ADVANCE HEALTHCARE PLANNING AT WWH
GUIDE FOR ATTORNEYS

Contents

Introduction: Overview of Documents and Process

The goal of WWH's advance healthcare planning will ideally be to get (a) a WWH-specific HIPAA release signed for any client who is also a WWH patient; (b) to get an Advance Directive / Power of Attorney (AD/POA, hereafter) and Disposition of Remains completed for any client for whom it is deemed appropriate; and (c) to get a universal HIPAA release signed for any client for whom it is deemed appropriate, which will be a smaller subset, thus making this document optional.

Appendix A explains the intake procedure and workflow for any clients interested in these services, including walk-ins, phone intakes, email intakes, and provider referrals.

Because of the logistics of having the documents witnessed, most clients will not complete the AD/POA or Disposition of Remains in their first meeting with the attorney. Therefore, they should leave with a printed and completed "Take-Away for Incomplete Advance Directives" document. Once the documents are completed, they should be given a printed and completed "Take-Away for Completed Advance Directives" form. In both cases, the client should be counseled on the information contained in those take-aways, and the take-aways should be copied and added to the client's legal file.

A brief outline of the available healthcare planning documents follows.

WWH-specific HIPAA Release:

This document authorizes WWH to release information to a person of the client's choosing. If the client authorizes the release of behavioral or mental health-related information, it will expire after one year. For this reason, as well as the general narrowness of the document's purpose, most clients will be encouraged to sign an AD/POA.

Universal HIPAA Release:

This document theoretically authorizes any medical provider (broadly defined) to release information to a person of the client's choosing. However, because it may be questioned by these providers, may not meet all the requirements of all jurisdictions, may confuse clients, and is generally limited like the WWH release, most clients will be encouraged to sign an AD/POA and only some will be recommended to sign this document at all (see below).

Advance Directive / Power of Attorney (AD/POA):

The AD/POA (a) selects an agent to make medical decisions (broadly defined) for the principal in the event that the principal can no longer do so; (b) authorizes disclosure of the principal's medical information to the agent; (c) instructs providers and the agent as to how the principal wants to be cared for, particularly in end-of-life situations; (d) states whether or not organs should be donated in the case of the principal's passing; and (e) is not only signed by the principal,

but also signed by two witnesses. Most clients will be advised to complete an AD/POA, even if their situation dictates that it be narrowed down significantly.

Disposition of Remains:

This document names the person the client wishes to take care of their bodily remains after death, and allows the client to provide instructions if desired. It must be signed and witnessed.

Document One: WWH-specific HIPAA Release

The first step in doing advance healthcare planning for any client who is also a WWH patient is to complete a WWH-specific HIPAA release. Unlike the releases generally used by WWH providers, in which patients give a one-time release (usually to another provider or healthcare entity), the release developed for Legal Services creates a blanket release from the client to the person of their choosing. The document is simple to complete and does not require witnesses.

Clients should be advised that this document will expire after one year for mental health information. Additionally, it will only work at WWH. For that reason, clients should be encouraged to complete an AD/POA, which will (among other things) authorize someone to receive medical information from any medical provider or healthcare entity.

As stated in Appendix A, this document should be scanned and emailed to be added to the clients' medical records once completed. A copy should also be added to the client's legal file.

Document Two: Universal HIPAA Release

In most cases, any Authorization for Release of Information that meets the requirements of the Health Insurance Portability and Accountability Act ("HIPAA") should be sufficient for a client to authorize a healthcare entity to release protected healthcare information to a designated third party. While a duly executed Healthcare Power of Attorney document itself is sufficient for any healthcare agent to access a client's protected health information, a HIPAA Authorization can be a useful tool for the agent to have as well, for several reasons.

First, most healthcare providers with whom the agent will come in contact will likely be frontline providers (e.g., nurses, physician assistants, as well as doctors) who tend to be far more familiar with HIPAA Authorizations in their daily practice than with Power of Attorney documents. As a result, a healthcare provider (especially in an emergency situation) may respond more quickly and readily to a HIPAA Authorization than to a Power of Attorney. Further, a HIPAA Authorization has no witness requirement, so it can be executed immediately with little effort. As a result, a HIPAA Authorization can also serve as a stopgap when the client needs time to settle the details of the Power of Attorney and Advance Directive. A HIPAA Authorization can also be a backup if for some reason a healthcare entity does not honor the Healthcare Power of Attorney, or requires that it be first reviewed by its legal counsel (resulting in delay).

There are some drawbacks to a HIPAA Authorization, however. First, they often expire one year after execution (depending on the jurisdiction). Second, some healthcare provider entities have a policy of accepting only their own form of the HIPAA Authorization (even though they have no legal right to do so). Third, the federal HIPAA statute only establishes a floor for protecting health information, allowing individual states to impose stricter requirements. Because the privacy requirements of state law can exceed those of the federal HIPAA statute, an entity outside of DC, Maryland, or Virginia (for which our document has been tailored) could reject this document as insufficient.

For all of these reasons, it is advisable that this document only be completed in the following instances:

1) The client is truly not ready to go through the process of creating an AD/POA, even with the option of narrowing down that document (e.g., removing the Advance Directive section); this document could be a stopgap in that it is better than not having anything.
2) The client travels out of the DC, Maryland, and Virginia area, and understands that this document is a backup but still is best paired with an AD/POA.
3) Another circumstance exists that makes this a necessity (e.g., the client wishes to name one person as their power of attorney, but wants to give broad authority to access medical records to another individual).

The client should always be advised that, at least in many jurisdictions, this document will expire after one year from the date of signing.

The universal HIPAA release is simple to fill out and does not require witnesses, so it can be completed quickly in one sitting with the client. It allows the attorney to add in any healthcare providers that the client sees regularly, but it is not limited to the entities that the client lists.

Once completed, a copy of the document should be added to the client's legal file. Because the WWH-specific release gets forwarded to the client's medical records, it is not necessary to forward this document to medical records.

Document Three: Advance Directive/Healthcare Power of Attorney (AD/POA)

Part I: Healthcare Power of Attorney

In the first part of the Advance Directive/Healthcare Power of Attorney (AD/POA), the client will appoint someone to be their healthcare power of attorney. Subsection A names that individual, and subsection B describes that individual's powers. This section, like the entire document, can be edited down to only those powers that the client wishes for the agent to have. Absent the client's objections or inability to select a strong agent, however, it is generally favorable to give the agent broad powers. The remaining subsections cover additional legal details.

The default rule is that the powers of a healthcare agent take effect only after the client has been certified to lack capacity to make healthcare decisions. In the District of Columbia and Maryland, however, the client can give her agent the power to act on her behalf immediately, even while the client is competent. This is advisable so that the agent can have access to the client's health information and have standing to advocate on the client's behalf with the client's healthcare providers when the client is not physically present.

Even when the client makes the agent's powers effective immediately, however, the client still retains the power and ultimate authority to direct her own care, so long as she retains the mental capacity to make informed decisions. While the client is competent, the client's decisions control—the agent must act solely according to the directions of the client. Only if and when the client has been certified to lack capacity to make her own healthcare decisions will the agent's decisions control the client's healthcare instead.[1] Even then, though, the agent's power will be circumscribed by the directions the client set out in the Advance Directive (a.k.a., "Living Will").

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[1] Each local jurisdiction has its own statutory definition of "incapacity," but they are similar. In the **District of Columbia,** incapacity means "incapable of understanding the health-care choice, making a decision concerning the particular treatment or services in question, or communicating a decision even if capable of making it." D.C. Code § 21-2204(b).

In **Maryland,** it means "inability of an adult patient to make an informed decision about the provision, withholding, or withdrawal of a specific medical treatment or course of treatment because the patient is unable to understand the nature, extent, or probable consequences of the proposed treatment or course of treatment, is unable to make a rational evaluation of the burdens, risks, and benefits of the treatment or course of treatment, or is unable to communicate a decision." Md. Code Ann., Health-Gen. § 5-601(m)(1).

Virginia defines incapacity as the "the inability of an adult patient, because of mental illness, intellectual disability, or any other mental or physical disorder that precludes communication or impairs judgment, to make an informed decision about providing, continuing, withholding or withdrawing a specific health care treatment or course of treatment because he is unable to understand the nature, extent or probable consequences of the proposed health care decision, or to make a rational evaluation of the risks and benefits of alternatives to that decision." Va. Code Ann. § 54.1-2982.

As a result, the client should be advised at the beginning of this process that, in the Advance Directive section of the document (which comes after the POA section), she will be able to state what kind of care she wants to receive if she becomes incapacitated, and/or give guidance to her agent regarding how the agent should make healthcare decisions for her. It should also be made clear that the client retains ultimate authority to control her healthcare while she remains mentally competent, and that her agent's decisions would take precedence over her own only if and when the client were deemed unable to make a competent decision herself.

A. Selection of Agent

The client should be advised that she should select two people to make healthcare decisions for her when she is physically or mentally incapable of doing so herself. One person is to be the client's first choice, the other is to be a substitute who only steps in if and when the first choice is unable or unwilling to serve.

The client should select individuals who are:

a. Trustworthy, i.e., will follow the client's directions and act in the client's best interest
b. Level-headed
c. Able to make rational decisions in a crisis
d. Geographically nearby (i.e., could be present at a hospital in an hour to two hours)

The client should avoid appointing someone as agent simply out of affection, or just because the person herself demands to be appointed. The client should choose an agent who could quickly and readily reach any hospital in the area where the client lives, and who would be readily available by phone otherwise. The agent should be able to physically see the client and speak face-to-face with healthcare providers on short notice without having to engage in major travel.

The client should be strongly dissuaded from appointing co-agents. Having multiple co-agents invites confusion, disagreement, and paralysis in decision-making. Two of the major objectives of a healthcare power of attorney and an advance directive are efficiency and finality. In order to effect the client's wishes, healthcare providers need to hear one, clear decision from one person.

The attorney cannot serve as the healthcare agent. Occasionally, a client will have no one in her life she feels she is able to ask to serve as her healthcare agent. The client may ask the attorney to serve in this capacity. Volunteer and staff attorneys are, however, not permitted to serve as healthcare agents (and are strongly discouraged from doing so). Other Whitman-Walker staff members are similarly not suitable to act as agent.

Each jurisdiction also provides a specific procedure for certification of incapacity. *See* D.C. Code § 21-2204(a); Md. Code Ann., Health-Gen. § 5-606; Va. Code Ann. § 54.1-2983.2(B).

If the client does not have anyone in her life who is appropriate to serve, we can still assist him or her to complete an advance directive that states his or her wishes in the event he or she is incapacitated. (See Part II.)

B. Powers and Rights of Healthcare Agent

The client has the legal ability to tailor the powers of the healthcare agent (otherwise known as the "attorney-in-fact"). The healthcare power of attorney template that we use contains a comprehensive list of powers taken from the Maryland statutory form healthcare power of attorney.[2] The client can remove any power he or she may not want exercised, but unless the client has a good and specific reason for doing so, this should be discouraged. It is impossible to predict what circumstances may arise in the future, so the client would be better off giving her healthcare agent plenary power to act on her behalf.

Many of the powers allow the agent to make decisions and act concurrently with the client, subject to the approval of the client. The purpose of some of the powers, however, is to give the agent the ability to act *without* the client's consent, or over her protest. Before these powers take effect, however, the client must be formally found to be incapable of making an informed decision.

We recommend that in editing the document, the attorney strike through any powers that the client does **not** want to confer, and that the client write their initials next to that strike-through.

The powers itemized in section (I)(B) of the Whitman-Walker Form Health Care Power of Attorney are:

1. To consent or withdraw consent to any treatment.

2. To request and receive healthcare information, including in the form of oral conversations.

3. To decide who the client's doctors and other healthcare providers will be.

4. To decide where the client will be treated.

5. To authorize admission to and discharge from any healthcare facility.

6. To authorize treatment for mental illness *limited to 10 days*.

   Note: Section (B)(6) should be included in the document only if the client specifically wants to limit any inpatient mental health treatment to no more than

[2] *See* Md. Code Ann., Health-Gen § 5-603 (Lexis, current through Mar. 2014). The Whitman-Walker form also incorporates the language of the statutory form healthcare powers of attorney and advance directives for the District of Columbia and Virginia. *See* D.C. Code § 7-622 (advance directive), § 21-2101 (health care power of attorney) (2000, Lexis current through Mar. 2014); Va. Code Ann. § 54.1-2984 (Lexis, current through Mar. 2014).

10 days. Please note that there is a much broader provision in section F of the Whitman-Walker template regarding mental health treatment. Review section F first (see instructions below). If the client has no specific objection to prescribed inpatient mental health treatment, then (B)(6) should be eliminated from the document, because it is duplicative and contradictory to section (F).

In contrast to section (F), section (B)(6) is tailored for the client who has a specific aversion to inpatient mental health care. Section (B)(6) provides two options: **the client should choose one.**

Option One: This authorizes the agent to admit the client for mental health care for 10 days, ***provided the client does not protest,*** and a doctor finds the client is incapable of making an informed decision. This option is *only* appropriate for the client who is clear that she *never* wants to be psychiatrically hospitalized against her will.

Option Two: This authorizes the agent to admit the client for mental health care for 10 days, ***even if the client protests,*** and a doctor finds the client is incapable of making an informed decision. Unless the client has a clearly stated objection to involuntary hospitalization, this choice is superior, because it empowers the agent to hospitalize the client if she has an incapacitating physical or psychiatric condition that also makes her protest treatment (e.g., dehydration-induced delirium).

7. To continue to serve as the client's agent, ***even over the client's protest,*** if her attending physician and one other physician both certify she is not capable of making an informed decision.

8. To authorize the treatment the client has identified in the advance directive, ***even if the client later protests,*** if her attending physician and one other physician both certify she is incapable of making an informed decision.

9. To authorize the client's participation in a healthcare study if it offers the prospect of direct therapeutic benefit to her.

10. To authorize the client's participation in a healthcare study for the purpose of increasing medical knowledge, even if it offers ***no*** prospect of direct therapeutic benefit to her (*it would be wise to include this power, because it obviates any quibbling under (9), above, about whether and to what degree a study might "offer the prospect of direct therapeutic benefit"*).

11. To direct persons involved in care to use the client's name and gender pronouns of their choice, and to preserve the appearance of that gender identity (this should be deleted for clients who are not trans or gender-nonconforming).

12. To enforce the terms of the power of attorney and advance directive.

13. To be present with the client, and to determine who else may visit the client.

Personalized Conditions and Limitations:

The form also provides space and opportunity for the client to state any conditions or limitations to these powers. Again, unless the client has a very specific reason for doing so, imposing conditions and limitations should be avoided, because they often involve abstract factual assumptions that will not necessarily fit future concrete circumstances. Nevertheless, if the client has particularly strong concerns about a particular medical procedure or health care provider, or wants to make sure that a particular friend or family member (not the designated agent) should always be allowed to visit – or never allowed to visit –then this condition could be stated. The attorney should discuss any such proposed condition with the client to ensure that the client understands the potential consequences.

C. How the Agent is to Decide Specific Issues

The WWH form provides that the agent is to first consider the client's preferences as set forth in Advance Directive portion of the document (Part II). Then, the agent should make a decision based on what the client would want to do. The agent can consider:

- conversations he/she has had with the client;
- the client's religious or philosophical beliefs;
- the client's personality; and
- how the client made medical and other important decisions in the past

If what to do is still unclear after considering all this, then the agent should do what the agent thinks is in the client's best interest.

D. People my Agent Should Consult

The client may list particular people the agent is encouraged to consult in making healthcare decisions for the client. This may be particularly helpful where the client appoints a friend or other non-family member as agent. (Contact information for such individuals should, of course, be included.) The agent can then know whom the client would like to be informed and consulted regarding her treatment. However, the attorney should remind the client that listing any such people is merely a suggestion and is not required. Furthermore, anyone listed in this section is not entitled to notice about the client's health situation or empowered to make any decisions about it. It should be noted that listing anyone in this section creates a risk of muddying the decision-making by giving non-agents the impression they do have control over the decision-making. If the client anticipates a struggle for control, the client may intentionally leave this section blank, and/or consider adding explicit language to address such potential struggles.

E. Access to My Health Information – HIPAA Authorizations

This section gives a broad authority to request and receive health information. The first paragraph of this provision allows a physician to discuss the client's capacity with the agent prior to a formal finding of incapacity. This provision is here because, in some cases, a power of attorney might only take effect if and when a physician has found the patient to have lost the capacity to make healthcare decisions. Without a provision allowing communication with the agent prior to a finding of incapacity, a physician might not be legally able to gather information necessary to assess capacity. This provision allows such communication.

Once the power of attorney is in effect, the rest of this section gives the agent broad power to request and receive medical information in any form, including oral conversation. It also appoints the healthcare agent as the client's personal representative under HIPAA (which formally allows healthcare providers to release information to the agent). "If under applicable law a person has authority [e.g., through a Power of Attorney] to act on behalf of an individual who is an adult or an emancipated minor in making decisions related to health care, a covered entity must treat such person as a personal representative." 45 C.F.R. §164.502(g)(2). "[A] covered entity must . . . treat a personal representative *as the individual*." §164.502(g)(2) (*emphasis added*). This means the health entity must release records to the personal representative the same as if she were the principal herself. The Personal Representative can even execute a HIPAA Authorization on behalf of the principal to release records to a third party.

F. Mental Health

This section allows the client to make more specific provisions regarding mental health care. If the client has no chronic mental illness, she should select option (1). She should select option (2) only if she receives active, ongoing mental health treatment and has specific wishes regarding who should treat her in an acute psychiatric episode and how she should be treated (e.g., if there are specific medications or other treatments she does, or does not, want to receive).

If the options in section (F) are sufficient to provide for the client's wishes, then the power listed in section (B)(6) should be deleted from the form, because its language contradicts section (F).

G. Effectiveness of This Part

A client has two options for when her healthcare power of attorney should become effective: either immediately upon signing, or only when the client is "not able to make informed decisions about [her] healthcare." Making it effective upon signing is preferable for several reasons. First, the agent may need at some point to interact with healthcare providers and instruct them on treatment options when the client cannot be physically present to do so herself (e.g., if the client were in a hospital and the agent had to make arrangements with staff of a rehabilitation facility to which the client needed to be transferred).

Second, making the power of attorney effective immediately does not cost the client anything: the client is still the ultimate decision-maker, so long as she is mentally competent. This may not be immediately apparent to clients. Some may assume that by signing a power of attorney that they are giving up power over their lives to someone else. The attorney should make sure the client understands that she retains full power to make her decisions while she is mentally competent, and that the agent is bound to follow those instructions.

Third, it can be very difficult to determine as of when exactly a person is "not able to make informed decisions." A person can drift in and out of capacity, or be capable of some decisions but not others. Consequently, the precise start point of an agent's power can be murky and subject to contention of it is contingent on determining when the client is no longer "able to make informed decisions."

If a client is concerned about the named agent acting improperly, the attorney should explore those concerns with the client and suggest naming someone else as the agent.

Part II: Advance Directive ("Living Will")

The Advance Directive (sometimes referred to as a "Living Will") allows the client to state her wishes regarding what treatment she does, and does not want, if and when she loses the capacity to make or communicate treatment decisions. The Advance Directive serves as the client's written instruction or guidance to her healthcare agent and healthcare providers regarding how they should conduct her care once she is no longer capable of giving that instruction herself. An Advance Directive therefore limits the discretion of the healthcare agent. The client can provide her instructions as either guidance (leaving ultimate discretion to the agent), or as mandatory orders (leaving no discretion to the agent). (See Section G, Effect of Stated Preferences, below.)

Please note that, even without an Advance Directive, the client's duly appointed healthcare agent can still withdraw treatment once two physicians certify the client has lost capacity to make her own informed decisions.

The Advance Directive is designed to apply in a number of different end-of-life scenarios. For example, it would apply if the client developed advanced Alzheimer's or dementia, and then suffer an acute condition, such as infection with multi-organ failure, from which there is no reasonable hope of recovery. Alternatively, it would apply if she suffered a massive stroke or subdural hematoma and slipped into a vegetative state, or had end-stage cancer and drifted into unconsciousness.

Advance Directives have been criticized by some commentators because they require the individual to make decisions based on inherently inadequate knowledge, since most individuals have never experienced extreme, end-of-life conditions prior to executing an advance directive. They do, however, give the client at least some ability to exercise control over their healthcare. They also

provide direction for the agent and for care givers, and can relieve them of the burden of having to withdraw care solely based on their own judgment. An Advance Directive can also reduce or eliminate conflict among family members or friends regarding what care the client would have wanted.

The WWH form provides a section where the client may state goals or values about end-stage treatment, e.g., "I want to die at home, if possible," "I do not want to receive treatment if there is no reasonable expectation of benefit or survival," or "I wish to receive Last Rites according to the rite of the Roman Catholic Church."

Instructions for Sections (A), (B), and (C)

The WWH form (in conformity with the Maryland statutory form) provides three different scenarios in which the client can articulate a choice along the spectrum from minimum to maximum treatment. The three scenarios are:

A. **Terminal Condition:** death from a terminal condition (e.g., multi-organ system failure) is imminent, even if life sustaining procedures are used.

B. **Persistent Vegetative State**: the client is not conscious and not aware of herself or her environment or able to interact with others, and there is no reasonable expectation that she will ever regain consciousness (i.e., brain death).

C. **End-Stage Condition**: an incurable condition that will continue in its course until death and has already resulted in loss of capacity and complete physical dependency (similar to "A"), e.g., end-stage pancreatic cancer.

In order for the client's preferences to be triggered, at least two physicians (one of whom must be the client's attending physician) must certify that she has reached one of these conditions.

The form offers the following range of treatment for each scenario: the client must select only one. Some clients may want to alter this language to account for their own personal medical needs or medical history. The attorney should incorporate those changes in plain language.

1. Minimum treatment

   - No treatment to extend life
   - No nutrition or fluids by tube or any other artificial means
   - Allow natural death to occur

2. Medium treatment: Food and Fluids

   - No treatment to extend life
   - DO provide nutrition and fluids, even by artificial means if necessary
   - Allow natural death to occur

3. Maximum treatment

- Extend life as long as possible, using all reasonable medical interventions
- Provide nutrition and fluids, even by artificial means if necessary

D. Pain Relief

Some pain medication carries the risk of hastening death. The client can instruct her agent and healthcare providers to administer pain medication in these circumstances anyway, even if doing so may cause her to die more quickly. In the alternative, the client can forego pain relief if it would hasten death.

E. Pregnancy

This section can be deleted for clients to whom it does not apply. Clients for whom pregnancy could be an issue can specify treatment in the event she is pregnant while in a terminal/vegetative/end-stage condition and no longer capable of deciding whether to continue to live. The form provides three options:

1. The agent shall have sole discretion to authorize or stop life-sustaining treatment for the client **(broadest power);**

2. The agent shall make any decision for or against treatment solely based on client's best interests, and not simply to sustain the pregnancy **(i.e., do not sustain client's life just for the unborn child);**

3. The agent shall make any decision for or against treatment based on the best interest of the unborn child **(i.e., do everything possible to bring child to birth).**

F. Respectful Relations

This section applies to trans or gender-nonconforming clients (and otherwise can be deleted). These clients may find that in receiving medical care, there is reluctance by medical professionals to use the client's chosen name and the gender pronouns with which she or he identifies, as well as to maintain the client's dress and appearance in a manner consistent with his or her gender identity. For example, care providers might refer to a transman as "she," refer to a client by a legal name of "Danielle" versus a chosen name of "Dan," and might address issues of how to dress or groom the patient in a way that would be contrary to the patient's gender identity and expression. This form permits the client to state their preferences should they have any concern that these issues come up. As with all sections in this directive, this section can be deleted if it is not applicable to a given client.

G. Effect of Stated Preferences

The reality of healthcare is that any given client's final course may not fit neatly into the categories and assumptions laid out in his or her Advance Directive. Advance Directives by their very nature require a client to make decisions based on partial knowledge at best, since few of us have first-hand experience of end-of-life conditions, or the treatment that can accompany them. Few clients will have ever actually been on a respirator, or lived with paralysis after a stroke, or lived with dementia. Hence it might be wise for the client to leave decisions in such circumstances to a trusted agent, with the Advance Directive serving as guidance. On the other hand, leaving such decisions to an agent's discretion may defeat the client's desire to control her end-of-life care. The form itself attempts to solve this problem by offering two alternatives for the effect of a client's preferences.

The first option indicates that the client's stated preferences are to be used as guidance for decision-making when she can no longer make decisions herself, but allows the healthcare agent and healthcare providers flexibility in applying them, so long as they act in the client's best interest. This leaves ultimate decision-making in the agent's discretion.

The second option, by contrast, requires the agent and healthcare providers "to follow my stated preferences exactly as written." If the client thinks the agent could be pressured by others to act contrary to the client's wishes (e.g., to terminate life support), then this may be the preferred option. If the client is confident in the agent's willingness and ability to carry out the objectives of her wishes, then the first option would be better, given the unpredictability of medicine.

Part III: After Death

A. Organ Donation

If the client wishes healthcare professionals to be able to harvest organs or tissue upon her death, she should indicate so here. If not, she should also so indicate. She may also restrict the use to which organs or tissue may be put.

B. Donation of Body

The client may donate her entire body for medical study if she wishes. She should indicate her wishes here.

C. Respectful Remembrance

Similar to the "Respectful Relations" section above, which refers to what shall happen while the client is incapacitated, this addresses the same gender identity and expression issues should the client pass away.

It is very important to tell the client that they need to complete a "Disposition of Remains" to designate someone to carry out these wishes (as well as all other preparations). If possible, this should be done at the same time as the Advance Directive. If not, the client could return to one of our estate planning clinics or a future meeting with the attorney. If the client says they already have such a document completed, they should be advised to inform the person they have selected about these wishes and to make sure that person will carry them out; if their existing Disposition of Remains was completed outside of WWH, they should be advised to provide us with a copy so that we can confirm that it meets the statutory requirements.

Part IV: Declaration, Signature & Witnesses

In order for the Healthcare Power of Attorney and Advance Directive to be effective in the District, Virginia, and Maryland (Maryland in particular), it must be carefully executed in the presence of two witnesses, neither of whom is:

- The agent;
- The client's healthcare provider (or an employee thereof);
- An heir by the law of intestacy (e.g., child, spouse, sibling, or parent);
- A beneficiary of the client's Will;
- Responsible in any way for the client's medical bills (e.g., a spouse);
- A financial beneficiary in any way of the client's death.

Should the client not have two witnesses present to sign, they should either (a) be sent home with the document (with a copy at WWH) to be signed and witnessed, or (b) scheduled to come in to an estate planning clinic to have the document signed and witnessed.

Be sure to follow the procedures described below in the Conclusion, under the sub-section on completing documents, as well as the procedures outlined in Appendix A.

Document Four: Disposition of Bodily Remains

The legal authority of the healthcare agent terminates the moment the life of the principal ends. Therefore, the client should separately appoint an agent to handle her bodily remains or else, by legal default, the client's body will become the property of the next of kin. The client can designate this agent and provide instructions about funeral and burial arrangements in in a document called the Disposition of Bodily Remains (hereafter "DOBR"). A DOBR is thus especially helpful when a client is estranged from (or simply geographically distant from) their family. Given that transgender or gender non-conforming clients may face discrimination or ignorance by both their legal next of kin and the parties involved with their remains (e.g., staff at a funeral home or cemetery), it is especially important that these clients complete a DOBR. As a result, there is a section of WWH's document that specifically addresses trans issues.

The DOBR allows the client to name the person she wants to be in charge of her remains; often, this will be the same person they appoint as their healthcare agent. It also allows the client to select an alternate. The client can also add instructions reflecting her wishes (e.g., whether she wants to be cremated or buried, whether she wants a memorial service of a certain type, etc.). However, the client need not capture every detail of their wishes so long as the person they are appointing knows how to carry them out, and the client trusts that individual to do so.

Like the AD/POA, the DOBR must be witnessed by two disinterested individuals; it therefore is logical for the client to complete this document at the same time as the AD/POA. If that is not possible, the client should be encouraged to return to an estate planning clinic or a future meeting with the attorney to complete the DOBR.

Be sure to follow the procedures described below in the Conclusion, under the subsection on completing documents, as well as the procedures outlined in Appendix A.

Conclusion: Completing Documents and Next Steps

Completing Documents

When all of the documents have been completed and return to WWH, the procedures listed below in Appendix A should be followed.

Attorney should offer to make copies of the document for the client. The client should keep the original in a safe place and should (ideally) take a copy with them while traveling. Additionally, a copy should be given to their primary and alternative agent. Finally, a copy should be given to any of their healthcare providers.

As Appendix A illustrates, all of the documents should be scanned and sent by email to the appropriate parties to be added to medical records, provided that the client is also a WWH patient. Hard copies of all documents should be made for the client's legal files.

When the documents are finished, all clients should be given a printed and completed "Take-Away for Completed Advance Directives" form and counseled on the information it provides. A copy of this take-away should be added to the client's file.

Next Steps

When all of the healthcare planning documents are completed, the client should advised that if she is interested, she can be given an intake to have additional documents completed at an estate planning clinic, or possibly as a daytime service. These documents include a will and a durable power of attorney for financial matters.

A will designates how the property (both real and personal) of the client shall be distributed upon death. Although not all clients will meet the income or asset requirement for WWH to provide this service, that determination shall be made on a case-by-case basis by a supervising attorney. The client should be encouraged to complete an intake to determine eligibility and, if eligible, to sign up for an estate planning clinic. This referral should be made to Becky Reeve, intake coordinator, at (202) 939-7630, or breeve@whitman-walker.org, with the assistance of the attorney completing the Advance Directive.

A durable power of attorney for finances empowers the agent to do anything regarding the client's money and property that the client could do herself (other than make gifts). In the first section (taken from the DC statutory form), the client can delegate any or all of a broad range of powers. The power of attorney can be more narrowly tailored, however, if the client prefers. The remainder of the document lays out in detail the powers delegated. It also should be witnessed by two disinterested individuals and notarized.

Appendix: Procedure for Phone & Email Intakes, and Walk-Ins

These instructions are applicable when a Patient is referred to Legal Services for advance healthcare planning, including HIPAA authorizations, healthcare powers of attorney, living wills, and disposition of remains.

Intake Instructions

Procedure at 1525 and ET:
At 1525 and ET, clients will be directed to the current staffer in charge of intake. Intake staff should explain the documents briefly so that clients understand what they are having completed. Clients should be directed to sign up for a clinic unless there is a reason not to (e.g. they need to be seen as soon as possible, they do not want to come in during an evening, etc.).

- If the client will come to a clinic: The RSVP list for the clinics is located Common / Clinics / Healthcare Planning Clinic; if possible, please also open a healthcare power of attorney / living will case and assign it to Allison with a note that the clinic has RSVP'd for a clinic on the appropriate date.
- If the client wants to schedule a staff appointment: Intake staff should (a) take the case themselves if they are able to do so or (b) assign the case to Allison if not, who can take the case or assign it to another attorney.
- If the client needs to be seen immediately: Intake staff should (a) take on the case if possible or (b) find an attorney who can.

Procedure at MRC:
At MRC, clients should be seen by a staff attorney on duty, who should take on the case themselves if possible and either assist the client immediately or schedule an appointment. The clinic is also open to MRC patients, but as they take place at ET, this is unlikely to be an appealing option.

Procedure for Part D Intakes (Outside of Open Enrollment Season):
Clients who indicate interest in healthcare planning services on a Part D intake should be advised by the attorney who receives the intake. They should preferably be directed to attend a clinic and put on the RSVP list if amenable; a healthcare power of attorney / living will case should be opened and assigned to Allison, with a note that they will attend the applicable clinic. If the client does not want to attend a clinic, the attorney assigned to the Part D case should take the healthcare planning case themselves. Note: during Open Enrollment season, clients who indicate interest in healthcare planning will be "pulled" in reports after cases are called, and staff will *not* handle these cases on an ongoing basis.

Provision of Service Instructions

First Meeting: Whenever Patient is first seen, a standard WWH HIPAA release will be immediately completed, signed, scanned, and emailed to Judy Jenkins and Sandra Douglas to be added to the medical record. Attorney will add a copy to Patient's legal file and return original to Patient.

Patient will then be counseled on the benefits of the other documents available. If appropriate, Attorney will then draft these documents for Patient during that same meeting.

Witnessing of Documents: Presuming Patient does not have independent witnesses present, Patient will be given two options.

1. Patient can take the documents home and have them witnessed independently, and then return to WWH with the signed documents.

2. Patient can return to an evening Estate Planning clinic at ETMC and have the documents witnessed by volunteers there.

Returning Documents to WWH: When Patient has finished documents in hand, Patient should be taken to the applicable Attorney to complete the following steps. If Attorney is not available, whoever encounters the Patient should attempt to complete the following steps instead.

1. If Patient is at ETMC and Lee or Becky is available, have one of them notarize the document on a separate piece of paper, separately signed by the Patient in their presence, and attached to the Advance Healthcare Directive. This is not a legal requirement but is worth doing if possible.

2. Scan the document to be sent by Attorney to Judy and Sandra.

3. Copy the document for Legal file.

4. Give Patient back the original, after having made copies for Patient as appropriate.

Closing the Case: Attorney shall close the case when all documents are completed. If Patient begins the process and does not complete documents after repeated efforts by Attorney, case shall be closed with "counseling provided."

If Patient Wants Additional Legal Services: If Patient wants to pursue a will, financial power of attorney, or other service, Attorney shall decide if Patient is eligible our services. For estate planning matters, this will generally mean they have income of no greater than 400% FPL and liquid assets of $25,000 or less (excluding a primary residence and a car). If Patient qualifies for the desired service, Patient shall be referred to Becky for a new intake (by opening a new case in Legal Server). If Patient's needs cannot be met internally at WWH, Attorney will provide a referral list of appropriate attorneys.