Preparing for future needs and honoring your present self: LGBTQ DIY Estate Tips During COVID19
WHO WE ARE

Lavender Rights Project (LRP) advances a more just and equitable society by providing low-cost civil legal services and community programming centered in values of social justice for trans and queer low-income people and other marginalized communities.

QLaw Foundation of Washington and its LGBTQ+ Legal Clinic promotes the dignity and respect of LGBTQ+ Washingtonians within the legal system through advocacy, education, and legal assistance.

SMOL LAW- A community supported law firm that provides essential legal services and casual legal advice to the queer, trans and non-monogamous community.
PRESENTERS:
Dusty LaMay, J.D. 2016, WSBA # not issued yet
Equal Justice Works Fellow, He/him pronouns
Legal Fellow for the Trans Advocacy in Rural Places program at LRP.

Melissa Hall is the founding attorney of Smol Law. WSBA# 55167. She/her pronouns

J. Denise Diskin, WSBA #41425
QLaw Foundation of Washington, She/her pronouns
Executive Director overseeing the LGBTQ+ Legal Clinic,
Family Matters Legal Clinic, and LGBTQ+ community legal education programs.
What are we doing today?

- Brief Intro to Issues 10 min
- HCD POA COVID 19 Considerations 20 min
- Going over relevant forms 30-45 min
- 1 hr QnA Wednesday April 8th at Noon
What else are we doing today?
Starting important conversations about hard to talk about topics!
Every person—no matter age or income—should have:

- a basic Will with funeral instructions
- a healthcare directive (HCD)
- a POLST
- Powers of Attorney for Finances and Health (POA)
- Instructions on where to find the documents given to the people who need to use them
Risks for LGBTQI+ People without HCDs & POAs

- Bio family **could have first right** to decide your care
- You could be kept alive or allowed to die **against your wishes**
- Misnaming and misgendering in care are always a risk
- Court could assign someone to decide your care
- Transition related care **could be stopped**
- *Non married partner won’t be able to visit you necessarily or decide end of life care for you or manage affairs*
- Live in partners and any partner who is not legally married to you will not have rights **UNLESS you say so in a POA. Same with stepchildren, poly relations, chosen family**
- *Exclusions* are allowed for parties like homophobic bio family or ex-spouses
- Guardianship of minor children can be assigned, otherwise risks bio family being given guardianship
Make Sure Your DIY Estate Documents are Properly Witnessed:

- Make your estate documents as secure as possible by using at least **two uninterested witnesses for each document** AND if possible 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.
How to Witness During COVID19

- **At minimum** your forms **must** be signed and dated **by yourself and two valid witnesses** at the same time and in the “presence” of each other.
- Notary is not required but is suggested
- Can use your neighbors and folks you are in contact with
- Can pass the forms between car window, fence etc but you and both witnesses must be “together” and be with the notary (on video) at the same time
- Currently electronic and video witnessing is not accepted in WA
- “**Together**” means in person
- But online notary is now allowed
Documents Covered Today

- Health Care Directives aka Living Wills aka Advanced Directives (HCD)
- Powers of Attorney (POA)
- HIPAA Releases
- POLST form

All of these documents apply while you are alive.
What Healthcare Directives Do

● List your desires for resuscitation
● List your preferences for care
● Let medical providers know about your regular medications, treatments and health issues
● Can assign organ donation and last rites
● Can list your primary doctor
● Can list your preference for place of care
● Can consent to ventilation, experimental treatment etc
● Instructs about what treatment you would want to refuse or would not consent to
● Lets you list your healthcare values
● Can provide consent for visitation
Trans and Gender related Care

- You can choose to list all names or not
- You can choose to be stealth or not if you like on your paperwork
- You can list values for care like being dressed according to your gender identity
- You can request that specific trans related care be continued ie Hormones
- You can name a preferred provider
- You can list values of care like being gendered and named appropriately by staff and in records
- You can exclude people from visitations
- You can pre-authorize your death certificate info
WHAT IS THE POLST

Physicians Order on Life Sustaining Treatment

- Green Form 2 sided
- Gives basic life saving instructions
- **Very likely to be used during COVID19 crisis**
- Must be signed by your Dr
- Is the most used forms in emergencies
- Keep a copy in your purse, bag or wallet if possible
- **If doing nothing else, do this form**
Why the POLST plus a HCD is key:

- Because a HCD isn’t a medical order, it can’t tell EMTs and hospitals what to do. Even if resuscitation or other end-of-life choices are specified- they may not be honored. It is a guidance tool. Standard emergency medical protocols must be followed unless a doctor’s orders say otherwise.
- POLST is for immediate emergencies
- HCD is for future planning and more general care and values
How to Revoke Health Care Directives

- A directive may be revoked at any time by any of the following methods:
  - (a) By being canceled, defaced, obliterated, burned, torn, or otherwise destroyed by the declarer or by some person in the declarer's presence and by the declarer's direction.
  - By a written revocation of the declarer expressing his or her intent to revoke, signed, and dated by the declarer. Such revocation shall become effective only upon communication to the attending physician by the declarer or by a person acting on behalf of the declarer.
  - A verbal revocation is ok as long as it is to your doctor
  - Executing a new HCD will revoke the old one
COVID 19 SPECIAL ISSUES for HCDs

1. **Ventilation Consent statements**
specifically considering COVID19 treatments

2. Life prolonging treatments or hospitalization may take longer than normal

3. **Consent to Experimental treatments**-
many of the COVID19 treatments are considered experimental

4. **Visitation- even by caregivers or those named in your HCD or POA**- is restricted under COVID19 treatment

5. Consent to electronic, video, phone and remote treatment
Powers of Attorney

- Assigns an agent to manage your affairs, accounts, care and decisions
- Should be for both finances and health decisions
- Can be together in one form or 2 distinct POA forms
- **Should assign back up agents**
- Can assign co-agents but must be empowered to act separately of each other
- Can be effective immediately or start based on circumstances or time
- **Must be witnessed** but best if also notarized if you want it to be effective in other states
- For finances, co-account holding is a non-POA way to share authority and access
- Can give agent power to control visitors
- Can assign guardianship of dependents
COVID 19 Special Issues for POAs

1. **Make them effective upon signing** so that your agent has authority to act on your behalf immediately

2. **Make them “durable”** so that they apply even if you are incapacitated. Include this statement: "This durable power of attorney shall not be affected by the disability or incapacity of the principal"

3. **Make sure you have a HIPAA release** section or form

4. **Assigned agents or caregivers may not be able to visit during quarantine so give thorough up-front instructions to your agent**
How to Revoke POAs

- Death
- Dissolution
- Formal revocation
- Deed is accomplished
- If incapacitated and not durable
- Executing a new POA which revokes all previous POAs
- Best practice to notify agents of revocation
HIPAA RELEASES

- Most commonly in Power of Attorney forms
- **Can be a stand alone form- is often practical to have it as such**
- *If you want anyone to know what is going on with you medically while you are incapacitated in treatment* (including if you are moved locations for quarantine), you will need to sign a HIPAA release. **Otherwise it is likely that only biological family or married partners will receive medical updates about you-if even them.**
- Some medical bills can’t be paid on behalf of someone without a HIPAA release
Completing the Forms
HEALTHCARE DIRECTIVE FOR Dusty Weber

This Health Care Directive is made this ___ day of _______ month in the year _____, in ___________________, Washington.

A. I, _______ Dusty Weber______________________, having the capacity to make healthcare decisions, willfully and voluntarily make known my desire that my dying shall or shall not be artificially prolonged under the following circumstances:

1. In the absence of my ability to give directions regarding the use of such life-sustaining treatment, it is my intention to have this directive honored by my caregivers, attorney-in-fact and physician(s) as the final expression of my legal right to refuse medical or surgical treatment, and I accept the consequences of such refusal. If I have appointed another person to make healthcare decisions for me, whether through a durable power of attorney or otherwise, then I request that my agent be guided by my desires as expressed in this directive or as otherwise communicated to my agent.

2. If at any time I should be diagnosed in writing to be in a terminal condition by the attending physician, or in a permanent unconscious condition by two physicians, and where the application of life-sustaining treatment would serve only to artificially prolong the process of my dying, I direct that such treatment be withheld, withdrawn or provided as I have directed and that I be permitted to die naturally or have my life prolonged medically in accordance with my desires and with consideration of any exceptional circumstances as set forth below.
2.1a. **Prolonging Life**: I want my life to be prolonged for ______ 3 months ______ within the limits of generally accepted healthcare standards by using all possible nutrition, hydration, medication, treatment, dialysis, CPR, ventilation and pain relief options available.

h Care DirectivePage ___ of ____ Initials: ____________

2.1b **Extraordinary Measures**: I want my attorney-in-fact to act to prolong my life so long as my medical providers believe I am capable of a recovery. I prefer the following measures to prolong my life or to hasten my death:

__DW × _ Do want extraordinary measures to prolong my life, or:

__Do not want extraordinary measures to prolong my life.
2.1c. **Burden to Family:**

_DW × _I do not want extraordinary measures to prolong my life; or,

__ I do not want my life to be a burden upon my family. If two doctors consider me to be medically “brain dead” and my attorney-in-fact determines that it is in my best interest to do so, please do not continue life support measures.

2.1d. **Vegetative State:** If two doctors believe I would remain in a persistent vegetative state I:

_DW × _I would prefer to have my life prolonged as long as possible; or,

__ I would prefer to not have my life prolonged.

2.1e. **Life Sustaining Treatment Decisions:** In making decisions about life sustaining treatment, I:

__ do want my attorney-in-fact to consider the relief of suffering and the quality of my life as well as the extent of the possible prolongation of my life; or,

_DW × _I do not want my attorney-in-fact to consider the relief of suffering and the quality of my life. My primary wish is to have my life prolonged even if to the detriment of my quality of life.
2.1f. **Place of Death:**

If I am dying, I would prefer:

- **DW☐** to die at home; or,
- _☐_ to die at the hospital; or,
- _☐_ to die at a hospice; or,
- _☐_ to die at the below listed place:

_____________________________________________________

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2.2. **Relief from Pain:**

I direct the following:

- _☐_ that treatment for alleviation of pain or discomfort be provided at all times, even if it hastens my death. I do not want to suffer or be left in pain if there is no chance of recovery; or,

- **DW☐** that treatment for alleviation of pain or discomfort be withheld at if it will hasten my death. I prefer to prioritize the chance of recovery over the relief from pain and suffering.
2.3 **Terminal Condition Definition:** I understand by using this directive that a terminal condition means an incurable and irreversible condition caused by injury, disease, or illness which would within reasonable medical judgment cause death within a reasonable period of time in accordance with accepted medical standards, and where the application of life-sustaining treatment would serve only to prolong the process of dying.

2.4 **Permanent Unconscious State Definition:** I further understand in using this directive that a permanent unconscious condition means an incurable and irreversible condition in which I am medically assessed within reasonable medical judgment as having no reasonable probability of recovery from an irreversible coma or a persistent vegetative state.

2.5 **Exceptional and Novel Circumstances definition:** In this directive, I intend for the terms exceptional and novel circumstances to include but not be limited to COVID-19 and other novel virus, influenza or yet unknown conditions.
3. Treatment During Terminal and Permanent Unconscious Conditions: If I am diagnosed to be in a terminal condition or in a permanent unconscious condition, then:
   
a. I want to have artificially provided nutrition for the following amount of time: __________________ 3 months _____________________.

   b. I want to have artificially provided hydration for the following amount of time: __________________ 3 months _____________________.

   c. I want to have artificially provided respiration and/or ventilation for the following amount
time: __________ 3 months ________________

c. I want to have artificially provided respiration and/or ventilation for the following amount of time: __________ 3 months ________________.

d. I:

    ___ do want to have any medication and/or medical or surgical care deemed necessary solely to alleviate pain, regardless of whether such treatment would hasten the moment of my death; or;

    _DW×_ do not want to have any medication and/or medical or surgical care deemed necessary solely to alleviate pain, if such treatment would hasten the moment of my death.
Treatment During Exceptional and Novel Circumstances: If I am being treated for an exceptional or novel condition such as COVID-19, I expressly request the following treatments regardless of my end of life desires expressed for use under normal circumstances. This directive section should be consulted as the primary instructions if I am being treated for a novel, exceptional or previously unknown condition. If I am being treated for COVID-19 or any other novel or exceptional condition, then I direct the following for my treatment even if it differs from the instructions provided in section 3:

a. I want to have artificially provided nutrition for the following amount of time:

   ________________ 1 year_________________

b. I want to have artificially provided hydration for the following amount of time:

   ________________ 1 year_________________

c. I want to have artificially provided respiration and/or ventilation for the following amount of time:

   ________________ 1 year_________________

d. I:
d. I: ___

Health Care Directive
Page ___ of ___ Initials:____________

___ do want to have any medication and/or medical or surgical care deemed necessary solely to alleviate pain, regardless of whether such treatment would hasten the moment of my death; or;

___DWX_ do not want to have any medication and/or medical or surgical care deemed necessary solely to alleviate pain, if such treatment would hasten the moment of my death.

e. I understand that novel conditions like COVID-19 may require experimental treatments some of which may include blood transfusions. I

___DWX_ do consent to experimental treatment for novel or exceptional conditions, or;

___ do not consent to experimental treatment for novel or exceptional conditions.
Consent to Electronic Treatment: I consent to all forms of remote and electronic treatment and communication with my medical providers including video appointments and treatment as well as telephonic and other internet based treatment and communications.
Transition Related Care:
1. I expressly request that in the event of my incapacitation that my physicians continue all transgender transition related care as informed by my attorney-in-fact, according to my directives in this document and with consideration to my personal choices at the time of my incapacitation. I request to continue my hormonal treatment as long as I am medically able to continue to do so despite any incapacitation. I request to continue all medical treatment and surgical recovery treatment that I was taking or undergoing at the time of my incapacitation.
2. I expressly request to be housed, treated, addressed, dressed and referred to according to my lived gender which is: ____ male/man/masculine ____
3. I expressly direct that all medical care be provided to me using my name, which is _______ Dusty Weber ______________;

my gender, which is, ____ male/transman ______; and,
the pronouns that I use, which are: ____ he/him/his __________.
C. **Last Rites:** I direct that in the event of my final moments of life there be:

___DWx___performances of Last Rites according to the following instructions:

________according to the Gnostic tradition________

__________________________________________

__________________________________________; or,

___ no religious ceremonies or religious last rites of any kind from any religion whatsoever.

D. **Physician of Choice:** I designate my physicians of choice as:_Dr. One of 1 Medicine_ and an alternate as__Dr Two of 2 Hospital___.

E. If the physicians I have designated above are not willing, able, or reasonably available to act as my primary physician, then I prefer that my designated health care agent determine a suitable physician.
F. **Organ Donation:** Upon my death,

_ DW × _ I do not wish to donate my organs at all to any program whatsoever.

__ I do wish to donate my organs and/or body according to the following instructions:

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

G. **Release of Body:** Upon my death, my body can be released to the following person or persons:

_____ Dan Weber and Mary Russell

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________
H. I understand the full importance of this directive and I am emotionally and mentally capable to make the health care decisions contained in this directive.

I. I understand that before I sign this directive I can add to, delete from, or otherwise change the wording of this directive. I further understand that at any time I may revoke this directive entirely or execute a new directive with different provisions.

Any changes must be consistent with Washington State law or federal constitutional law to be legally valid.

J. I wish this directive to be fully implemented. If any part is held invalid, I wish the remainder of this directive to be implemented.

K. This health care directive hereby revokes all other health care directives which I may have previously made.

L. A copy of this form has the same effect as the original.

I attest that the above directions are my wishes for medical care and end of life treatment should I not be able to advocate for myself. I have the capacity to execute this document and am aware of the future possibilities of the treatment instructions I have provided.

Signed on this _____ day of the _________ month of ______ in ________, Washington.

________________________
Signature

________________________
Printed Name
POLST EXAMPLE

- green areas are for your doctor to complete
green areas are for your doctor to complete
HIPAA RELEASE

Patient Name: __Dusty Weber________________
Patient DOB: __________________
Patient SS#: __________________

I, ______Dusty Weber__________________,
grant the following permissions to the below listed individuals (hereafter referred to as “Agents”:
Name: ______Dan Weber__________________
Relationship to me: ___Brother____________
Name: ___Mary Russell___________________
Relationship to me: ___Friend__________

Permission to Access to Medical Records:
I hereby authorize all physicians and psychiatrists who have treated me, and all other providers of healthcare, including hospitals, to release all information contained in my medical records to my Agents upon request. With respect to my Agents, I hereby waive all privileges attached to the physician-patient relationship and to any communication, verbal or written, including electronic communications, arising out of said relationship. My Agents are authorized to request, receive, and review any information, verbal or written, pertaining to my physical or mental health, including medical and hospital records, and to execute any releases, waivers, or other documents required to obtain such information, and to disclose such information to such persons, organizations, or health care providers as my Agents may designate.

Health Insurance Portability and Accountability Act (“HIPAA”):
I hereby authorize my Agents to act as my “personal representative” as defined in 45 C.F.R. §164.502 (g), the regulations enacted pursuant to HIPAA, and as hereafter amended, for the purpose of authorizing the release of my complete health record as may be necessary in order to obtain for my benefit medical treatment or consultation. The powers granted by this release shall be effective immediately.

Signed: ______________________________
Printed Name: ________________________
Date: ____________
DURABLE POWER OF ATTORNEY FOR FINANCES AND HEALTH CARE
GIVEN BY
Dusty Weber

TO
Dan Weber and Mary Russell

1. APPOINTMENTS: I, ________________ Dusty Weber ________________, (Principal) a resident of the State of Washington, hereby appoint ________________ Dan Weber ________________ (first agent), of ________________ Seattle, WA ________________ (place) as my Attorney-In-Fact Agent for financial matters with full authority to make decisions on my behalf, manage all of my property, and conduct all of my affairs as authorized in this document. If ________________ Dan Weber ________________ (first agent) is unable or unwilling to act as my Attorney-In-Fact Agent, I appoint ________________ Mary Russell ________________ (back up agent) as my successor Attorney-In-Fact Agent for financial matters. At no time are any of my biological family members to be designated as attorney-in-fact or agents with any power of attorney over my financial or healthcare decisions whatsoever under any circumstances.

   I, ________________ Dusty Weber ________________, (Principal) hereby appoint ________________ Mary Russell ________________ (first agent) as my Attorney-In-Fact for all healthcare and medical decisions with full authority to make decisions on my behalf, manage all of my healthcare matters and conduct all management of my medical affairs in accordance with this document and the supplemental Healthcare Directive signed on ________________ (date). If ________________ Mary Russell ________________ (first agent) is unable or unwilling to act as my Healthcare Attorney-In-Fact, I appoint ________________ Dan Weber ________________ (back up agent) as my successor Healthcare Attorney-In-Fact. At no time are any of my biological family members to be designated as attorney-in-fact or agents with any power of attorney over my financial or healthcare decisions whatsoever under any circumstances.

   I expressly empower each of these agents to act independently despite being designated as co-agents. As per the requirements of RCW 11.25.110, I authorize both the financial agent and the healthcare agent to each act independently of each other.

2. REVOCAUTION AND AMENDMENT OF POWER OF ATTORNEY: I revoke all prior durable or general powers of attorney that I may have executed and I retain the right to
2. **REVOCATION AND AMENDMENT OF POWER OF ATTORNEY:** I revoke all prior durable or general powers of attorney that I may have executed and I retain the right to revoke or amend this instrument and to substitute other persons in the Agent’s place. Amendments to this instrument shall be made in writing by myself personally (not the Agent), attached to the original of this instrument and recorded in the same county or counties as the original if the original is recorded.

3. **EFFECTIVENESS AND DURATION:** This power of attorney shall become effective immediately.

3.1 **Durability:** This durable power of attorney shall not be affected by my disability, incapacity or incompetency and will remain in effect to the extent permitted by Chapter 11.125 of the Revised Code of Washington or until it is revoked, notwithstanding any uncertainty as to whether I am dead or alive.

3.2 **Powers granted by paragraph 5.2 of this document regarding the Health Insurance Portability and Accountability Act (“HIPAA”)** shall become effective immediately.
4. **AUTHORITY:** My Attorney-In-Fact shall have full power and authority to do anything as fully and effectively as I could do personally if I were competent. This power shall include, but not be limited by, the following:

4.1 **Disclaimer:** The Attorney-In-Fact is authorized, in the Attorney-In-Fact’s discretion, to disclaim pursuant to Chapter 11.86 of the Revised Code of Washington all or any of the assets, property or interest to which I might otherwise be entitled as a beneficiary, as that term is defined in RCW 11.86.010. In so disclaiming, the Attorney-In-Fact may rely on the advice of my attorney regarding my estate-planning objectives if I have retained such an attorney and provided consent for sharing.

4.2 **Gift:** The authority to make gifts of any property owned by me, whether outright or in trust, including gifts to my Attorney-In-Fact, provided such gifts effectuate my most current estate plan.

4.3 **Transfers to Trust:** The authority to make transfers of my property, both real and personal, to any trust, provided such transfers effectuate my most current estate plan.

4.4 **Documents:** The authority to make, amend, alter, or revoke any of my life insurance, annuity or other similar beneficiary designations, employee benefit
4.5 **Additional:** Further examples of the complete and general authority granted by this power of attorney are enumerated in Exhibit A.

4.6 **Attorney-In-Fact’s Post-Death Authority:**

My Attorney-In-Fact is authorized to make anatomical gifts, authorize an autopsy, and direct disposition of my remains. Instructions for disposition of my remains can be found in the Disposition of Remains supplement document signed on ______________________ (date).

4.7 **Funeral and Burial Care Authorization:**

My Attorney-In-Fact is authorized and directed to plan my burial according to the instructions included in my supplemental Distribution of Remains Directions signed on ______________________ (date). My Attorney-In-Fact may refer to the alternate Attorney-In-Fact for help with any burial related decisions. As directed in the Disposition of Remains Document, I request that my funeral and services be completed according to my specific instructions of my funeral planning documents.

4.8 **Authority NOT granted:** My Attorney-In-Fact shall NOT have the power to make, amend, alter, or revoke any of my wills, codicils, or community property agreements.
5. DELEGATION OF HEALTH CARE DECISIONS: I hereby grant to my healthcare Attorney-In-Fact full power and authority to make healthcare decisions to the same extent I myself could make, if not for my incapacity. In exercising this authority, first preference of my health care treatment shall be given to my desires set forth herein, second to those stated in my latest unrevoked Healthcare Directive supplement document signed on ________________ (date), and finally to my best interests. These health care decisions include, but are not limited to, my desires concerning the obtaining, refusing, or withdrawing of life-sustaining care. The power and authority to make healthcare decisions shall include, but is not limited by, the following:
5.1 Attorney-In-Fact's Obligation:

5.1a. My healthcare Attorney-In-Fact shall make healthcare decisions for me in accordance with this power of attorney for health care, any instructions I give in this document and in the supplemental Healthcare Directive and my other wishes to the extent known to my Attorney-In-Fact. To the extent my wishes are unknown; my Attorney-In-Fact shall make healthcare decisions for me in accordance with what my Attorney-In-Fact determines to be in my best interest. In determining my best interest, my Attorney-In-Fact shall consider my personal values to the extent known to them. The instructions I give to my Attorney-In-Fact are guidelines to assist him/her in making the best medical decisions for me.

5.1b. The subject of unacceptable treatments is a complex one. Whether I would or would not want a particular medical intervention might depend on context. At some point, there might be a conflict between treatment instructions I have given and what my Attorney-In-Fact thinks best in circumstances that I could not have predicted. I trust that my Attorney-In-Fact will honor my goals and values.

5.1c. My Attorney-In-Fact shall provide a copy of this POA and my healthcare directive to any healthcare provider or facility that takes on responsibility for my care.
5.2 Access to Medical Records:

5.2a. I hereby authorize all physicians and psychiatrists who have treated me, and all other providers of healthcare, including hospitals, to release all information contained in my medical records to my Attorney-In-Fact upon request. With respect to my Attorney-In-Fact only, I hereby waive all privileges attached to the physician-patient relationship and to any communication, verbal or written, including electronic communications, arising out of said relationship. My Attorney-In-Fact is authorized to request, receive, and review any information, verbal or written, pertaining to my physical or mental health, including medical and hospital records, and to execute any releases, waivers, or other documents required to obtain such information, and to disclose such information to such persons, organizations, or health care providers as my Attorney-In-Fact may designate.
5.2b. Health Insurance Portability and Accountability Act ("HIPAA"): I hereby authorize my Attorney-In-Fact to act as my "personal representative" as defined in 45 C.F.R. §164.502 (g), the regulations enacted pursuant to HIPAA, and as hereafter amended, for the purpose of authorizing the release of my complete health record as may be necessary in order to obtain for my benefit medical treatment or consultation. Regardless of any springing effect of the rest of this power of attorney, powers granted by this paragraph shall be effective immediately.
5.3 **Employment Authorization:** My Attorney-In-Fact is authorized to employ and discharge health care providers, including physicians, psychiatrists, dentists, nurses, and therapists, as my Attorney-In-Fact shall deem appropriate for my physical, mental, and emotional well-being. In addition, Attorney-In-Fact is authorized to pay reasonable fees and expenses for such services contracted.

5.4 **Admission to Facilities:** My Attorney-In-Fact is authorized to apply for my admission to a medical, nursing, residential, or similar facility, execute any consent or admission forms required by such facility, and enter into agreements for my care at such facility or elsewhere during my lifetime or for such lesser periods of time as my Attorney-In-Fact may designate. However, my Attorney-In-Fact is not authorized to arrange for my commitment to or placement in a mental health treatment facility, except pursuant to Chapter 71.05 of the Revised Code of Washington.
5.5 Consent to Procedures: My Attorney-In-Fact is authorized to consent or refuse consent to any care, treatment, service, or procedure to maintain, diagnose, or otherwise affect a physical or mental condition, including the administration of drugs and all transgender related care; but my Attorney-In-Fact is not authorized to arrange for or consent to (a) therapy or other procedures given for the purpose of inducing convulsions, (b) surgery solely for the purpose of psychosurgery, (c) sterilization, or (d) sexual orientation or transgender conversion therapy. The power to make healthcare decisions for me shall include the power to give consent, refuse consent, or withdraw consent to any care, treatment, service, or procedure to maintain, diagnose, or treat a physical or mental condition. I expressly empower my Attorney-In-Fact to advocate for, consent to or refuse consent to all transgender or gender transition related care, treatment and maintenance I may need and as would have been in alignment with my personal decisions at the time of my incapacitation.
5.6 Reserved Rights: Notwithstanding any provision herein to the contrary, I retain the right to make medical and other health care decisions for myself provided I am able to give informed consent with respect to a particular decision. In addition, no treatment may be given to me over my objection, so long as I can make an informed decision related to each particular medical need, and health care necessary to keep me alive may not be stopped if I object if I am in fact lacking capacity to make such a decision.

5.7 Withdrawal of Life-Sustaining Procedures: If I have executed a directive to physicians or other similar document expressing my intentions with respect to the use, continuation, or withdrawal of life-sustaining procedures, then I direct my Attorney-In-Fact to consent to the provision, withholding, or withdrawal of artificial nutrition and hydration and all other forms of health care to keep me alive, including cardiopulmonary resuscitation, according to my wishes as stated in my supplemental Healthcare Directive signed on ____________ (date).
5.8 **Visitation Rights:** The Attorney-In-Fact shall have the power to visit me in any hospital or similar facility in the same manner and to the same effect as if the Attorney-In-Fact were related to me by blood or marriage. Additionally, the Attorney-In-Fact shall have the power to grant and deny visitation rights to others. I expressly and intentionally empower my Healthcare Attorney-In-Fact to deny any requests made by my biological family to visit me in a hospital, hospice or facility. My Healthcare Attorney-In-Fact may permit my biological family to visit me but only if Attorney-In-Fact believes it to be in my best interest.
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6. NOMINATION OF CONSERVATOR OR GUARDIAN: If a conservator or guardian of my person needs to be appointed for me by a court, I nominate the Financial Attorney-In-Fact designated in this form. If that agent is not willing, able or reasonably available to act as conservator, I nominate the alternate Attorneys-In-Fact whom I have named, in the order designated. If none of the listed Attorneys-In-Fact are able to act as conservator, I request that anyone other than any of my biological family members be appointed as conservator.

6.1 Cultural Competency: I request that should any Court appoint a Conservator or Guardian on my behalf, that the Court should also then appoint a Mediator of Issues to ensure the culturally competent management of my affairs with regards to my gender identity and/or sexual orientation.

6.2 For the care of the vulnerable adults or minor children for whom I am responsible, I nominate ________________ to be Guardian for the below listed vulnerable adults or minor children for whom I am responsible:

Name: ___________________________ Age: ____
Name: ___________________________ Age: ____
Name: ___________________________ Age: ____
Name: ___________________________ Age: ____

6.3 For the care of the below listed pets, I nominate ____________ Al Lari to act as the caregiver and guardian if I am incapacitated. My pets are listed as follows:

Name: ______Wiley________ Age: 15 __ Type of pet: ____Dog____
Name: ___________________ Age: ____ Type of pet: ______
Name: ___________________ Age: ____ Type of pet: ______
Name: ___________________ Age: ____ Type of pet: ______
7. **SIGNATURE DIRECTIONS:** In transacting business on my behalf, the Agent shall sign documents the following way: “____Dusty Weber______”.

8. **EXCLUSIONS:** I am intentionally and explicitly excluding my biological family from all decision making authority over my matters whether they be financial or health related. This exclusion includes all biological family members of any kind of biological relation. My friends, chosen family and community are to have priority above any biological families in assignment, decision making authority, and all visitation rights in regards to management of my person and property.

8.1 The persons to be excluded from having any rights to act as my agents include the following:

   Name: ____Janet Weber_____ Relation to me: ____Sister______
   Name: ____________________ Relation to me: ____________________
   Name: ____________________ Relation to me: ____________________
   Name: ____________________ Relation to me: ____________________
   Name: ____________________ Relation to me: ____________________

9. **PERSONAL CARE DECISIONS:** I direct that my Agent may authorize personal care on my behalf including, but not limited to, choice of residence, choice of clothing, receipt of my mail, care for my personal belongings, care for my pet, and all other decisions of a personal nature not included in the description of Financial or Healthcare Directives. I direct that at no time are any of my biological families to be in charge of my personal care.
18. **POWER OF ATTORNEY NOT AFFECTED BY PRINCIPAL’S INCAPACITATION:**
This power of attorney shall not be affected by my subsequent incapacity. I declare that I understand the importance of this durable power of attorney, recognize that the Agent is granted broad power to hold, administer, and control my assets, and recognizes that this durable power of attorney will become effective immediately on execution and will continue indefinitely until specifically revoked or terminated by my death.

19. **APPLICABLE LAW:** The laws of the State of Washington shall govern this Power of Attorney.

20. **EFFECT OF COPY:** A copy of this form has the same effect as the original.

21. **SUGGESTED ATTORNEY:** If any assistance is needed with matters regarding management of my financial or healthcare decisions, I encourage my agents to contact the attorneys of ________________________________.

Signed on this _____________ day of __________________, 20___.

____________________________________________________
Principal Signature
1. To buy, receive, lease, accept, or otherwise acquire or dispose of; to assign, sell, convey, mortgage, hypothecate, pledge, disclaim, quit claim or otherwise encumber or release; to contract or agree for the acquisition, disposal or encumbrence of; or in any manner deal in or with any real or personal property whatsoever or any custody, possession, interest, or right therein, upon such terms as my said attorney-in-fact shall think proper.

2. To take, hold, possess, invest, lease, let, or otherwise manage any real or personal property or any interest therein; to eject, remove, or relieve tenants or other persons from and recover possession of such property by all lawful means; and to maintain, protect, preserve, insure, remove, store, transport, repair, rebuild, modify, or improve the same or any part thereof.

3. To make, do, and transact all and every kind of business of whatsoever nature or kind, including the receipt, recovery, collection, payment, compromise, settlement, disclaimer, and adjustment of all accounts, legacies, bequests, interests, dividends, annuities, demands, debts, taxes, and obligations, which may now or hereafter be due, owing, or payable by me or to me.

4. To make, endorse, accept, receive, sign, seal, execute, acknowledge, and deliver deeds, assignments, agreements, leases, mortgages, stock certificates, hypothecations, checks, notes, bonds, vouchers, receipts, and such other instruments in writing of whatever kind and nature as may be necessary, convenient, or proper in the circumstances.

5. To deposit and withdraw, in either my attorney-in-fact's name or my name or jointly in both our names, in or from any banking or financial institution any funds, negotiable paper, or moneys which may come into my said attorney-in-fact's hands as attorney-in-fact, or which I now or hereafter may have on deposit or to which I may be entitled.

6. To use any credit cards in my name, to make purchases, to sign charge slips on my behalf as may be required to use such credit cards, and to close my charge accounts and terminate my credit cards when the Agent considers such acts to be in my best interest.

7. To institute, prosecute, defend, compromise, arbitrate and dispose of legal, equitable, or administrative hearings, actions, suits, attachments, arrests, distresses or other proceedings, or otherwise engage in litigation in connection with my assets, liabilities and affairs.

8. To act as my attorney or proxy in respect to any stocks, shares, bonds, or other investments, rights or interests I may now or hereafter hold, whether for voting or transfer or the exercise of rights to subscribe for additional securities, or for any other purpose.

9. To engage and dismiss agents, counsel, and employees, and to appoint and remove at pleasure any substitute for my attorney-in-fact, all upon such terms as my attorney-in-fact shall think fit.

10. To execute vouchers in my behalf for any amounts properly payable to me by the United States, and to receive, endorse and collect the proceeds of checks payable to my order drawn on the Treasury of the United States.

11. To prepare, execute and file any tax return or document required by any federal or state government or any local taxing authority.

12. To execute, acknowledge and deliver all and every such agreements, deeds, assignments, and other instruments whatever in writing of whatsoever kind and nature as may be necessary, convenient, or proper in the circumstances.
The undersigned attesting witnesses, after being sworn on oath, each states:

1. **Request of Principal.** The Principal, __Dusty Weber______________, requested that all the attesting witnesses make this affidavit.

2. **Execution.** The Power of Attorney to which this affidavit is attached was executed by __Dusty Weber______________ on this _____ day of _____, 20__, in _________________, ________________ County, Washington.

3. **Declarations.** Immediately prior to execution, __Dusty Weber______________ declared the document to be her/his/their Power of Attorney and directed or requested the witnesses to subscribe their names.

4. **Signatures.** __Dusty Weber______________ signed the document in the presence of all the witnesses, and the witnesses attested the execution by subscribing their names in the presence of ________________ and of each other.

5. **Competency.** At the time of execution of this document each witness states the following:
   
   (i). The Principal has been personally known to me;
   
   (ii). I believe the Principal to be of sound mind and capable of making informed decisions;
   
   (iii). I am not
      
      a. related to the Principal by blood or marriage, nor am I in a Registered Domestic Partnership with the Principal;
      
      b. the Principal’s attending physician or an employee of either the attending physician or a healthcare facility in which the Principal is a patient;
      
      c. Entitled nor have a claim, to the best of my knowledge, to any portion of the Principal’s estate upon their death under any Will or Codicil or by operation of existing law;
      
      d. A person designated to make medical decisions on the principal’s behalf;
      
      e. Incapacitated;
      
      f. A minor; and,
(iv). The Principal signed the foregoing Power of Attorney willfully and voluntarily.

Witness:

Signature of Witness 1
Print Name
Address
City, State ZIP

Signature of Witness 2
Print Name
Address
City, State ZIP

CERTIFICATE OF ACKNOWLEDGMENT OF NOTARY PUBLIC
For the Power of Attorney of
Dusty Weber

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 his/her/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____.

STATE OF WASHINGTON )
COUNTY OF ____________, ) ss.

Notary Public:________________________

NOTARY PUBLIC in and for the State of Washington, residing at
________________________, _________________ County, Washington.

My commission expires on: __________________________

Power of Attorney
Of ____________________________
Initials: ____________________________
Lavender Rights Project:
206-639-7955
www.lavenderrightsproject.org

Smol Law-
Melissa@smol-law.com

QLaw LGBTQ+ Legal Clinic
206-235-7235 or
www.qlawfoundation.org
Professional Estate Support

- Endoflifewa.org
- Northwest Justice Project Senior Legal Help Line: Seniors (age 60 and over) can also call CLEAR*Sr at 1-888-387-7111 (statewide)
- Washington Law Help: [https://www.washingtonlawhelp.org/resource/health-care-directive-or-living-will](https://www.washingtonlawhelp.org/resource/health-care-directive-or-living-will)
- Check out the providers lists at: [https://nwlgbtseniorcare.org/](https://nwlgbtseniorcare.org/)
- LGBTQ Friendly Funeral Home- Acacia Memorial Park and Funeral Home
Q n A

Live QnA with the presenters Wednesday April 8th at Noon