beneficiary.
- **Beneficiary Designation:** the part of a contract that says who should be the beneficiary. For example, the beneficiary designation in a life insurance policy is the part that says who will get the money after you die.
- **Binding Arbitration:** a process for resolving legal disputes with a company outside of a court. Usually, arbitration limits your right to a jury trial, limits the amount of money you can be awarded, and prevents you from bringing a class action lawsuit against the company. Also, arbitrators are usually picked by the company.
- **Community Property Agreement:** a written agreement between a married couple or domestic partners that says when one dies, all of their property will automatically go to the other.
- **Durable:** “Durable” means your document still has legal power and agent can keep helping you even if you become sick or injured and cannot make decisions for yourself.
- **Notary (or Notary Public):** a person who is licensed by the State to witness signatures on documents. You must sign your power of attorney document in front of a notary who will also sign the document and place an official notary stamp on it.
- **Personal Property:** things like cash, stocks, jewelry, clothing, furniture or cars.
- **Real Property:** buildings and land.
- **Revoke:** to cancel.
- **Rights of survivorship:** a written agreement between people who own property together. The agreement says when one co-owner dies, the other co-owner(s) automatically gets the property.
- **Trust:** a written agreement where money and property is owned by a trust and managed by one person (trustee) for the benefit of another person or people (beneficiary or beneficiaries). Usually you need to hire a lawyer to set up a trust.
- **Trustee:** the person who manages a trust.

HIPAA PERMITS DISCLOSURE OF POLST TO OTHER HEALTH CARE PROVIDERS AS NECESSARY

Physician Orders for Life-Sustaining Treatment (POLST)

Last Name - First Name - Middle Name or Initial

Date of Birth Last 4 #SSN (optional)

FIRST follow these orders, THEN contact physician, nurse practitioner or PA-C. The POLST is a set of medical orders intended to guide medical treatment based on a person's current medical condition and goals. Any section not completed implies full treatment for that section. Completing a POLST form is always voluntary. Everyone shall be treated with dignity and respect.

Medical Conditions/Patient Goals:

Agency Info/Sticker

A CARDIOPULMONARY RESUSCITATION (CPR): Person has no pulse and is not breathing.

Check One

- Attempt Resuscitation/CPR When not in cardiopulmonary arrest, go to part B.
- Do Not Attempt Resuscitation/DNAR (Allow Natural Death) Choosing DNAR will include appropriate comfort measures.

B MEDICAL INTERVENTIONS: Person has pulse and/or is breathing.

Check One

- FULL TREATMENT - primary goal of prolonging life by all medically effective means. Includes care described below. Use intubation, advanced airway interventions, mechanical ventilation and cardioversion as indicated. **Transfer to hospital if indicated. Includes intensive care.**
- SELECTIVE TREATMENT - goal of treating medical conditions while avoiding burdensome measures. Includes care described below. Use medical treatment, IV fluids and cardiac monitor as indicated. Do not intubate. May use less invasive airway support (e.g. CPAP, BiPAP). **Transfer to hospital if indicated. Avoid intensive care if possible.**
- COMFORT-FOCUSED TREATMENT - primary goal of maximizing comfort. Relieve pain and suffering with medication by any route as needed. Use oxygen, oral suction and manual treatment of airway obstruction as needed for comfort. **Patient prefers no hospital transfer: EMS consider contacting medical control to determine if transport is indicated to provide adequate comfort.**

Additional Orders: (e.g. dialysis, etc.)

C SIGNATURES: The signatures below verify that these orders are consistent with the patient's medical condition, known preferences and best known information. If signed by a surrogate, the patient must be decisionally incapacitated and the person signing is the legal surrogate.

Discussed with:

- Patient Parent of Minor
- Guardian with Health Care Authority
- Spouse/Other as authorized by RCW 7.70.065
- Health Care Agent (DPOAHC)

PRINT — Physician/ARNP/PA-C Name

Phone Number

Physician/ARNP/PA-C Signature (mandatory)

Date (mandatory)

PRINT — Patient or Legal Surrogate Name

Phone Number

Patient or Legal Surrogate Signature (mandatory)

Date (mandatory)

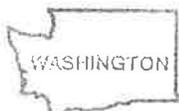
- Person has:
- Health Care Directive (living will)
 - Durable Power of Attorney for Health Care

Encourage all advance care planning documents to accompany POLST

SEND ORIGINAL FORM WITH PERSON WHENEVER TRANSFERRED OR DISCHARGED

Revised 8/2017

Photocopies and faxes of signed POLST forms are legal and valid. May make copies for records. For more information on POLST visit www.wsma.org/polst.



See back of form for non-emergency preferences ▶

HIPAA PERMITS DISCLOSURE OF POLST TO OTHER HEALTH CARE PROVIDERS AS NECESSARY

Patient and Additional Contact Information (if any)

Patient Name (last, first, middle)	Date of Birth	Phone Number
Name of Guardian, Surrogate or other Contact Person	Relationship	Phone Number

D NON-EMERGENCY MEDICAL TREATMENT PREFERENCES

ANTIBIOTICS:

- Use antibiotics for prolongation of life.
- Do not use antibiotics except when needed for symptom management.

MEDICALLY ASSISTED NUTRITION:

Always offer food and liquids by mouth if feasible.

- No medically assisted nutrition by tube.

- Trial period of medically assisted nutrition by tube. (Goal: _____)
- Long-term medically assisted nutrition by tube.

ADDITIONAL ORDERS: (e.g. dialysis, blood products, implanted cardiac devices, etc. Attach additional orders if necessary.)

<input checked="" type="checkbox"/> Physician/ARNP/PA-C Signature	Date
<input checked="" type="checkbox"/> Patient or Legal Surrogate Signature	Date

DIRECTIONS FOR HEALTH CARE PROFESSIONALS

Completing POLST

- Completing a POLST form is always voluntary.
- Treatment choices documented on this form should be the result of shared decision-making by an individual or their surrogate and medical provider based on the person's preferences and medical condition.
- POLST must be signed by a physician/ARNP/PA-C and patient, or their surrogate, to be valid. Verbal orders are acceptable with follow-up signature by physician/ARNP/PA-C in accordance with facility/community policy.

Using POLST

Any incomplete section of POLST implies full treatment for that section.

This POLST is valid in all care settings including hospitals until replaced by new physician's orders.

The POLST is a set of medical orders. The most recent POLST replaces all previous orders.

The POLST does not replace an advance directive. An advance directive is encouraged for all competent adults regardless of their health status. An advance directive allows a person to document in detail his/her future health care instructions and/or name a surrogate decision maker to speak on his/her behalf. When available, all documents should be reviewed to ensure consistency, and the forms updated appropriately to resolve any conflicts.

NOTE: A person with capacity may always consent to or refuse medical care or interventions, regardless of information represented on any document, including this one.

SECTIONS A AND B:

- No defibrillator should be used on a person who has chosen "Do Not Attempt Resuscitation."
- When comfort cannot be achieved in the current setting, the person should be transferred to a setting able to provide comfort (e.g., treatment of a hip fracture).
- An IV medication to enhance comfort may be appropriate for a person who has chosen "Comfort-Focused Treatment."
- Treatment of dehydration is a measure which may prolong life. A person who desires IV fluids should indicate "Selective" or "Full Treatment."

SECTION D:

- Oral fluids and nutrition must always be offered if medically feasible.

Reviewing POLST

This POLST should be reviewed periodically whenever:

- (1) The person is transferred from one care setting or care level to another, or
- (2) There is a substantial change in the person's health status, or
- (3) The person's treatment preferences change.

To void this form, draw line through "Physician Orders" and write "VOID" in large letters. Any changes require a new POLST.

Review of this POLST Form

Review Date	Reviewer	Location of Review	Review Outcome
			<input type="checkbox"/> No Change <input type="checkbox"/> Form Voided <input type="checkbox"/> New form completed
			<input type="checkbox"/> No Change <input type="checkbox"/> Form Voided <input type="checkbox"/> New form completed

SEND ORIGINAL FORM WITH PERSON WHENEVER TRANSFERRED OR DISCHARGED

Photocopies and faxes of signed POLST forms are legal and valid. May make copies for records.

For more information on POLST visit www.wsma.org/polst.

OVER ▶

Durable Power of Attorney for Health Care for

_____ [My Name]

1. **Agent.** I choose _____ as my Agent with full authority to manage my health care.
2. **Alternate.** If _____ is unable or unwilling to act, I choose _____ as my Agent with full authority to manage my health care.
3. **My Rights.** I keep the right to make health care decisions for myself as long as I am capable.
4. **Durable.** My Agent can still use this power of attorney document to manage my affairs even if I become sick or injured and cannot make decisions for myself. This power of attorney shall not be affected by my disability.
5. **Start Date.** This power of attorney document is effective on the day I sign it in front of a notary public.
6. **End Date.** This power of attorney document will end if I revoke it or when I die. If my spouse or domestic partner is my Agent, this power of attorney document will end if either of us files for divorce in court.
7. **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 document at any time by giving written notice of revocation to my Agent.
8. **Powers.** My Agent shall have full power and authority to do anything as fully and effectively as I could do myself, including 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, and to visit me at any hospital or other medical facility where I reside or receive treatment
9. **Mental Health Treatment.** 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. **No Power to Agree to Binding Pre-Dispute Arbitration.** I recognize that some long-term-care providers will ask me or my Agent to sign a binding pre-dispute arbitration agreement. These agreements limit my right to sue the provider before any injury or dispute occurs. I think these agreements are unfair and unacceptable. Therefore, my agent does not have the power to agree to pre-dispute binding

arbitration or any other process involving my person or property that limits my right to a jury, to sue for money, or to join a class action.

11. **Accounting.** My Agent shall keep accurate records of my financial affairs and show these records to me at my request.
12. **Nomination of Guardian.** I nominate my Agent as the guardian of my person for consideration by the court if guardianship proceedings become necessary.
13. **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.

My Signature

Date

Witness 1

Witness 2

Signature

Signature

Name

Name

Address

Address

Notarization (Optional)

State of Washington

County of _____

I certify that I know or have satisfactory evidence that _____, is the person who appeared before me, signed above, and acknowledged that the signing was done freely and voluntarily for the purposes mentioned in this instrument.

SUBSCRIBED and SWORN to before me on _____.

SIGNATURE OF NOTARY

PRINT NAME OF NOTARY

NOTARY PUBLIC for the State of Washington.

My commission expires _____.

Revocation of Durable Power of Attorney
for

Finances

Health Care

I, _____, hereby revoke the Durable Power of Attorney I gave to

_____.

Signature

Date

Notarization (optional)

State of Washington

County of _____

I certify that I know or have satisfactory evidence that _____, is the person who appeared before me, signed above, and acknowledged that the signing was done freely and voluntarily for the purposes mentioned in this instrument.

SUBSCRIBED and SWORN to before me on _____.

SIGNATURE OF NOTARY

PRINT NAME OF NOTARY

NOTARY PUBLIC for the State of Washington.

My commission expires _____.

Health Care Directive (or “Living Will”)

What is a health care directive?

It lets you state what kind of medical treatments you do or do *not* wish to have if you are terminally ill or permanently unconscious. A health care directive also lets you write down your health care values and any other directions to your medical providers.

Does it need to be notarized?

You should sign your health care directive in front of a notary. If you cannot find a notary, you can sign in front of two “disinterested” witnesses, but notarization is recommended.

What should I do after I sign it?

You should give it to your medical provider, your agent, and a trusted friend or relative.

Can I still make my own decisions?

Yes. You can still make your own health care decisions if you are capable. You can also change or cancel your directive at any time.

What does “revoke” mean?

It means to cancel. You can revoke your health care directive at any time and make a new one.

Are there other kinds of directives?

Yes. There are health care directives that let you state your preferences for mental health treatments and also for dementia care. You can find these other directives online at:

WashingtonLawHelp.org.

What if I need legal help?

Outside King County: Call 1-888-201-1014 weekdays, 9:15 a.m. - 12:15 p.m.

King County: Call 211 for info and referral to a legal services provider, weekdays 8:00 am – 6:00 pm. You can also call (206) 461-3200 or toll-free 1-877-211-WASH (9274). You can also get info on King County legal service providers at www.resourcehouse.com/win211/.

Deaf, hard of hearing or speech impaired callers can call CLEAR or 211 (or toll-free 1-877-211-9274) using the relay service of their choice.

CLEAR and 211 will conference in free interpreters when needed.

Free legal education publications, videos and self-help packets covering many legal issues are available at WashingtonLawHelp.org.

This publication provides general information concerning your rights and responsibilities. It is not intended as a substitute for specific legal advice. This information is current as of August 2019.

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Health Care Directive of

[My Name]

I am of sound mind and body and voluntarily execute this health care directive. If I cannot make decisions for myself about life sustaining medical treatment, my relatives, friends, agents and medical providers should fully honor every part of this directive. If any part of this directive is invalid, the remainder should be honored. I revoke any health care directives I have signed in the past.

1. **Withhold or Withdraw Treatment.** If my attending physician diagnoses me with a terminal condition, or if two physicians determine that I am in a permanent unconscious condition, and if my physician(s) determine that life-sustaining treatment would only artificially prolong the process of dying, the following treatment should be withheld or withdrawn from me:

(check all that apply)

- Artificial nutrition
- Artificial hydration
- Artificial respiration
- Cardiopulmonary Resuscitation (CPR), including artificial ventilation, heart regulating drugs, diuretics, stimulants, or any other treatment for heart failure
- Surgery to prolong my life or keep me alive
- Blood dialysis or filtration for lost kidney function
- Blood transfusion to replace lost or contaminated blood
- Medication used to prolong life, not for controlling pain
- Any other medical treatment used to prolong my life or keep me alive artificially

2. **Comfort Care and Pain Medication.** If I appear to be experiencing pain or discomfort, I want treatment and medications to make me comfortable, even if my medical providers believe it might unintentionally hasten my death.

3. **Health Care Institutions.** If I am admitted to a hospital or other medical institution that will not honor this directive due to religious or other beliefs: (1) my consent to admission is not implied consent to treatment, and (2) I want to be transferred as soon as possible to a hospital or other medical institution that will honor my directive.
4. **Changes and Revocation.** I understand that I can change the wording of this directive before I sign it. I also understand that I can revoke this directive at any time.
5. **Additional Directions:** I make the following additional directions regarding my care:

My Signature

Date

Notarization

State of Washington

County of _____

I certify that I know or have satisfactory evidence that _____, is the person who appeared before me, signed above, and acknowledged that the signing was done freely and voluntarily for the purposes mentioned in this instrument.

Date

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

Glossary

Here are some terms you may find helpful when reading a health care directive:

- **Attending Physician:** the physician selected by, or assigned to you and who has primary responsibility for your treatment and care.
- **Disinterested Witness:** a person who is not related to you, will not inherit from you, and is not your medical provider.
- **Life-sustaining treatment:** any mechanical or artificial medical intervention that, when applied to a person diagnosed with a terminal condition or a person in a permanent unconscious condition, would only prolong the process of dying. Life-sustaining treatment does not include medication or medical intervention necessary to alleviate pain only.
- **Permanent unconscious condition:** an incurable and irreversible condition; a condition where a person has no reasonable probability of recovery from an irreversible coma or a persistent vegetative state according to reasonable medical judgment.
- **Physician:** a person licensed under Washington State physician and osteopathy laws.
- **Revoke:** to cancel.
- **Terminal condition:** an incurable and irreversible condition caused by injury, disease, or illness, that will cause death within a reasonable period of time according to accepted medical standards, and where the application of life-sustaining treatment serves only to prolong the process of dying.

Mental Health Advance Directive
NOTICE TO PERSONS
CREATING A MENTAL HEALTH ADVANCE DIRECTIVE

This is an important legal document. It creates an advance directive for mental health treatment. Before signing this document you should know these important facts:

(1) This document is called an advance directive and allows you to make decisions in advance about your mental health treatment, including medications, short-term admission to inpatient treatment and electroconvulsive therapy.

YOU DO NOT HAVE TO FILL OUT OR SIGN THIS FORM.
IF YOU DO NOT SIGN THIS FORM, IT WILL NOT TAKE EFFECT.

If you choose to complete and sign this document, you may still decide to leave some items blank.

(2) You have the right to appoint a person as your agent to make treatment decisions for you. You must notify your agent that you have appointed him or her as an agent. The person you appoint has a duty to act consistently with your wishes made known by you. If your agent does not know what your wishes are, he or she has a duty to act in your best interest. Your agent has the right to withdraw from the appointment at any time.

(3) The instructions you include with this advance directive and the authority you give your agent to act will only become effective under the conditions you select in this document. You may choose to limit this directive and your agent's authority to times when you are incapacitated or to times when you are exhibiting symptoms or behavior that you specify. You may also make this directive effective immediately. No matter when you choose to make this directive effective, your treatment providers must still seek your informed consent at all times that you have capacity to give informed consent.

(4) You have the right to revoke this document in writing at any time you have capacity.

YOU MAY NOT REVOKE THIS DIRECTIVE WHEN YOU HAVE BEEN FOUND TO BE INCAPACITATED UNLESS YOU HAVE SPECIFICALLY STATED IN THIS DIRECTIVE THAT YOU WANT IT TO BE REVOCABLE WHEN YOU ARE INCAPACITATED.

(5) This directive will stay in effect until you revoke it unless you specify an expiration date. If you specify an expiration date and you are incapacitated at the time it expires, it will remain in effect until you have capacity to make treatment decisions again unless you chose to be able to revoke it while you are incapacitated and you revoke the directive.

(6) You cannot use your advance directive to consent to civil commitment. The procedures that apply to your advance directive are different than those provided for in the Involuntary Treatment Act. Involuntary treatment is a different process.

(7) If there is anything in this directive that you do not understand, you should ask a lawyer to explain it to you.

(8) You should be aware that there are some circumstances where your provider may not have to follow your directive.

(9) You should discuss any treatment decisions in your directive with your provider.

(10) You may ask the court to rule on the validity of your directive.

PART I.

**STATEMENT OF INTENT TO CREATE A
MENTAL HEALTH ADVANCE DIRECTIVE**

I, being a person with capacity, willfully and voluntarily execute this mental health advance directive so that my choices regarding my mental health care will be carried out in circumstances when I am unable to express my instructions and preferences regarding my mental health care. If a guardian is appointed by a court to make mental health decisions for me, I intend this document to take precedence over all other means of ascertaining my intent.

The fact that I may have left blanks in this directive does not affect its validity in any way. I intend that all completed sections be followed. If I have not expressed a choice, my agent should make the decision that he or she determines is in my best interest. I intend this directive to take precedence over any other directives I have previously executed, to the extent that they are inconsistent with this document, or unless I expressly state otherwise in either document.

I understand that I may revoke this directive in whole or in part if I am a person with capacity. I understand that I cannot revoke this directive if a court, two health care providers, or one mental health professional and one health care provider find that I am an incapacitated person, unless, when I executed this directive, I chose to be able to revoke this directive while incapacitated.

I understand that, except as otherwise provided in law, revocation must be in writing. I understand that nothing in this directive, or in my refusal of treatment to which I consent in this directive, authorizes any health care provider, professional person, health care facility, or agent appointed in this directive to use or threaten to use abuse, neglect, financial exploitation, or abandonment to carry out my directive.

I understand that there are some circumstances where my provider may not have to follow my directive.

**PART II.
WHEN THIS DIRECTIVE IS EFFECTIVE**

YOU MUST COMPLETE THIS PART FOR YOUR DIRECTIVE TO BE VALID.

I intend that this directive become effective (*YOU MUST CHOOSE ONLY ONE*):

. Immediately upon my signing of this directive.

. If I become incapacitated.

. When the following circumstances, symptoms, or behaviors occur: . . .

**PART III.
DURATION OF THIS DIRECTIVE**

YOU MUST COMPLETE THIS PART FOR YOUR DIRECTIVE TO BE VALID.

I want this directive to (*YOU MUST CHOOSE ONLY ONE*):

. Remain valid and in effect for an indefinite period of time.

. Automatically expire years from the date it was created.

**PART IV.
WHEN I MAY REVOKE THIS DIRECTIVE**

YOU MUST COMPLETE THIS PART FOR THIS DIRECTIVE TO BE VALID.

I intend that I be able to revoke this directive (*YOU MUST CHOOSE ONLY ONE*):

. Only when I have capacity.

I understand that choosing this option means I may only revoke this directive if I have capacity. I further understand that if I choose this option and become incapacitated while this directive is in effect, I may receive treatment that I specify in this directive, even if I object at the time.

..... Even if I am incapacitated.

I understand that choosing this option means that I may revoke this directive even if I am incapacitated. I further understand that if I choose this option and revoke this directive while I am incapacitated I may not receive treatment that I specify in this directive, even if I want the treatment.

PART V.

PREFERENCES AND INSTRUCTIONS ABOUT TREATMENT, FACILITIES, AND PHYSICIANS [, PHYSICIAN ASSISTANTS,] OR PSYCHIATRIC ADVANCED REGISTERED NURSE PRACTITIONERS

A. Preferences and Instructions About Physician(s), Physician Assistant(s), or Psychiatric Advanced Registered Nurse Practitioner(s) to be Involved in My Treatment

I would like the physician(s), physician assistant(s), or psychiatric advanced registered nurse practitioner(s) named below to be involved in my treatment decisions:

Dr., PA-C, or PARNP Contact information: . . .

Dr., PA-C, or PARNP Contact information: . . .

I do not wish to be treated by Dr. or PARNP. . . .

B. Preferences and Instructions About Other Providers

I am receiving other treatment or care from providers who I feel have an impact on my mental health care. I would like the following treatment provider(s) to be contacted when this directive is effective:

Name Profession Contact information. . . .

Name Profession Contact information. . . .

C. Preferences and Instructions About Medications for Psychiatric Treatment (*initial and complete all that apply*)

..... I consent, and authorize my agent (if appointed) to consent, to the following medications:

..... I do not consent, and I do not authorize my agent (if appointed) to consent, to the administration of the following medications:

..... I am willing to take the medications excluded above if my only reason for excluding them is the side effects which include. . . .

and these side effects can be eliminated by dosage adjustment or other means

..... I am willing to try any other medication the hospital doctor, physician assistant, or psychiatric advanced registered nurse practitioner recommends

..... I am willing to try any other medications my outpatient doctor, physician assistant, or psychiatric advanced registered nurse practitioner recommends

..... I do not want to try any other medications.

Medication Allergies

I have allergies to, or severe side effects from, the following:

Other Medication Preferences or Instructions

..... I have the following other preferences or instructions about medications.

D. Preferences and Instructions About Hospitalization and Alternatives

(initial all that apply and, if desired, rank "1" for first choice, "2" for second choice, and so on)

..... In the event my psychiatric condition is serious enough to require 24-hour care and I have no physical conditions that require immediate access to emergency medical care, I prefer to receive this care in programs/facilities designed as alternatives to psychiatric hospitalizations.

..... I would also like the interventions below to be tried before hospitalization is considered:

..... Calling someone or having someone call me when needed.

Name:

Telephone:

..... Staying overnight with someone

Name:

Telephone:

..... Having a mental health service provider come to see me

..... Going to a crisis triage center or emergency room

..... Staying overnight at a crisis respite (temporary) bed

..... Seeing a service provider for help with psychiatric medications

..... Other, specify:

Authority to Consent to Inpatient Treatment

I consent, and authorize my agent (if appointed) to consent, to voluntary admission to inpatient mental health treatment for days *(not to exceed 14 days)*

(Sign one):

..... If deemed appropriate by my agent (if appointed) and treating physician, physician assistant, or psychiatric advanced registered nurse practitioner

.....
(Signature)

or

..... Under the following circumstances (specify symptoms, behaviors, or circumstances that indicate the need for hospitalization)

.....
(Signature)

..... I do **not** consent, or authorize my agent (if appointed) to consent, to inpatient treatment

.....
(Signature)

Hospital Preferences and Instructions

If hospitalization is required, I prefer the following hospitals:

I do not consent to be admitted to the following hospitals:

E. Preferences and Instructions About Preemergency

I would like the interventions below to be tried before use of seclusion or restraint is considered *(initial all that apply)*:

..... "Talk me down" one-on-one

..... More medication

- Time out/privacy
- Show of authority/force
- Shift my attention to something else
- Set firm limits on my behavior
- Help me to discuss/vent feelings
- Decrease stimulation
- Offer to have neutral person settle dispute
- Other, specify

F. Preferences and Instructions About Seclusion, Restraint, and Emergency Medications

If it is determined that I am engaging in behavior that requires seclusion, physical restraint, and/or emergency use of medication, I prefer these interventions in the order I have chosen (choose "1" for first choice, "2" for second choice, and so on):

- Seclusion
- Seclusion and physical restraint (combined)
- Medication by injection
- Medication in pill or liquid form

In the event that my attending physician, physician assistant, or psychiatric advanced registered nurse practitioner decides to use medication in response to an emergency situation after due consideration of my preferences and instructions for emergency treatments stated above, I expect the choice of medication to reflect any preferences and instructions I have expressed in Part III C of this form. The preferences and instructions I express in this section regarding medication in emergency situations do not constitute consent to use of the medication for nonemergency treatment.

G. Preferences and Instructions About Electroconvulsive Therapy (ECT or Shock Therapy)

My wishes regarding electroconvulsive therapy are (sign one):

..... I do not consent, nor authorize my agent (if appointed) to consent, to the administration of electroconvulsive therapy

.....
(Signature)

..... I consent, and authorize my agent (if appointed) to consent, to the administration of electroconvulsive therapy

.....
(Signature)

..... I consent, and authorize my agent (if appointed) to consent, to the administration of electroconvulsive therapy, but only under the following conditions:

(Signature)

H. Preferences and Instructions About Who is Permitted to Visit

If I have been admitted to a mental health treatment facility, the following people are not permitted to visit me there:

Name:

Name:

Name:

I understand that persons not listed above may be permitted to visit me.

I. Additional Instructions About My Mental Health Care

Other instructions about my mental health care:

In case of emergency, please contact:

Name:

Address:

Work telephone:

Home telephone:

Physician, Physician Assistant, or Psychiatric Advanced Registered
Nurse Practitioner:

Address:

Telephone:

The following may help me to avoid a hospitalization:

I generally react to being hospitalized as follows:

Staff of the hospital or crisis unit can help me by doing the following:

J. Refusal of Treatment

I do not consent to any mental health treatment.

.
(Signature)

PART VI.

DURABLE POWER OF ATTORNEY (APPOINTMENT OF MY AGENT)

(Fill out this part only if you wish to appoint an agent or nominate a guardian.)

I authorize an agent to make mental health treatment decisions on my behalf. The authority granted to my agent includes the right to consent, refuse consent, or withdraw consent to any mental health care, treatment, service, or procedure, consistent with any instructions and/or limitations I have set forth in this directive. I intend that those decisions should be made in accordance with my expressed wishes as set forth in this document. If I have not expressed a choice in this document **and my agent does not otherwise know my wishes**, I authorize my agent to make the decision that my agent determines is in my best interest. This agency shall not be affected by my incapacity. Unless I state otherwise in this durable power of attorney, I may revoke it unless prohibited by other state law.

A. Designation of an Agent

I appoint the following person as my agent to make mental health treatment decisions for me as authorized in this document and request that this person be notified immediately when this directive becomes effective:

Name:

Address:

Work telephone:

Home telephone:

Relationship:

B. Designation of Alternate Agent

If the person named above is unavailable, unable, or refuses to serve as my agent, or I revoke that person's authority to serve as my agent, I hereby appoint the following person as my alternate agent and request that this person be notified immediately when this directive becomes effective or when my original agent is no longer my agent:

Name:

Address:

Work telephone:

Home telephone:

Relationship:

C. When My Spouse is My Agent *(initial if desired)*

. If my spouse is my agent, that person shall remain my agent even if we become legally separated or our marriage is dissolved, unless there is a court order to the contrary or I have remarried.

D. Limitations on My Agent's Authority

I do not grant my agent the authority to consent on my behalf to the following:

E. Limitations on My Ability to Revoke this Durable Power of Attorney

I choose to limit my ability to revoke this durable power of attorney as follows:

F. Preference as to Court-Appointed Guardian

In the event a court appoints a guardian who will make decisions regarding my mental health treatment, I **nominate** the following person as **my guardian**:

Name:

Address:

Work telephone:

Home telephone:

Relationship:

The appointment of a guardian of my estate or my person or any other decision maker shall not give the guardian or decision maker the power to revoke, suspend, or terminate this directive or the powers of my agent, except as authorized by law.

.
(Signature required if nomination is made)

**PART VII.
OTHER DOCUMENTS**

(Initial all that apply)

I have executed the following documents that include the power to make decisions regarding health care services for myself:

. Health care power of attorney (chapter 11.125 RCW)

. "Living will" (Health care directive; chapter 70.122 RCW)

. I have appointed more than one agent. I understand that the most recently appointed agent controls except as stated below:

**PART VIII.
NOTIFICATION OF OTHERS AND CARE OF PERSONAL AFFAIRS**

(Fill out this part only if you wish to provide nontreatment instructions.)

I understand the preferences and instructions in this part are **NOT** the responsibility of my treatment provider and that no treatment provider is required to act on them.

A. Who Should Be Notified

I desire my agent to notify the following individuals as soon as possible when this directive becomes effective:

Name:

Address:

Day telephone:

Evening telephone:

Name:

Address:

Day telephone:

Evening telephone:

B. Preferences or Instructions About Personal Affairs

I have the following preferences or instructions about my personal affairs (e.g., care of dependents, pets, household) if I am admitted to a mental health treatment facility:

C. Additional Preferences and Instructions:

**PART IX.
SIGNATURE**

By signing here, I indicate that I understand the purpose and effect of this document and that I am giving my informed consent to the treatments and/or admission to which I have consented or authorized my agent to consent in this directive. I intend that my consent in this directive be construed as being consistent with the elements of informed consent under chapter 7.70 RCW.

Signature:

Date:

Printed Name:

This directive was signed and declared by the "Principal," to be his or her directive, in our presence who, at his or her request, have signed our names below as witnesses. We declare that, at the time of the creation of this instrument, the Principal is personally known to us, and, according to our best knowledge and belief, has capacity at this time and does not appear to be acting under duress, undue influence, or fraud. We further declare that none of us is:

- (A) A person designated to make medical decisions on the principal's behalf;
- (B) A health care provider or professional person directly involved with the provision of care to the principal at the time the directive is executed;
- (C) An owner, operator, employee, or relative of an owner or operator of a health care facility or long-term care facility in which the principal is a patient or resident;
- (D) A person who is related by blood, marriage, or adoption to the person, or with whom the principal has a dating relationship as defined in RCW 26.50.010;
- (E) An incapacitated person;
- (F) A person who would benefit financially if the principal undergoes mental health treatment; or
- (G) A minor.

Witness 1: Signature:

Date:

Printed Name:

Telephone:

Address:

Witness 2: Signature:

Date:

Printed Name:

Telephone:

Address:

**PART X.
RECORD OF DIRECTIVE**

I have given a copy of this directive to the following persons:

DO NOT FILL OUT PART XI UNLESS YOU INTEND TO REVOKE

THIS DIRECTIVE IN PART OR IN WHOLE

**PART XI.
REVOCATION OF THIS DIRECTIVE**

(Initial any that apply):

..... I am revoking the following part(s) of this directive (specify):

..... I am revoking all of this directive.

By signing here, I indicate that I understand the purpose and effect of my revocation and that no person is bound by any revoked provision(s). I intend this revocation to be interpreted as if I had never completed the revoked provision(s).

Signature:

Date:

Printed Name:

**DO NOT SIGN THIS PART UNLESS YOU INTEND TO REVOKE THIS
DIRECTIVE IN PART OR IN WHOLE**



VALUES WORKSHEET

The following are questions you may want to consider as you make decisions and prepare documents concerning your health care preferences. You may want to write down your answers and provide copies to your family members and health care providers, or simply use the questions as "food for thought" and discussion.

How important to you are the following items?

	VERY IMPORTANT			NOT IMPORTANT	
	4	3	2	1	0
Letting nature take its course.	4	3	2	1	0
Preserving quality of life.	4	3	2	1	0
Staying true to my spiritual beliefs/traditions	4	3	2	1	0
Living as long as possible, regardless of quality of life.	4	3	2	1	0
Being independent.	4	3	2	1	0
Being comfortable and as pain free as possible.	4	3	2	1	0
Leaving good memories for my family and friends.	4	3	2	1	0
Making a contribution to medical research or teaching.	4	3	2	1	0
Being able to relate to family and friends.	4	3	2	1	0
Being free of physical limitations.	4	3	2	1	0
Being mentally alert and competent.	4	3	2	1	0
Being able to leave money to family, friends, or charity.	4	3	2	1	0
Dying in a short while rather than lingering.	4	3	2	1	0
Avoiding expensive care.	4	3	2	1	0

What will be important to you when you are dying (e.g., physical comfort, no pain, family members present, etc.)?

How do you feel about the use of life-sustaining measures in the face of terminal illness? Permanent coma? Irreversible chronic illness, such as Alzheimer's disease?

Do you have strong feelings about particular medical procedures? Some procedures to think about include mechanical breathing (respirator), cardiopulmonary resuscitation (CPR), artificial nutrition and hydration, hospital intensive care, pain relief medication, chemo or radiation therapy, and surgery.

What limitations to your physical and mental health would affect the health care decisions you would make?

Would you want to have financial matters taken into account when treatment decisions are made?

Would you want to be placed in a nursing home if your condition warranted?

Would you prefer Hospice care, with the goal of keeping you comfortable in your home during the final period of your life, as an alternative to hospitalization?

In general, do you wish to participate or share in making decisions about your health care and treatment?

Would you always want to know the truth about your condition, treatment options, and the chance of success of treatments?

Important Quick Information for My Executors and Funeral Planners:

Important Personal Information:

My current legal name is: _____

I have had the following previous legal names: _____

If you need a copy of my name change order, you can find it here:

My Date of Birth is: _____

I was born here: _____

Here is important information for my funeral and disposition of my body:

I have or have not completed a Will. If so, it can be found here: _____

I have or have not completed Funeral instructions. If so, it can be found here:

For Ceremony:

I do or do not want an end of life service.

If a service is performed, I prefer a:

Funeral (the body is present)

Memorial (the body will not be present)

I do or do not wish to have a viewing of my body at the services.

If a service is held, I prefer for it to be at the following location:

Notices:

I do or do not want notices published in the newspaper.

If so, please use the following name and gender identifiers:

And please publish in the following paper:

Memorialization and Gifts on my behalf:

I do or do not prefer memorial gifts in lieu of flowers. If memorials are requested, I ask that donations be sent to the following:

Organ and Tissue Donation:

I do or do not wish to donate my eyes at the time of my death to the eye bank.

If yes, contact: _____

I do or do not wish to donate such other organs, bones or tissue, at the time of death as may be considered medically useful. This also authorizes the donation of a pacemaker.

If yes, contact: _____

I do or do not wish to donate my full body to the University of Washington, Washington State University or other university willed body program for teaching or research purposes.

If yes, contact: _____

Other Important End of Life Decisions Information:

Information Required for my Death Certificate:

Full Legal Name:

Other names used/AKAs:

Personal Info:

Date of birth: _____

Birthplace: _____

Social Security Number: _____

Education Completed: _____

Sex: _____ Race: _____

Hispanic Identity: Yes No If yes, please describe: _____

Has ever served in Armed Forces? Yes No

Residence:

County of Residence: _____

Address:

Resided in County Since: _____

Residence is inside City limits: Yes No Unknown

Member of a tribal nation? Yes No If so, which tribe: _____

Tribal Reservation location:-

Marital Status:

Never Married Married Widowed Divorced Domestic Partner

Name and contact information of Spouse:

Occupation:

During most of my working life, I worked in the following field or occupation:

Parental Information:

My father's full name:

My mother's full maiden name:

Doctor's Information:

My Doctor's name is _____.

My doctor practices at the _____

Clinic or hospital whose address is:

Phone Number: _____

Other Important Information:

Notification List:

I would like the following people notified of my death:

Name:

Address:

Phone or Email:

1.	_____	_____	_____
2.	_____	_____	_____
3.	_____	_____	_____
4.	_____	_____	_____
5.	_____	_____	_____
6.	_____	_____	_____
7.	_____	_____	_____
8.	_____	_____	_____
9.	_____	_____	_____
10.	_____	_____	_____
11.	_____	_____	_____
12.	_____	_____	_____
13.	_____	_____	_____
14.	_____	_____	_____
15.	_____	_____	_____
16.	_____	_____	_____
17.	_____	_____	_____
18.	_____	_____	_____
19.	_____	_____	_____
20.	_____	_____	_____
21.	_____	_____	_____
22.	_____	_____	_____

- 23. _____
- 24. _____
- 25. _____
- 26. _____
- 27. _____
- 28. _____
- 29. _____
- 30. _____
- 31. _____
- 32. _____
- 33. _____
- 34. _____
- 35. _____
- 36. _____

IMPORTANT INFO FOR MY CARE AND MY END OF LIFE:

- I am responsible for the following children, vulnerable adults, and/or pets. Please check on their welfare immediately in case of my incapacitation or death:

- The following is my important contact and identifying information:

Current legal name: _____

Social Security Number: _____

Current address: _____

Current Phone: _____

Current guardian or caregiver if any, and their contact info: _____

- I have completed the following estate documents and their location is listed next to each document:

_____ Last Will and Testament: _____

_____ Remains and Funeral Instructions: _____

_____ Financial Power of Attorney: _____

_____ Health Power of Attorney: _____

_____ Health Care Directive: _____

_____ POLST Form: _____

_____ Mental Health Care Directive: _____

- In my Will, I named the following people as my Executor and back up executors:

- In my POA and Health Care Directive I named the following as my agent and back up agents:

- I receive the following payments from a pension, SSDI, SSI, etc:

Type: _____
Amount: _____
Frequency: _____
Account or address payment received by: _____

Type: _____
Amount: _____
Frequency: _____
Account or address payment received by: _____

Type: _____
Amount: _____
Frequency: _____
Account or address payment received by: _____

- I have Insurance Policies that are described and can be found in the following locations:

- I have the following bank accounts:

Account Number: _____
Located at the following bank:

Account Number: _____
Located at the following bank:

Account Number: _____

Located at the following bank:

- I have the following other financial accounts, stocks or retirement plans:

Account Number: _____

Account type: _____

Located at the following institution:

Account Number: _____

Account type: _____

Located at the following institution:

Account Number: _____

Account type: _____

Located at the following institution:

Account Number: _____

Account type: _____

Located at the following institution:

Account Number: _____

Account type: _____

Located at the following institution:

- I have an attorney. The attorney's name and firm info is:

- I have a safety deposit box:

The Key can be found here: _____

Account/Box Number: _____

Located at the following bank:

- I have a storage unit:

The Key can be found here: _____

Account/Unit Number: _____

Located at the following storage facility:

- I own the following real estate. Listed below are the Parcel Numbers, the real addresses, the bank which hold a mortgage if any on the property and the location of the deeds:

Parcel #: _____

Address: _____

Bank or Lienholder: _____

Location of Deed: _____

Parcel #: _____

Address: _____

Bank or Lienholder: _____

Location of Deed: _____

Parcel #: _____

Address: _____

Bank or Lienholder: _____

Location of Deed: _____

Parcel #: _____

Address: _____

Bank or Lienholder: _____

Location of Deed: _____

- I own the following vehicles. Listed below are the license numbers, the make, year and model, the bank which hold a mortgage if any on the vehicle and the location of the title:

Tag #: _____

Make, Model, year: _____

Bank or Lienholder: _____

Location of Title: _____

Tag #: _____

Make, Model, year: _____

Bank or Lienholder: _____

Location of Title: _____

Tag #: _____

Make, Model, year: _____

Bank or Lienholder: _____

Location of Title: _____

- The location of my computer accounts information logins and passwords are listed below or the information itself is listed below:

- Information for other valuables, stocks, bonds or any other important items or information is listed below:

I compiled this information on this date: _____

Signed: _____

Printed Name: _____

AFTER A DEATH OCCURS – A Checklist

Here is a checklist of important things to do when someone close to you dies.

This can be a very overwhelming and emotional time. It is a good idea to read this checklist before a death occurs, in order to plan and understand the practical steps of this difficult process.

It is also helpful to keep all your important information in one location and tell someone where you keep it.

The words “deceased” and “decedent” mean “the person who died.” “Estate” is the property belonging to the person who died.

1. Immediate Steps

- Call 911 right away if there is an unexpected death in your home. The medical team will help you figure out the next steps. If the deceased was receiving hospice care, call the hospice.
- Call your doctor or your hospice before an expected death, to discuss what to do when or if a death happens in your home.
- Most deaths occur in hospitals and other places such as nursing homes. Talk to the staff about their process.
- Contact close family and/or friends of the deceased, the deceased’s doctor (if a hospice is not involved), and the deceased’s lawyer, if any.
- Look for any written instructions (sometimes called a “Letter of Instruction,” “Final Instructions”, or “Disposition Authorization”) for funeral or memorial service arrangements, and burial or cremation arrangements. Also look to see if the deceased named a “Designated Agent” to take care of those arrangements (sometimes this is included in the deceased's advance directive documents such as in their Durable Power of Attorney for Health Care). If not found, ask close friends, the deceased's doctor or the deceased’s lawyer if they know where these instructions are. Ask if there are any pre-paid services.
- Look for records of the deceased person’s desire to donate organs or tissue (usually noted on a Washington State driver’s license with a red heart symbol or the word “Donor,” or mentioned in the deceased’s “Final Instructions”). Give this information to the deceased’s doctor or hospice immediately (or before the death, if possible).



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- If you are the named "Designated Agent" (or if none, if you are the person allowed by Washington State law such as the surviving spouse, adult children, parents, or siblings), you should arrange for funeral or memorial services, and burial or cremation. Washington State usually requires embalming if the body will be held or transported more than 24 hours after death. See the listings under Funerals in the Resources section at the end of this document.

- Death Certificates:** You can order certified copies of the death certificate from the funeral director or your hospice. Often you can get them from the local Department of Health office in the county where the death occurred. See the listings under For Death Certificates and Notification of Death in the Resources section at the end of this document.

Generally, you will need one certified copy of the death certificate for each major asset, such as cars, land, or bank accounts, for which you will need to transfer ownership. You may also need a certified copy for items such as life insurance policies, veterans' survivor benefits, and annuities. Certified copies are expensive (approximately \$20- \$32 each, plus fees). Ask if a non-certified photocopy is allowed, or if the company would return the original certified copy to you so you could use it later.

2. Next Steps - Locate Important Papers

Find the deceased's important papers and documents as soon as possible. If necessary, ask close family, friends, or the deceased's doctor or lawyer if they know where these important papers can be found, and the location of a bank safety deposit box, if any.

In Washington State safety deposit boxes of the deceased are not sealed. Anyone who has legal access has the right to open the safety deposit box. (See the For More Information section at the end of this document to learn what to do if there is no one available with access to the safety deposit box.)

- The Will** – First, find out if the deceased left a Will and/or a trust.

If there is a Will, notify the Personal Representative named in the Will (and the Trustee, if named in a trust) right away. The Personal Representative is responsible for taking care of the deceased's estate and for following the terms of the Will, while the Trustee is responsible for managing the trust. Sometimes the Personal Representative is called the "Executor" or "Executrix".

In Washington, a valid and signed Will must be filed with the Superior Court, usually in the deceased's county of residence, within 30 days of the death. This is an extremely important step to complete if there is a Will.

If there is a Will and/or trust, give all of the important papers to the Personal Representative and/or Trustee as soon as possible.

If there is no Will, the court will administer the estate according to Washington State law.

For more information about wills, estate administration and what happens when there is no will, see the listings under [Estate Administration and Legal Help](#) in the Resources section at the end of this document

- Other Items** – Locate other important papers and documents as soon as possible.

Here is a list of some things to look for:

Deeds and Titles

- Property deeds (including any recent appraisals)
- Mortgage documents (and promissory/loan notes)
- Vehicle titles and registrations (car, boat, RV, etc.)
- Membership certificates

Insurance Policies

- Life insurance (including premium payment records)
- Accidental life insurance
- Veterans' insurance
- Employers or pension insurance
- Funeral insurance (or other death-related benefit plans)
- Mortgage and/or credit insurance
- Credit card insurance (for balances)
- Health insurance (including Medicare or Medicaid, "Medigap" insurance, private health insurance, dental, and long term care insurance)
- Property insurance (homeowners/renters insurance, car insurance, etc.)
- Workers' compensation insurance (and payment records)

Financial Accounts

Including most recent statements for all accounts and the list of Beneficiaries, if any.

- Bank accounts - checking, savings, CD's, etc.
- Investment/brokerage accounts, IRA's, 401-K's, etc.
- Stocks and bonds
- Annuities
- Credit and debit card accounts
- List of safety deposit boxes, where to find keys, and names of authorized users

Other Financial Records

- Survivor annuity benefit papers
- Employer/retirement benefit (pension) plans, pension/profit-sharing plans, etc.
- Veterans' benefit records

- Disability payment documents (State, Veterans', etc.)
- Income tax returns (from the current year)
- Gift tax returns (for all years)
- Property tax records and statements
- Business interests held, financial statements and agreements, contracts, etc.
- Loan papers
- Other - investment records, etc.

Legal Papers

- Court documents for adoptions and divorce (including any property settlement agreements, name changes, prenuptial agreements, etc.)
- Military service papers, including discharge records
- Will and/or trusts
- Deceased's Final Instructions, Disposition Authorization, and/or Designated Agent forms (sometimes included in an advance directive such as a Durable Power of Attorney for Health Care)
- Pre-paid funeral contracts
- Organ/tissue donation record
- Social Security card (or number)
- Birth certificates (of all family members)
- Marriage license or certificate
- Community property agreements
- Domestic Partnership Registration
- Driver's license
- Passport, citizenship, immigration and/or alien registration papers

Personal Information

- Names and contact information of closest family and friends
- Names and contact information of all lawyers, accountants, doctors, etc.
- Family Tree, if available (especially if there is no Will).

3. Practical Steps and Information

- Make a list of regular bills to have as a reminder. Be sure to note if any are on automatic payment plans and note when payments are due.
- Give all unpaid bills to the Personal Representative (if any) to be paid.
Some examples of bills to locate:
 - Utility bills (electric, heating, telephone, cell phones, water/sewer/garbage, etc.)
 - Long term debts (home mortgages, bank line of credit, car loans, etc.)
 - Rental fees (home, apartment, assisted living, or nursing home, etc.)
 - Credit card bills
 - Insurance bills (health, long term care, home, car, life insurance, etc.)
 - Property tax bills (if paid separately and not included in home mortgage)

- Access to bank accounts: If you are a co-signer or have a joint account with the deceased, you should be able to use some of the money in the account to pay the regular bills of the deceased. Keep detailed records of all the bills you pay and any withdrawals of cash from the account.
- Power of Attorney: If you were the holder of a Power of Attorney (sometimes called an “attorney-in-fact” or the “agent”) for the deceased, your authority to act under the Power of Attorney ends at the time of death. The only exception to this is if you were also listed in the Power of Attorney as the deceased's "Designated Agent" for after-death arrangements. In this case, you will have the authority to make funeral or memorial arrangements as well as burial or cremation arrangements.
- Check and take care of the deceased’s home, property, and pets, if necessary. Put valuables (cash, jewelry, collectible items) in a safe place. Be sure the house is locked, if no one is home.
- Contact the Post Office (listed in the telephone directory as United States Postal Service) with forwarding information, if necessary. Stop all deliveries of unneeded newspapers, home care services (such as meal delivery or nursing services), and cancel any appointments for doctors, dentists, etc.
- Cancel services that are no longer needed (such as cell phones, internet, or cable TV). Do not cancel utilities, as they may still be needed.

4. Notification of Death (and Check for Benefits)

Once you have notified all close family and friends, the deceased’s doctor and lawyer (if any), and the Personal Representative and/or Trustee (if one is named in a Will and/or trust), you should give notice of the death as soon as possible to the agencies and companies listed below.

At the same time, you should check and apply for any death benefits or survivor benefits from these organizations. This is money paid after a death to the person or persons named as “beneficiary”. A “beneficiary” is a person who receives money or property, such as from the deceased’s life insurance policy, retirement pension, or annuity.

It can take two or more months for benefits to arrive, so be sure to start soon. Call these offices to find out their requirements, such as sending a certified copy of the death certificate. Make a note with the date you made your calls, and write down what is required as a reminder of what you need to do. Contact information for some of these offices is listed in the Resources section below.

Here is a list of some agencies and companies to notify:

Social Security: You must notify the Social Security Administration of the death, and apply for any possible Social Security death benefits and survivors' benefits. You will need the deceased's Social Security number and date of birth. The Social Security office automatically notifies Medicare of the death. For information on Survivors' benefits see the Resources section at the end of this document.

Date & Notes: _____

Insurance Companies: Contact all the insurance companies on the list you made from the deceased's records. This includes policies that might pay death benefits to the beneficiary or beneficiaries named in the policy (such as life insurance or annuities). Contact an insurance company if you see its policy might pay for account balances (such as for mortgages, credit cards or other loans).

Date & Notes: _____

All other insurance companies (property insurance, health and dental insurance, long term care insurance, etc.): Notify each of the death so that the policy can either be changed or canceled. Ask for any unused premium to be returned to you.

Date & Notes: _____

Employee Pensions and Benefits: If you are the beneficiary, contact the deceased's employer and ask about any possible death benefits, retirement annuity or pension plans, and life and health insurance coverage. Unions and other professional organizations may provide benefits also. Note: Sometimes you must return the deceased's final monthly pension payment to the pension company before they send a new, adjusted payment.

Date & Notes: _____

Veterans Affairs: If the deceased was a veteran, notify the VA to ask about possible death benefits and survivor's benefits. See the Resources section of this document to find information about veteran's benefits.

Date & Notes: _____

Banks, Financial Institutions, and Credit Card Companies: If you were a co-signer or had a joint account with the deceased, you must notify the Bank or other Financial Institutions of the death. For joint accounts “with the right of survivorship” the survivor owns all of the money in the account, but you still must notify the bank of the death.

Date & Notes: _____

Office of Financial Recovery (OFR): If you are responsible for the deceased's estate, you must send notification of the death to Washington State's Office of Financial Recovery. This office is part of DSHS/Medicaid. See the memo "Estate Recovery for Medical Services Paid for by the State" listed in the Resources section at the end of this document.

Date & Notes: _____

Washington State Department of Revenue (DOR): The DOR needs to be notified of the death if the deceased had an active sole proprietor business or owes any Washington State tax (e.g., employee, sales, or other excise taxes).

Date & Notes: _____

Washington State Department of Labor & Industries; Crime Victim's Compensation Program: Contact this agency for help and possible benefits if the death was the result of a criminal act.

Date & Notes: _____

Washington State Department of Labor & Industries: Notify this agency for possible Worker's Compensation benefits if a job-related injury or illness caused the death.

Date & Notes: _____

Credit Bureaus: It is recommended to notify the three major Credit Bureaus of the death, to help avoid possible identity theft. These are Equifax, Experian and TransUnion.

Date & Notes: _____

Landlord: Notify the deceased's landlord as soon as possible, to discuss lease or rental agreements, and moving out dates if necessary. Ask about the possible return of the deceased's security deposit.

Date & Notes: _____

Final Steps

See the "For More Information" section below to find information about Funerals and the Estate Administration process.

Feedback

We hope this checklist has been helpful. If you have any feedback regarding this checklist or the information provided, please send an email to info@legalvoice.org. Your feedback helps us improve our materials and keep information up to date. *Thank you.*

Resources:

General Resources:

- **Legal Voice:** Publication Handbook for Washington Seniors: Legal Rights and Resources (2012): Information and resources on a broad range of legal issues facing seniors.
Online: www.legalvoice.org/tools/faq.html#9, click "Order books online here."
Phone: 206-682-9552 x114
NOTE: Currently in very limited supply. Second edition coming 2015.

For Death Certificates and Notification of Death:

- **Washington State Department of Health, Center for Health Statistics:**
This office will give you the contact information for the local Department of Health in the county where the death occurred. If the death occurred three or more months ago and the death certificate is no longer available at the local Department of Health office, you can apply directly to this office.
Email: ContactCHS@doh.wa.gov
Phone: (360) 236-4300
Online:
www.doh.wa.gov/LicensesPermitsandCertificates/BirthDeathMarriageandDivorce

- **Vital Statistics** - Public Health Seattle & King County: For death certificates, if the death occurred in King County
Phone: 206-897-4551
In person: 908 Jefferson St, 2nd Floor, Seattle WA 98104
Online: www.kingcounty.gov/healthservices/health/vitalstats/death.aspx
- **Social Security Administration**: For notification of death and to check for benefits
Phone: 1-800-772-1213 (toll-free) Eastern time, (TTY) 1-800-325-0778
Online: www.socialsecurity.gov/survivors/
- **Veterans Affairs**: For notification of death and to check for benefits
Phone: 1-800-827-1000 (toll-free) Eastern time
Online: www.va.gov/opa/persona/dependent_survivor.asp
- **Office of Financial Recovery**, Washington State Department of Social and Health Services: For legally required notification of a death in the state of Washington. Send notice, including the deceased's Social Security number and date of death, by certified mail with return receipt requested.
See the Columbia Legal Services publication "Estate Recovery for Medical Services Paid for by the State," listed below.
Phone: 1-800-562-6114 (toll-free)
By mail: PO Box 9501, Olympia, WA 98507-9501
- **Washington State Department of Revenue (DOR)**: For notification of the death if the deceased had an active Sole Proprietor business or owes any Washington State tax (e.g., estate, employee, sales, or other excise taxes).
Phone: 1-800-647-7706 (toll-free)
Online: www.dor.wa.gov
By mail: Estate Tax Section, P.O. Box 47488, Olympia, WA 98504
- **Washington State Department of Labor & Industries**: Contact immediately if death was due to work-related illness or injury.
Phone: 1-800-LISTENS (1-800-547-8367) (toll-free) for claims;
1-800-4BE-SAFE (1-800-321-6742) (toll-free) to report workplace fatalities
Online:
www.lni.wa.gov/Safety/TrainingPrevention/Help/ReportFatalityHospitalization.asp
- **Crime Victim's Compensation Program** – Washington State Department of Labor & Industries: Contact for help if death was due to a crime.
Phone: 1-800-762-3716 (toll-free), (TTD) 360-902-5797
Online: www.lni.wa.gov/ClaimsIns/CrimeVictims/Homicide

Benefits

- **Social Security Administration:** Information on Social Security survivor benefits.
Phone: 1-800-772-1213 (toll-free) Eastern time, (TTY) 1-800-325-0778
Online: www.socialsecurity.gov/planners/survivors/#sb=4
- **Washington State Department of Veterans Affairs:** Information on Death Benefits and Survivor Benefits for Veterans:
Phone: 1-800-562-2308 (toll-free)
Online: www.dva.wa.gov/i-am-survivor

Estate Administration and Legal Help

- **Columbia Legal Services:** Publication "Estate Recovery for Medical Services Paid for by the State"
Online: www.washingtonlawhelp.org: In the search box at the top of the web page, type the publication's title, then click on that title in the search results.
- **Estate Planning Council of Seattle:** Publication "Dealing With the Death of a Loved One"
Online: www.epcseattle.org/cat/publications1.cfm
- **WApobate.com**, by Richard Wills, Esq.:
 - For information on Safety Deposit Boxes:
www.wa-probate.com/Instructions/Opening/Access-Safety-Box.htm
 - If the person did not leave a Will:
www.wa-probate.com/Instructions/Opening/Opening.htm#Filing

NOTE: This website is no longer being maintained. However, as of the date of this publication, the information on these pages was accurate.
- **Senior Rights Assistance** (at Senior Services): This brochure lists legal help for estate planning, including wills and powers of attorney for financial matters and health care. Call for a list of probate lawyers.
Phone: 206-448-5720, 1-800-972-9990 (toll-free)
Online:
www.seniorservices.org/financiallegalprograms/SeniorRightsAssistance/AdditionalResources.aspx ; click on "Legal Resources"

Funerals

- **Federal Trade Commission:** Publications "Paying Final Respects: Your Rights When Buying Funeral Goods and Services" and "Shopping for Funeral Services" (both available in Spanish)
Online: www.consumer.ftc.gov/blog/planning-funeral-know-your-rights

- **People's Memorial Association (PMA):** A Washington State non-profit organization providing education and consumer information about cremation and burial.
Email: info@peoplesmemorial.org
Phone: 1-866-325-0489 (toll-free)
Online: www.peoplesmemorial.org/funeral_education/

Grieving

- **People's Memorial Association (PMA):** Maintains a resource list for grief support.
Email: info@peoplesmemorial.org
Phone: 1-866-325-0489 (toll-free)
Online: www.peoplesmemorial.org/grief-support.html

This publication provides general information concerning your rights and responsibilities. It is not intended as a substitute for specific legal advice. This information is current as of March 16, 2015.
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