Advance Healthcare Directive

# Healthcare Power of Attorney *and* Living Will

*Presented by*

ALLEGHENY COUNTY BAR ASSOCIATION

*Serving the Pittsburgh Legal Community*


ALLEGHENY COUNTY MEDICAL SOCIETY

Congratulations on taking this first step towards completing your Advance Healthcare Directive! The Allegheny County Medical Society and Allegheny County Bar Association have made this document available, as a public service, to support you in making important decisions to record your wishes for end of life healthcare. By selecting a healthcare agent, and writing down your wishes, you are helping your family and physician honor your wishes and empowering your loved ones to advocate on your behalf. We recognize that the decisions contained in this document are difficult and are not to be made lightly. We hope that this document will serve to guide and help you to think about and record those important decisions, and provide you and your family with the gift of peace of mind.

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www.ACBA.org/LivingWill



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# Making Healthcare Decisions

In Pennsylvania, you have the legal and ethical right to make decisions about the type of medical care you receive. As long as you are able to express your wishes to your doctor, you will be directly involved in all decisions about your medical treatment. However, if you lose the ability to make these decisions, others will have to make them for you. By acting now, you can designate, in advance, what happens if/when you become unable to make or communicate these decisions, and you can choose who may speak for you.

There are several things you can do, right now, to prepare for this situation:

- Name a ***Healthcare Agent***

  This person will make medical decisions for you if/when you become unable to do so for yourself.

- Create a ***Living Will***

  This document will instruct and guide your doctors and your ***Healthcare Agent*** as to what medical care you want or do not want. This document does not include or predict all possible medical situations and potential outcomes as an individual's medical circumstances are subject to change.

- Specify ***Organ and Tissue Donation(s)***

  At the time of your death, by donating organs (e.g. kidneys, liver) or tissues, you may be able to help others who may be dying, perhaps even saving their lives.

The following pages will guide you through the necessary steps to plan ahead for these decisions. Some possible scenarios where this document could become important include:

- You have a serious life-limiting medical condition which will eventually end in death, no matter what treatment is given (in other words you have a terminal illness such as incurable cancer or advanced state of heart failure).
- You are unconscious and have no possibility of recovering.
- You have an irreversible medical condition (such as Alzheimer's Disease) where you are unable to care for yourself or may even be unable to recognize or communicate with loved ones.

# Frequently Asked Questions

## *Q. What is an Advance Healthcare Directive?*

An Advance Healthcare Directive is a set of written instructions expressing your wishes for medical treatment and end-of-life care, including organ and tissue donations. A discussion of Advance Healthcare Directives touches on sensitive matters. Most of us would rather not think about being sick or dying. But, by considering these issues now, you can save your family and those close to you the burden of having to make choices for you without your guidance. Talking with your family, physician, religious advisor, and others whose views you respect may help you make decisions best suited for you.

## *Q. What are the components of an Advance Healthcare Directive?*

An Advance Healthcare Directive often contains a Healthcare Power of Attorney (where you name a person called a "Healthcare Agent" who can make treatment decisions for you). An Advance Healthcare Directive also typically contains a Living Will (healthcare treatment instructions about your choices to start, continue, refuse, or stop life-preserving treatment, as well as other specific directions about end-of-life care and your views regarding organ and tissue donations). The attached form contains both a Living Will and a Healthcare Power of Attorney.

## *Q. If I am unable to make or communicate decisions, what happens if I don't have an Advance Healthcare Directive?*

If you do not designate a Healthcare Agent, a Healthcare Representative may be selected for you according to Pennsylvania law. However, this selected person may not be the one you wish to make decisions for you.

Without a Living Will to express your wishes, your family members may not know what to do at this difficult time, or may disagree about what care to give you. Simply put, without an Advance Healthcare Directive, your wishes may not be followed.



## *Q. What is a Healthcare Agent?*

A Healthcare Agent is a person you choose to make healthcare decisions for you. You can name a family member or a friend who is familiar with your beliefs and values to interpret your instructions and to make these decisions. This Healthcare Agent can authorize, withhold or withdraw treatment.

## *Q. When does my Healthcare Agent speak for me?*

This form gives your Healthcare Agent the power to speak for you when you cannot make decisions for yourself. At any time, if you get better and are again able to make your own decisions, you may always do so. In this form, you can also choose to give your Healthcare Agent the power to speak for you immediately, if you wish. If you wish to have your Healthcare Agent make decisions for you when you can communicate, you should personally inform your attending physician, who should record this choice in your medical record.

If you have any questions about your Healthcare Agent, you may wish to consult with your attorney and physician to be sure that your wishes are clearly expressed.

## *Q. Should I talk to my Healthcare Agent about my wishes?*

Absolutely. You should be sure that the person you choose is willing to act as your Healthcare Agent. It is also very important that you discuss your wishes with your Healthcare Agent so that your Healthcare Agent understands your wishes and priorities as well as possible.

*Cont....*

You should also tell your Healthcare Agent whether you want to donate organs, or donate eyes, hands, facial tissue, limbs, or other parts of your body. Donation of hands, limbs or facial tissue could impact funeral arrangements (for example, an open casket may not be possible).

### *Q. Will my Healthcare Agent be responsible for my medical bills?*

No. Your Healthcare Agent makes decisions about your care. The cost of this care is your responsibility or the responsibility of your insurance company.

### *Q. What if my physician or healthcare provider does not want to follow my Advance Healthcare Directive?*

Your physician or healthcare provider must tell you, or your Healthcare Agent, if they cannot in good conscience follow your wishes or if the policies of the institution prevent them from honoring your wishes. By law the physician or healthcare provider must help transfer you to another physician or healthcare provider willing to carry out your directives, if one exists.

### *Q. Can I change my Advance Healthcare Directive?*

Yes! You can change your mind by telling your physicians at any time. You can write a new Advance Healthcare Directive and replace all old copies with the new one. You should update your Advance Healthcare Directive whenever major life events occur (e.g. marriage, divorce, or death of a spouse), or if your goals change. You should discuss any changes with your Healthcare Agent, your physician, as well as family members and loved ones.

If your wishes about donating organs, eyes, hands, facial tissue, limbs, or other body parts change, tell your physician and write a new Advance Healthcare Directive to replace your old one. If you do not wish to donate your hands, facial tissue or limbs, it is important to make that clear in your Advance Healthcare Directive.



### *Q. What should I do with my completed Advance Healthcare Directive?*

You should give a copy of your Advance Healthcare Directive to your Healthcare Agent, to your alternative Healthcare Agents and to your physician, and you should discuss it with them. Tell your family that you have written this document and discuss it with them and with others, such as your attorney or religious advisor. Keep a copy of your Advance Healthcare Directive in an accessible but secure place. Note that a copy kept in a safe deposit box may not be accessible when needed.

### *Q. What if I fill out an Advance Healthcare Directive in one state and I am hospitalized in a different state?*

Legal requirements vary from state to state. Your Advance Healthcare Directive helps your doctors understand your wishes no matter where you are. If you spend a lot of time in another state you might consider consulting an attorney in that state to make sure that your wishes will be honored in that state.

### *Q. Who can I contact for additional information?*

You can contact: Allegheny County Bar Association: 412-261-6161
Allegheny County Medical Society: 412-321-5030

# Instructions Booklet

***Please use the instruction booklet to complete the form.***

## DISCARD THESE INSTRUCTIONS WHEN THE DOCUMENT IS COMPLETE

The Advance Healthcare Directive Document has 5 sections.

**Section 1. Appointing a Healthcare Agent**
Appoint a specific person who will have the power to make healthcare decisions for you.

**Section 2. Healthcare Agent Powers**
Authorize your Healthcare Agent to make certain decisions for you.

**Section 3. Healthcare Treatment Instructions – Living Will**
Tell your Healthcare Agent and your healthcare providers about the specific healthcare treatments you do want and do not want to receive to prolong life in certain situations.

**Section 4. Organ Donation and Anatomical Gifts**
Choose to donate organs or make other anatomical gifts.

**Section 5. Signature, Witnesses, Notarization**
Your signature and two witnesses are required by law.

**NOTE:** This document is a template that does not include all possible medical situations and outcomes. The document can be modified as needed.

**Sections 1-4:** You may choose which of these sections you wish to complete. We highly recommend that you complete at least Section 1. Because you cannot predict your future medical needs, it is critical to appoint a Healthcare Agent to make decisions for you when you cannot.

**Section 5:** You must have your signature and two witness signatures at the end of the document.

# Instructions for Section 1

## *Specific Instructions for Section 1 – Appointing a Healthcare Agent*

**Name and County.**
Fill in your full name and the county where you live.

**Appointment of Healthcare Agent and Alternates.**
Fill in the full name, address, telephone numbers, and email address of your Healthcare Agent and any alternative agents. Note that you may not appoint your doctor or other healthcare provider as your Healthcare Agent unless they are family members. If, for any reason, your agent is not reasonably available, your alternative agents will be contacted in the order you list them.

**Only One Healthcare Agent at a Time.**
This form gives only one Healthcare Agent the power to act at any time. You are strongly urged to discuss your wishes with your Healthcare Agent, alternate agent, other family members, clergy and other trusted advisors. You are strongly urged to advise your Healthcare Agent to discuss decisions with the alternate healthcare agents, other family members, clergy and other trusted advisors, if possible, to ensure that your wishes are followed. If you wish for two or more of your Healthcare Agents to act together, you should consult with your attorney and physician to prepare a form that deals with an agent's unavailability or disagreement among the Healthcare Agents.

**Separate HIPAA Authorization (optional HIPAA waiver).**
Your Healthcare Agent has full access to your medical records when they are acting on your behalf, but before that time, those records are private. However, it may be helpful for your doctor to be able to discuss your medical records with your Healthcare Agent even while you are still able to make your own decisions for yourself. In this document you can give your doctor permission to provide access to and discuss your medical records with your Healthcare Agent immediately. Even without this HIPAA waiver, your doctor may still be able to discuss your medical records with your family as necessary for treatment.

# Instructions for Section 2

## *Specific Instructions for Section 2 – Healthcare Agent Powers*

**List of Healthcare Agent's Powers.**
The form lists nine broad powers for your agent.

Pay particular attention to number 2, which gives your agent the power to withhold or withdraw food or water supplied by tube. You may wish to consult with a religious advisor if you have questions about whether this decision agrees with the teachings of your faith.

If you have any questions about these powers, consult a doctor and an attorney for guidance. You may cross out any power you do not wish to give to your agent, but if you do, be sure to discuss it with your doctor and your lawyer to make sure that your wishes are clearly expressed.

If in this form you allow your Healthcare Agent to carry out funeral and burial arrangements, this form should not conflict with any other documents or plans you may have that state your funeral and burial wishes.

**Mental Healthcare.**
This form grants powers to your Healthcare Agent which generally include both physical and mental healthcare. It does not include specific wishes concerning mental health conditions apart from severe brain damage or brain disease. It assumes that you do not have a separate mental healthcare power of attorney or mental healthcare declaration which deals directly with specific mental health issues and is governed by Chapter 58 of the Probate, Estates and Fiduciaries Code. If you do have such a separate document, or you wish to express specific wishes concerning mental healthcare, you should consult with your lawyer and your doctor and use a different form or forms to do so.

**Appointment of Healthcare Agent as Guardian of the Person.**
By signing a Healthcare Power of Attorney appointing a Healthcare Agent to make decisions for you when you are unable to do so yourself, you reduce the chance that a court proceeding will be necessary under Pennsylvania's Guardianship laws to appoint a guardian of your person to make decisions about your care. However, should such a guardian of your person be required for any reason, (e.g. if your Healthcare Agent's decisions are challenged, or if your other family members or your doctors cannot agree with your agent's decisions) you can nominate your Healthcare Agent, or another person as guardian.

**Healthcare Agent Authority.**
You can choose to have your Healthcare Agent make decisions for you only when you cannot understand, make or communicate your own healthcare choices. This helps you keep control of your healthcare decisions as long as you can. You can also choose to have your Healthcare Agent make healthcare decisions for you right away.

**Guidance for Healthcare Agent.**
This section gives you the opportunity to separately state your healthcare goals should you suffer from an end-stage medical condition or other extreme and irreversible medical condition. This is an opportunity to express the values that are most important to you, whether it is the preservation of your life for as long as possible, or to be cared for at home as long as possible- even if this might result in a shortened life, or whether you want to let your agent decide what is best, or any other preference you may have. You may also include any religious, personal, or spiritual values.

# Instructions for Section 2 *(Continued)*

## *Specific Instructions for Section 2 – Healthcare Agent Powers*

**Severe Brain Damage or Brain Disease.**
This section refers to conditions currently believed to be irreversible, including:

- Severe brain damage, or
- Permanent unconsciousness, or
- Severe brain disease such as advanced dementia (e.g. severe Alzheimer's Disease)

In such situations, you might not be in an end-stage medical condition or permanently unconscious. However, you might not be able to care for yourself, recognize loved ones, or communicate or interact with other people. You may find there is still meaning and quality to life, and you may wish to continue living as long as possible. On the other hand, you may consider such conditions unacceptable and may find any aggressive medical care to extend your life to be burdensome. You can tell your Healthcare Agent and your doctor whether you wish medical care to be applied aggressively or not in that situation. You may also insert any other personal priorities, to help to guide your agent.

For example, if you had severe Alzheimer's Disease and developed a life-threatening but curable illness (e.g. curable pneumonia) and needed life preserving measures (e.g. a ventilator), you may wish for your doctor and your Healthcare Agent to use aggressive medical treatment to keep you alive. On the other hand, if you had severe brain damage, and developed an incurable condition such as incurable cancer, you may wish only to be kept comfortable, avoid aggressive medical treatment, and allow death to occur.

This form contains limited options for treatment. You may modify it or use a different form e.g. a dementia-specific advance directive. You should review your choices with your physician and religious advisor if applicable.

**Agent's Use of Instructions.**
Initial the first choice if you want your Healthcare Agent to be bound by your instructions. Initial the second choice if you want your Healthcare Agent to be able to override your instructions and do what he or she thinks is best for you. It is important to select a Healthcare Agent who knows you and your values, and to have conversations with your agent about your wishes and preferences to help guide your agent.

# Instructions for Section 3

## *Healthcare Treatment Instructions – Living Will*

**1. End-Stage Medical Condition.**
In this document you can decide what medical care you do want or do not want, if you are in an end-stage medical condition. This is different from your Healthcare Power of Attorney, which applies whenever you are unable to understand, make or communicate a healthcare decision.

***Aggressive medical care.*** By initialing your choice that you do or do not want aggressive medical care in those situations, you agree to the instructions set out below those statements. Read these instructions carefully to make sure they state your wishes accurately. If they do not, you may modify them. You should review any modifications to these instructions with your physician and an attorney to make sure that your wishes are expressed clearly.

***Special Rules for Pregnancy.*** If you are a woman and are diagnosed as being pregnant at the time a healthcare decision would otherwise be made pursuant to this form, special rules apply. Pennsylvania law directs that life-sustaining treatment, including nutrition and hydration, be given unless your attending physician and an obstetrician who have examined you certify in your medical record that such treatment will not permit the continuing development and birth of the unborn child, will be harmful to you, or will cause pain that cannot be alleviated by medication. If you wish to express your wishes in this regard, and it is different from the Pennsylvania law, you may wish to discuss this matter with your physician and an attorney.

**2. Tube Feedings.**
Initial one of the three choices. Note: the option of tube feeding (nutrition) without hydration (water) is intentionally omitted.

**3. Guidance for Healthcare Agent.**
This section gives you the opportunity to separately state your healthcare goals, or religious, spiritual, or personal values should you suffer from an end-stage medical condition. For example, your **goals** may be:

- To preserve my life as long as possible, even if I am suffering.
- To attempt all treatments, even if they are painful.
- To be kept comfortable, and to be treated for physical, mental, or emotional pain, even if it may shorten my life.
- To keep my mental function.
- To be able to eat and drink on my own.
- To not be kept on a ventilator or dialysis if there is no meaningful chance of recovering.
- To receive care at home, even if it might shorten my life.
- To be kept alive long enough for my loved ones to have an opportunity to say goodbye.
- To not have CPR, surgery, or treatment if there is no meaningful chance of recovering.
- To let my Healthcare Agent decide what is best for me.

# Instructions for Section 3 *(Continued)*

## *Healthcare Treatment Instructions – Living Will*

**4. Agent's Use of Instructions.**
Initial the first choice if you want your Healthcare Agent to be bound by your instructions. Initial the second choice if you want your Healthcare Agent to be able to override your instructions and do what he or she thinks is best for you. It is important to select a Healthcare Agent who knows you and your values, and to have conversations with your agent about your wishes and preferences to help guide your agent.

***Follow your Instructions.*** If you direct that your Healthcare Agent is to follow your instructions, you are taking full responsibility for the choices that you have directed. Your doctor and your Healthcare Agent will still have a lot of authority to make judgments about your healthcare choices since they must decide if there is realistic hope of a significant recovery. But otherwise, your instructions must be followed.

***Full Power to Healthcare Agent.*** If you give your Healthcare Agent full power and final authority, even to override your instructions, you will have given your Healthcare Agent all of the power which you yourself possess over your healthcare. If you choose to give your Healthcare Agent this full power and authority, you may list any limitations on that authority in the lines below. If you list such limitations, it is extremely important that you express your wishes clearly, so it is advisable to review the wording with your doctor and your lawyer. Allowing your Healthcare Agent to override your instructions may let your agent respond flexibly to changes in your medical condition.

# Instructions for Section 4

## *Specific Instructions for Section 4 – Organ Donation and Anatomical Gifts*

***Organ Donation and Anatomical gifts.*** This section allows you to state your preference about donating your organs or other body parts. It is important that you make your wishes known so that your loved ones are prepared.

Your organs can only be donated after you are declared legally dead. In Pennsylvania, in accordance with accepted medical standards, a determination of death is made when:

1. your circulatory (heart) and respiratory (lungs) functions irreversibly stop, or
2. all functions of your entire brain, including the brain stem irreversibly stop (brain death)

It is important to know the effect of organ and anatomical donations on your decisions about end-of-life care so that your wishes about end-of-life care will be fulfilled. For example:

- For an organ transplant to be successful, the dead donor may be kept on a ventilator in order to keep oxygen flowing until transplant surgery is performed. You may want to review your organ donation choices with your physician, and with your religious advisor to determine whether your decision agrees with the teachings of your faith. Most major religions support organ donation.
- Donating a hand, limb or facial tissue may impact funeral arrangements and an open casket may not be possible.

You may wish to donate all or only some organs (e.g., heart, lung, liver, kidney), tissue, eyes, or other body parts (e.g., hands, facial tissue and limbs, also known as vascularized composite allografts). The organ donor designation on the driver's license authorizes you to donate what we traditionally think of as organs (e.g. heart, lung, liver, kidney) and tissue. The driver's license donor designation does not authorize donation of hands, facial tissue, limbs, or other vascularized composite allografts.

Under Pennsylvania law, you must *explicitly* and *specifically* consent to donate hands, facial tissue, limbs or other vascularized composite allografts. You may use this document to make clear your wish to donate or not to donate hands, facial tissue or limbs.

Note that if you wish to allow organ donation for transplant only, and not for medical study or other purposes, you may indicate that preference in this document or write in that limitation.

# Instructions for Section 5

### *Specific Instructions for Section 5 – Signature, Witnesses, Notarization*

**Legal Protection.**
This provision is added so that you and your financial estate stand behind your agent and healthcare providers to protect them from lawsuits against them simply because they followed your wishes. It does not excuse negligence or malpractice in the way your instructions are carried out. If you have any questions about this release, consult an attorney for guidance.

**Signature and Witnessing.**
Date and sign the document with your full name in the presence of two witnesses who are at least 18 years old. Your address and birth date are added to ensure that your Advance Healthcare Directive is not confused with that of another person of the same or similar name.

**Signature by Mark or by Another.**
If you are physically unable to sign your name, you may sign by making your mark in place of your signature, and then have another person subscribe your name either before or after you make your mark. Or you may have someone sign or initial for you at your direction. Note that neither a healthcare provider nor an employee of a healthcare employer who provides healthcare services to you can sign your name for you.

**Witnesses.**
Two witnesses' signatures are required for your Advance Healthcare Directive to be valid in Pennsylvania. If you sign by mark or if you direct someone to sign your name for you, that person who signs your name may not be a witness. It is best where possible to avoid the use of witnesses who may be financially interested persons such as your heirs, your creditors, or your healthcare providers.

**Notarization.**
Notarization is not required in Pennsylvania, but it is required in some other states, such as West Virginia. The form is more likely to be followed in other states if it is notarized.

**What to do now?**
Carefully remove the sheets which are your Advance Healthcare Directive from this brochure, and discard the instructions. Make copies of your Advance Healthcare Directive to give to your doctor and your Healthcare Agents. Tell your doctor to add your Advance Directive to your medical record. Keep the original in a safe and accessible place. Make sure to tell your agents where you keep your original.



## NEXT STEPS

- **YOU ONLY NEED ONE ORIGINAL SIGNED FORM**
- **MAKE COPIES OF YOUR SIGNED FORM AND GIVE COPIES TO:**
  - **YOUR HEALTHCARE AGENTS**
  - **YOUR PHYSICIAN**
  - **YOUR HOSPITAL MEDICAL RECORDS OFFICE**
  - **ANY OTHER FAMILY MEMBERS YOU WISH**
- **DISCARD THESE INSTRUCTIONS WHEN THE FORM IS COMPLETE**

# ADVANCE HEALTHCARE DIRECTIVE

## SECTION 1 — HEALTHCARE POWER OF ATTORNEY

I,_____, of _____County, Pennsylvania, appoint the person named below to be my Healthcare Agent to make health and personal care decisions for me whenever I cannot understand, make or communicate a choice regarding a healthcare decision, as determined by my doctor, unless I give my Healthcare Agent immediate authority to make health and personal decisions in this document. My agent may not delegate the authority to make decisions.

**APPOINTMENT OF HEALTHCARE AGENT:**

I appoint the following as my Healthcare Agent: *You may not appoint your doctor or other healthcare provider as your Healthcare Agent unless related to you by blood, marriage or adoption.*

Healthcare Agent: _____
(Name and Relationship)

Address:_____

Home Phone:_____ Work Phone:_____ Cell Phone:_____

Email:_____

If my Healthcare Agent is not able or not willing to act in a timely manner, or if my Healthcare Agent is my spouse and an action for divorce is filed by either of us after the date of this document, I appoint the person or persons named below in the order named. (It is helpful, but not required, to name alternative Healthcare Agents).

Alternative Healthcare Agent: _____
(Name and Relationship)

Address:_____

Home Phone:_____ Work Phone:_____ Cell Phone:_____

Email:_____

*Your signature and two witness signatures are also required at the end of this document – See Section 5.*

**SEPARATE HIPAA PRIVACY AUTHORIZATION EFFECTIVE IMMEDIATELY (Optional)**

Effective immediately and continuously until my death or revocation by a writing signed by me or someone authorized to make healthcare treatment decisions for me, I authorize all healthcare providers or other covered entities to disclose to my Healthcare Agent, upon my agent's request, any information, oral or written, regarding my physical or mental health, including, but not limited to: medical and hospital records and any other private, privileged, protected or personal health information, such as health information as defined and described in the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), the regulations issued under HIPAA and any other State or local laws and rules. Information disclosed by a healthcare provider or other covered entity may be redisclosed and may no longer be subject to these privacy rules.

Signature: _____ Date:_____

** Even without this HIPAA waiver, HIPAA may still allow your doctor to share your information as necessary for treatment. **

# ADVANCE HEALTHCARE DIRECTIVE

## SECTION 2 — HEALTHCARE AGENT POWERS

My Healthcare Agent has all of the following powers subject to the healthcare treatment instructions that follow in SECTION 3. (Cross out any powers you do not want to give your Healthcare Agent):

1. To **authorize, withhold** or **withdraw** medical care and surgical procedures.
2. To **authorize, withhold** or **withdraw nutrition (food) or hydration (water) medically supplied by tube through my nose, stomach, intestines, arteries or veins.**
3. To authorize my admission to or discharge from a medical, nursing, residential or similar facility and to make agreements for my care and obtain health insurance for my care, including hospice and/or palliative care.
4. To hire and fire medical, social service and other support personnel responsible for my care.
5. To request that a physician responsible for my care issue a do-not-resuscitate (DNR) order, including an out-of-hospital DNR order, a Physician Order for Life-Sustaining Treatment (POLST) or other order to carry out my wishes and to sign any required documents and consents.
6. To carry out my wishes regarding funeral, burial, and the disposition of my body.
7. To take any legal action necessary to do what I have directed.
8. To authorize or refuse to authorize donation of organs (for example, heart, lung, liver, kidney), tissue, eyes, or other parts of the body.
9. To authorize or refuse to authorize donation of hands, facial tissue, limbs, or other vascularized composite allografts.

The powers listed above shall apply to both physical and mental health care as defined under Section 5422 of the Probate, Estates and Fiduciaries Code. I do not have a mental healthcare power of attorney or declaration under Chapter 58 of the Probate, Estates and Fiduciaries Code. (Modify or use a different form as needed if you have a mental healthcare power of attorney or declaration)

I nominate my Healthcare Agent as the guardian of my person, should such a guardian be necessary.

**HEALTHCARE AGENT AUTHORITY.** My Healthcare Agent shall have authority to make health and personal decisions for me: (Initial one option only)

Initials: _____ Only whenever I cannot understand, make or communicate a choice as determined by my doctor.

OR

Initials: _____ Immediately upon my signing of this document.

**GUIDANCE FOR HEALTHCARE AGENT (Optional)**

***Goals:*** If I have an end stage medical condition or other extreme irreversible medical condition, my goals in making medical decisions are as follows (insert your priorities, such as to receive comfort care, to not suffer with physical, mental, or emotional pain, to live as long as possible even if suffering pain, to keep mental function, to receive care at home, to let my agent decide what is best for me, to let my agent make the decision they think I would want, to live long enough to give my loved ones a chance to say goodbye if they choose to, your religious preferences, etc.):

_____

_____

_____

*Cont...*

# ADVANCE HEALTHCARE DIRECTIVE

## SECTION 2 — HEALTHCARE AGENT POWERS *(Continued)*

**1. SEVERE BRAIN DAMAGE OR BRAIN DISEASE OR PERMANENT UNCONSCIOUSNESS:**

This document contains only limited options for severe brain damage, severe brain disease, or permanent unconsciousness. You may use a different form if you would like more options e.g. for mild or moderate dementia.

(You may cross out any options with which you do not agree)

IF

- I become severely brain damaged, or
- I am permanently unconscious (e.g. in an irreversible coma or a persistent vegetative state), or
- I have severe dementia or other severe brain disease (e.g. severe Alzheimer's Disease) which has made me unable to recognize or interact with other people

AND my doctors believe there is no realistic hope of significant recovery,

I request that my agent respond to any **incurable** (and/or) **curable** (e.g. pneumonia) life-threatening conditions as follows:

Initials: _____ Keep me comfortable and allow death to occur

Initials: _____ Use all medical treatment that is needed to keep me alive

***Goals:*** If I should suffer from permanent unconsciousness or severe and irreversible brain damage or brain disease which has made me unable to recognize or interact with other people, and from which my doctors believe there is no realistic hope of significant recovery of brain function, my goals in making medical decisions are as follows: (insert your personal priorities such as: aggressively treat me if I get sick, avoid aggressive treatments, keep me alive as long as possible, I want to receive comfort care, I want to receive treatment for physical, mental and emotional pain, etc.):

_____

_____

**2. HEALTHCARE AGENT'S USE OF INSTRUCTIONS (Initial one option only).**

Initials: _____ My Healthcare Agent must follow these instructions.

OR

Initials: _____ These instructions are only guidance. My Healthcare Agent shall have the final say and may override any of my instructions. (Indicate below any desired limitation of agent's authority.)

_____

_____

Signature: _____ Date:_____

*Your signature and two witness signatures are also required at the end of this document – See Section 5.*

# ADVANCE HEALTHCARE DIRECTIVE

## SECTION 3 – LIVING WILL

### HEALTHCARE TREATMENT INSTRUCTIONS IN THE EVENT OF END-STAGE MEDICAL CONDITION

The following healthcare treatment instructions exercise my right to make my own healthcare decisions. These instructions are intended to provide clear and convincing evidence of my wishes to be followed when I cannot understand, make or communicate my treatment decisions.

**1. If I have an end-stage medical condition which will result in my death, despite the introduction or continuation of medical treatment and there is no realistic hope of significant recovery, then I choose the following** (indicate your choice by initialing your preference):

Initials: _____ **I do NOT want aggressive medical care,** and give the following instructions (cross out any treatment instructions with which you do not agree):

i. I direct that I be given healthcare treatment to relieve pain or provide comfort even if such treatment might shorten my life, suppress my appetite or my breathing, or be addictive. Medical or surgical treatment to relieve pain or provide comfort may be given even though I do not want it as a life prolonging procedure.

ii. I direct that all life prolonging procedures be withheld or withdrawn.

OR

Initials: _____ **I DO want aggressive medical care,** and give the following instructions:
I wish to receive all medical and surgical treatment needed to keep me alive as long as possible, even though my doctor believes that it will only delay the time of my death or maintain me in a state of permanent unconsciousness, and even though the treatment may cause me pain. In addition, I direct that I be given healthcare treatment to relieve pain or provide comfort provided that it does not hasten my death.

**2. Tube Feeding:** Artificial nutrition (food) or hydration (water) medically supplied by a tube through the nose, stomach, intestine, arteries, or veins.

If I am unable to eat or drink on my own and **I have an end-stage medical condition or I am permanently unconscious** and there is no realistic hope of significant recovery **(Initial one option only):**

Initials: _____ **I DO** want tube feedings (nutrition and hydration) to be given.

OR

Initials: _____ **I DO** want hydration *only* to be given.

OR

Initials: _____ **I do NOT** want tube feedings (nutrition or hydration) to be given.

*Cont...*

# ADVANCE HEALTHCARE DIRECTIVE

## SECTION 3 – LIVING WILL *(Continued)*

**3. Guidance for Healthcare Agent:**

***Goals:*** If I have an end-stage medical condition or other extreme irreversible medical condition and there is no realistic hope of significant recovery, my specific goals in making medical decisions are as follows: (insert your personal priorities, such as comfort care, preservation of mental function, care at home, whether you want or do not want specific life prolonging procedures such as heart-lung resuscitation (CPR), mechanical ventilation (breathing machine), dialysis (kidney machine), surgery, chemotherapy, radiation treatment or antibiotics, your religious preferences, etc.):

_____

_____

_____

**4. Healthcare Agent's Use of Instructions (Initial one option only).**

Initials: _____ My Healthcare Agent **must follow** these instructions.

OR

Initials: _____ These instructions are **only guidance.** My Healthcare Agent shall have final say and may override any of my instructions. (Indicate any desired limitation of agent's authority.)

_____

_____

_____

*Your signature and two witness signatures are also required at the end of this document – See Section 5.*

# ADVANCE HEALTHCARE DIRECTIVE

## SECTION 4 – ORGAN DONATIONS AND ANATOMICAL GIFTS

**1. Organ Donations:** (initial one option only):

When I die, donate

● Initials: _____ ANY/ALL of my organs

● Initials: _____ ONLY the following organs (e.g. kidneys, liver, pancreas, skin, etc.)

Organs: _____

Please insert any limitations you desire on donation of organs (e.g. medical research, transplant only):

Limitations: _____

I understand that the hospital may provide artificial support, which may include a ventilator, after I am declared legally dead in order to make the above donations.

● Initials: _____ I do NOT want to donate my organs.

Signature: _____ Date:_____

**2. Gift of Hands, Facial Tissue, Limbs, and Other Vascularized Composite Allografts:**

Initials: _____ I DO consent to making a gift of my hands, facial tissue, limbs or other vascularized composite allografts and revoke any prior decision I have made to donate such body parts.

I also understand that:

- I have the option of requesting reconstruction of my body in preparation for burial
- In the case of donation of hands, facial tissue or limbs, it is possible my identity will not be protected
- Burial arrangements may be affected, and an open casket may not be possible.
- The hospital may provide artificial support, which may include a ventilator, after I am declared dead in order to make the donation.

Please insert any limitations you desire on donation of hands, facial tissue, limbs or other vascularized composite allografts:

_____

I would like reconstructive surgery BEFORE burial (initial one option only): _____ Yes _____ No

OR

Initials: _____ I do NOT consent to making a gift of my hands, facial tissue, limbs or other vascularized composite allografts.

Signature: _____ Date:_____

*Your signature and two witness signatures are also required at the end of this document – See Section 5.*

# ADVANCE HEALTHCARE DIRECTIVE

## SECTION 5 — WITNESSES

**Legal Protection**

Pennsylvania law protects my Healthcare Agent and healthcare providers from any legal liability for their good faith actions in following my wishes as expressed in this form or in complying with my Healthcare Agent's direction. On behalf of myself, my executors and heirs, I further hold my Healthcare Agent and my healthcare providers harmless and indemnify them against any claim for their good faith actions in recognizing my Healthcare Agent's authority and in following my treatment instructions.

Having carefully read this document, I have signed it **this** _____ **day of** _____, **20** _____, revoking all previous healthcare powers of attorney and healthcare treatment instructions.

Signature:_____

Name:_____

Address:_____

Date of Birth:_____

*Two witnesses at least 18 years of age are required by Pennsylvania law and should witness your signature in each other's presence. A person who signs this document in your place and on your behalf may not be a witness. (It is preferable if the witnesses are not your heirs, nor your creditors, nor employed by any of your healthcare providers.)*

Witness 1 Signature: _____

Print Name: _____

Date: _____

Address: _____

_____

Witness 2 Signature: _____

Print Name: _____

Date: _____

Address: _____

_____

**NOTARIZATION (OPTIONAL)**

*(Notarization of document is not required by Pennsylvania law, but if the document is both witnessed and notarized, it is more likely to be honored by the laws of some other States.)*

On **this** _____ **day of** _____, **20** _____, before me personally appeared the aforesaid principal, to me known to be the person described in and who executed the foregoing instrument and acknowledged that he/she executed the same as his/her free act and deed.

IN WITNESS WHEREOF, I have hereunto set my hand and affixed my official seal in the County of

_____, State of _____ the day and year first above written.

_____
My commission expires

_____
Notary Public

**ADVANCE HEALTHCARE DIRECTIVE NOTIFICATION**

My Name: _____

I have a Healthcare Power of Attorney and a Living Will, and I have talked with my family and my doctor about the care I want. If I am unable to speak for myself, please contact:

| Name of Agent: | Name of Alternate Agent: |
| --- | --- |
| _____ | _____ |
| Best Telephone No.: | Best Telephone No.: |
| _____ | _____ |

Fill out this card, cut it out along the border line, and keep it in your wallet with your medical insurance card and driver's license.