ADVANCE DIRECTIVE PLANNING:

HEALTH CARE POWER OF ATTORNEY & LIVING WILL FORM

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Explanation and Disclaimer: This form and its information are provided free of charge by Cressman & Erde, LLC as part of its *Project Certainty*, which seeks to promote better planning opportunities for families throughout Western Pennsylvania. Please read its accompanying instructions carefully with your family prior to finalizing the form. Also, this document is not intended to take the place of legal representation or medical advice from your physician. As such, if you have any questions, please contact an attorney or physician to assist you in completing and executing the form.

General Instructions: Health Care Powers of Attorney and Living Wills are types of “Advance Directives,” which allow a person to determine what actions will be taken in the future regarding that person's medical care. In Pennsylvania, you will be involved in your own medical care decision-making as long as you are competent to do so. However, once you no longer have the capacity to make health care decisions, another person designated by you is permitted to make several types of health care decisions, as long as you have a signed Health Care Power of Attorney document.

Thus, the attached documents really permit you do two (2) things: first, you are able to appoint a trusted person or persons who can make health care decisions for you if you become unable to do so for yourself; and second, you are able to make certain health care decisions for yourself in advance if you were to later enter an end-stage medical condition or other permanent state of unconsciousness.

The goal of preparing documents such as these is to give you a greater voice and choice in your own care (even if you are unable to speak for yourself), and to ensure that your wishes regarding end-of-life care are respected.

Completing this Document: Your Health Care Power of Attorney and Living Will should be signed by you at the end of the document. Your signature should be witnessed by two (2) persons and a notary. Without the witnesses and notary signing, you cannot be certain that a health care provider will honor this document.

After Completion: Take this signed and notarized document to your doctor so that he or she may make a copy. Then, *most importantly*, provide a copy to your Primary Agent and Alternative Agent so that they may ask you any questions and discuss this with you to ensure they understand your health care desires and wishes.

Specific Instructions: Please follow these instructions when filling out the Health Care Power of Attorney and Living Will form:

Page 5 (Selecting Agents):

Your Primary Agent is the person who will be making health care decisions on your behalf if you are unable to do so yourself. It is very important that you trust this person's judgment and values, especially in regards to important medical treatment and end-of-life care. Also, consider choosing a person who is geographically close in proximity to you, so that the person would be able to reasonably participate in your medical decision-making.

Your Alternative Agent is a "back up" to the Primary Agent. If something were to happen to your Primary Agent, who would be the next best person to step into the role of the Primary Agent, and make health care decisions for you? The same qualities that were present for the Primary Agent should also be present in the Alternative Agent, especially that you trust him or her to make important health care decisions for you.

Page 6 (Powers of your Health Care Agents)

The Agent(s) you selected on Page 5 must have certain powers to act on your behalf. Some of these powers will be subject to limitations that you include in the Living Will portion of this document. However, you must review carefully these powers that your Agent has, and cross out any powers you *do not* wish your Agent(s) to have. If you do not cross out any powers, your Agent(s) will be presumed to have all of these powers.

Page 7 (Guidance For The Health Care Agent)

This section is Optional—you do not *need* to write anything here, but you may *wish* to do so, if you have specific instructions for your Agent(s). Typically, you should have selected Health Care Agent(s) who share your specific health care values, so this section likely contemplates any additional guidance that you may wish to assist the Agent(s) in making decisions, such as if you desire *not* to have a certain treatment, such as blood transfusions, or another treatment or medication. It is generally not necessary to list medication allergies or other medical information in this section, since your physician should be aware of those issues. This guidance is intended to relate more to your Agent(s)' decision-making.

Specific Instructions (continued):

Page 7 (Severe Brain Damage or Brain Disease)

This section is very important, as it governs the decisions of your Health Care Agent(s) in the future, if you were to suffer from severe brain damage or brain disease. Generally, the types of brain disease contemplated by this section are degenerative mental ailments, such as Alzheimer's Disease, Parkinson's Disease, and other types of dementia-related illnesses. If you suffered from such a disease and were permanently unconscious as a result, would you desire continuing treatment to keep you alive, or would you want any life-extending procedures to be withheld or withdrawn?

By placing your initials beside "I Agree", you are asking that the Health Care provider respond to such a condition in the same manner as you will specify in the "End-Stage Medical Condition" question that is part of the Living Will section.

By placing your initials beside "I Disagree", you are asking that the Health Care provider respond to such a condition by using all procedures to keep you alive as long as possible.

LIVING WILL INSTRUCTIONS – These instructions only apply if you are in an End-Stage medical condition. The answers you provide to these questions will not apply in any other situation.

Page 8 (End Stage Medical Condition or Permanent Unconsciousness)

This section is very important, as it relates to the nature of treatment you wish to receive in an end-stage medical condition. This condition is defined within the document itself, and please read that definition very carefully. The Agent(s) you appoint are bound to follow these instructions unless you allow your Agent(s) to override your decisions on Page 9. You may cross out any directions that you do not agree with. (For example, if you place your initials within the box labeled "I DO NOT want aggressive medical care," but you *do* want antibiotics to be used in an end-stage medical condition, but no other treatment, then you would put your initials on the appropriate line and draw a line through the word "antibiotics" in the box to the right.) If you are unsure you about your answer to such a question, make sure to consult your lawyer or doctor prior to signing the document.

Specific Instructions (continued):

Page 9 (Tube Feeding)

This section allows you to designate whether or not you wish to receive two (2) types of tube feeding in the case of an end-stage medical condition only. The two (2) types of tube feeding relate to food and water. In the question, they are presented as Tube Feeding (Nutrition) and Tube Feeding (Hydration), which relate to artificial food and water, respectively, delivered through a tube or other intravenous delivery.

Page 9 (Health Care Agent's Use of Instructions)

This section allows you to decide whether to make your health care decisions within the Living Will portion of the document *mandatory* or *permissive*. In other words, you may direct that your Health Care Agent MUST follow your instructions, or you may direct that your Health Care Agent may override your instructions and choose whatever he or she sees fit.

Page 9 (Organ Donation)

This section allows you to decide whether to donate your organs and other tissues or not. Please read this section's descriptions carefully, since organ donation applies to more than just your internal organs.

Page 10 (Legal Protection)

This section specifically provides that if a health care provider follows your Agent's instructions as they are provided for in this document, they may not be held liable under any lawsuit for doing so.

Page 10 (Signing)

This section requires your signature, which should be witnessed by two (2) persons over the age of eighteen (18) years old. This signing should be done in front of a notary. If you cannot sign the document yourself, you may sign by way of a mark or by another person, so long as the signing is witnessed by the above persons.

Additional Assistance:

If you require additional assistance in the preparation of this document, please consider contacting the law offices of Cressman & Erde, LLC at (814) 807-1071.

HEALTH CARE POWER OF ATTORNEY AND LIVING WILL

PART I – DURABLE HEALTH CARE POWER OF ATTORNEY

I, ____________________________, of ______________ County, Pennsylvania, appoint the person named below to be my health care agent to make health and personal care decisions for me whenever I cannot understand, make or communicate a choice regarding a health care decision as determined by my doctor or whenever I personally inform my doctor. My agent may not delegate the authority to make decisions.

APPOINTMENT OF HEALTH CARE AGENT: I appoint the following health care agent: (You may not appoint your doctor or other health care provider as your health care agent unless related to you by blood, marriage, or adoption.)

PRIMARY HEALTH CARE AGENT	
Name:	Address:
Relationship:	Phone 1:
E-Mail:	Phone 2:

If my health care agent is not reasonably available, or is unable or unwilling to act in a timely manner, or if my health care 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 health care agents.)

1ST ALTERNATIVE HEALTH CARE AGENT	
Name:	Address:
Relationship:	Phone 1:
E-Mail:	Phone 2:

SEPARATE HIPAA AUTHORIZATION: EFFECTIVE IMMEDIATELY: Effective immediately and continuously until my death or revocation by a writing signed by me or someone authorized to make health care treatment decisions for me, I authorize all health care providers or other covered entities to disclose to my health care 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 what is otherwise 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 health care provider or other covered entity may be redisclosed and may no longer be subject to these privacy rules.

HEALTH CARE AGENT POWERS

My health care agent has all of the following powers subject to the health care treatment instructions that follow in PART II (cross out and initial next to any powers you do not want to give your health care 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 effectuating 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.

The foregoing powers shall apply with respect to both physical and mental health care as defined under Section 5422 of the Probate, Estates and Fiduciaries Code (PEF). I do not have a mental health care power of attorney or declaration under Chapter 58 of the PEF Code.

I nominate my health care agent as the guardian of my person, should such a guardian be necessary.

(The remainder of this page is left intentionally blank.)

GUIDANCE FOR HEALTH CARE AGENT (OPTIONAL)

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 personal priorities, such as comfort care, preservation of life for as long as possible, preservation of mental function, care at home, etc.):

SEVERE BRAIN DAMAGE OR BRAIN DISEASE

If I should suffer from 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, I would consider such a condition unacceptable and the application of aggressive medical care to extend my life in this condition to be burdensome. I therefore request that my health care agent respond to any life-threatening conditions in the same manner as directed for an end-stage medical condition or permanent unconsciousness as I have indicated below.

Initial in the left box below next to your desired choice:	
	I AGREE. Please respond to any severe and irreversible brain damage or brain disease in the same manner as if I suffered from an end-stage medical condition as provided in my Living Will.
	I DISAGREE. Use all medical treatment that is needed to keep me alive.

PART II – LIVING WILL

The following health care treatment instructions exercise my right to make my own health care 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:

END-STAGE MEDICAL CONDITION OR PERMANENT UNCONSCIOUSNESS

If I have an end-stage medical condition (which will result in my death, despite the introduction or continuation of medical treatment) or am permanently unconscious such as in an irreversible coma or an irreversible vegetative state, and there is no realistic hope of significant recovery, then I choose the following (indicate your choice by initialing your preference):

Initial in the left box below next to your desired choice:	
	I DO NOT want aggressive medical care.
	I direct that I be given health care treatment to relieve pain or provide comfort even if such treatment might shorten my life, suppress my appetite or my breathing, or be habit forming. 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.
Initials	I direct that all life-prolonging procedures be withheld or withdrawn.
	I specifically do not want any of the following as life-prolonging procedures: Heart-lung resuscitation (CPR), Dialysis (kidney machine), chemotherapy, antibiotics, mechanical ventilation (breathing machine), surgery, and/or radiation treatment.
	I DO want aggressive medical care.
Initials	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. In addition, I direct that I be given health care treatment to relieve pain or provide comfort provided that it does not hasten my death.

TUBE FEEDING

I have indicated below, by my initials, whether I want nutrition (food) or hydration (water) medically supplied by a tube into my nose, stomach, intestine, arteries, or veins if I have an end-stage medical condition or I am permanently unconscious and there is no realistic hope of significant recovery.

Initial in the left box below next to your desired choice:	
	I DO NOT want tube feeding (nutrition).
	I DO want tube feeding (nutrition).
	I DO NOT want tube feeding (hydration).
	I DO want tube feeding (hydration).

HEALTH CARE AGENT'S USE OF INSTRUCTIONS

Initial in the left box below next to your desired choice:	
	My health care agent must follow these instructions.
	These instructions are only guidance. My health care agent shall have final say and may override any of my instructions.

ORGAN DONATION

Initial in the left box below next to your desired choice:	
	I DO consent to donate my organs and tissues at the time of my death for the purpose of transplant, medical study or education. If life prolonging measures are required for a short period in order to carry out my transplant wishes, I want my health care agent to decide how to best carry out my wishes.
	I DO NOT consent to donate my organs or tissues at the time of my death.

LEGAL PROTECTION

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

SIGNATURE AND WITNESSES AND NOTARY

Having carefully read this document, I have signed it this ____ day of ______________, 2014, revoking all previous health care powers of attorney and health care treatment instructions.

_____________________________ : ___________________________________

Name (Printed) Signature

___________________________________ ___________________________________

Witness #1 Witness #2

NOTARY

On this _____ day of _________________, 2014, before me personally appeared ______________________________, 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 Crawford, State of Pennsylvania, the day and year first above written.

____

Notary

My Commission Expires: