Legal Forms & Services

FirstName LastName

PENNSYLVANIA HEALTH CARE DIRECTIVE & LIVING WILL

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Legal Forms & Services

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The answers you provide in the questionnaire are incorporated in this document at your direction. The form was developed by attorneys based on the laws of your state. You are responsible for finalizing the document and having it reviewed by an attorney.

Finalizing a Health Care Directive & Living Will in Pennsylvania
After printing your document, you will need to finalize it. Below are the steps:

1. Print out your document
2. Review, initial, sign, and date in front of two witnesses
3. Have witnesses sign and date
4. Keep document in a safe place

Notice: Some state laws require the principal to initial next to the instructions they have provided in order for that instruction to be effective. Review the state laws applicable to health care directives and living wills, review the document carefully, and initial where required by law.

Some state laws prohibit the designation of certain people as a health care agent. To avoid that result, you should review your state laws applicable to who can and cannot be a health care agent.

Some state laws prohibit certain people from being witnesses to a health care directive and living will. Review your state's laws on witness requirements for health care directives and living wills.

HEALTH CARE DIRECTIVE & LIVING WILL

FOR

FirstName LastName

This document includes the following:

> Health care power of attorney naming a health care agent to make my health care decisions based on these instructions if I am unable to speak or make them myself. If my wishes are unknown, my health care agent should act in my best interest.
>
> Living will with health care instructions to guide those making health care decisions on my behalf in the event I am unable to communicate or make my health care decisions on my own.

PART I: HEALTH CARE POWER OF ATTORNEY

I, FirstName LastName, of Pennsylvania, appoint the person named below to be my health care agent to make health and personal care decisions for me.

This document will take effect when and only when I lack the ability to understand, make or communicate a choice regarding a health or personal care decision as verified by my attending physician. My health care agent may not delegate the authority to make decisions.

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 (Public Law 104-191, 110 Stat. 1936), the regulations promulgated thereunder 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 the privacy rules provided by 45 C.F.R. Pt. 164.

MY HEALTH CARE AGENT HAS ALL OF THE FOLLOWING POWERS SUBJECT TO THE HEALTH CARE TREATMENT INSTRUCTIONS THAT FOLLOW IN PART III (CROSS OUT 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 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 take any legal action necessary to do what I have directed.

6. To request that a physician responsible for my care issue a do-not-resuscitate (DNR) order, including an out-of-hospital DNR order, and sign any required documents and consents.

7. To authorize or refuse to authorize donation of what we traditionally think of as organs (for example, heart, lung, liver, kidney), tissue, eyes or other parts of the body.

8. To authorize or refuse to authorize donation of hands, facial tissue, limbs or other vascularized composite allografts.

APPOINTMENT OF HEALTH CARE AGENT

I appoint the following health care agent:

Name: FirstName LastName

Relationship: Spouse

Address: 111 Street Address

City, Pennsylvania 12345

Phone: 555-555-5555

Email: name@email.com

IF YOU DO NOT NAME A HEALTH CARE AGENT, HEALTH CARE PROVIDERS WILL ASK YOUR FAMILY OR AN ADULT WHO KNOWS YOUR PREFERENCES AND VALUES FOR HELP IN DETERMINING YOUR WISHES FOR TREATMENT. NOTE THAT 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.

If my health care agent is not readily available 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.

First Alternative Health Care Agent:

Name: FirstName LastName

Relationship: Son

Address: 222 Street Address

City, Pennsylvania 12345

Phone: 555-555-5555

Email: name@email.com

GUIDANCE FOR HEALTH CARE AGENT GOALS (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 mental function, etc.:

I do not wish to state goals at this time.

SEVERE BRAIN DAMAGE OR BRAIN DISEASE

If I should suffer from severe and irreversible brain damage or brain disease with no realistic hope of significant recovery, I would consider such a condition intolerable and the application of aggressive medical care to be burdensome. I therefore request that my health care agent respond to any intervening (other and separate) life-threatening conditions in the same manner as directed for an end-stage medical condition or state of permanent unconsciousness as I have indicated below.

_____☑ I disagree

PART II: HEALTH CARE TREATMENT INSTRUCTIONS IN THE EVENT OF

END-STAGE MEDICAL CONDITION

OR PERMANENT UNCONSCIOUSNESS

(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 lack the capacity to understand, make or communicate my treatment decisions:

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 AN IRREVERSIBLE COMA OR AN IRREVERSIBLE VEGETATIVE STATE AND THERE IS NO REALISTIC HOPE OF SIGNIFICANT RECOVERY, ALL OF THE FOLLOWING APPLY:

(Cross out treatment instruction if you do not agree.)

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.

(Cross out treatment instruction if you do not agree.)

~~I direct that all life prolonging procedures be withheld or withdrawn. You may want to consult with your physician and attorney in order to determine whether your designated choices regarding end-of-life care are compatible with anatomical donation. In order to donate an organ your body may need to be maintained on artificial support after you have been declared dead to facilitate anatomical donation. Detailed information about the procedure for being declared brain dead or dead by lack of cardiac function and information about organ donation can be found on the Department of Transportation's publicly accessible Internet website~~.

I specifically do NOT want any of the following as life prolonging procedures:

(If you wish to receive any of these treatments, write “I DO WANT” after the treatment.)

heart-lung resuscitation (CPR) I DO WANT

mechanical ventilator (breathing machine) I DO WANT

dialysis (kidney machine) I DO WANT

surgery I DO WANT

chemotherapy I DO WANT

radiation treatment I DO WANT

antibiotics I DO WANT

I want the following regarding tube feedings:

(Initial only one statement.)

TUBE FEEDINGS

_____☑ I want tube feedings to be given

OR

NO TUBE FEEDINGS

[☐ I do not want tube feedings to be given.]

If I have authorized donation of an organ (such as a heart, liver or lung) or a vascularized composite allograft in the next section of this document, I authorize the use of artificial support, including a ventilator, for a limited period of time after I am declared dead to facilitate the donation.

HEALTH CARE AGENT'S USE OF INSTRUCTIONS

(Initial only one option.)

☐ My health care agent must follow these instructions.

OR

_____☑ These instructions are only guidance.

My health care agent shall have final say and may override any of my instructions.

Exceptions: I do not have any exceptions at this time.

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: ______________________________

INFORMATION ABOUT ANATOMICAL DONATION

Donating an organ or other part of the body is a voluntary act. Under Pennsylvania law, you do not have to donate an organ or any other part of your body. It is important to know the effect of organ donation on your decisions about end-of-life care so that your wishes about end-of-life care will be fulfilled. If someone wishes to become an organ donor, the person may be kept on artificial support after the person has been declared dead to facilitate anatomical donation. Detailed information about the procedure for recovering organs and other parts of the body and detailed information about brain death and cardiac death may be found on the Department of Transportation's publicly accessible Internet website.

Under Pennsylvania law, the organ donor designation on the driver's license authorizes the individual to donate what we traditionally think of as organs (for example, heart, lung, liver, kidney) and tissue and does not authorize the individual to donate hands, facial tissue, limbs or other vascularized composite allografts.

Under Pennsylvania law, explicit and specific consent to donate hands, facial tissue, limbs and other vascularized composite allografts is needed. Donation of these parts of the body is voluntary. Information about the procedure to transplant hands, facial tissue and limbs can be found on the Department of Transportation's publicly accessible Internet website. It is important to know that donating a hand, limb or facial tissue may impact funeral arrangements and that an open casket may not be possible.

ORGAN DONATION

GIFT OF HANDS, FACIAL TISSUE, LIMBS AND OTHER VASCULARIZED COMPOSITE ALLOGRAFTS

_____☑ I consent to making an anatomical gift. This gift includes my hands, facial tissue, limbs or other vascularized composite allografts. I also understand that I have the option of requesting reconstruction of my body in preparation for burial and that anonymity of identity may not be able to be protected in the case of donation of hands, facial tissue or limbs. I also understand that burial arrangements may be affected and that an open casket may not be possible. I also understand that the hospital may provide artificial support, which may include a ventilator, after I am declared dead in order to facilitate donation.

Please insert any limitations you desire on donation of hands, facial tissue, limbs or other vascularized composite allografts and whether you request reconstructive surgery before burial: I do not wish to insert any limitations at this time.

SIGNATURES

This document must be signed and dated by me. It also must be verified by two witnesses and signed and dated when it is witnessed.

I, FirstName LastName, sign this directive voluntarily and declare I am capable of understanding the instructions I have given and the choices I have made therein. I understand that I may revoke this directive at any time prior to my incapacity.

My Signature: ____

Date signed: ____

If I cannot sign my name, I ask the below named person to sign for me.

(Note: A person who signs this document on behalf of and at the direction of a principal may not be a witness. A health care provider and its agent may not sign on behalf of the principal if providing health care services to the principal.)

Signature: ____

Printed Name:____

TWO WITNESSES

Witness One. In my presence on _____________________ (date) FirstName LastName acknowledged his/her/their signature on this document or acknowledged that he/she/they authorized the person signing this document to sign on his/her/their behalf. I certify the following:

- I am at least 18 years of age.
- I am not the individual who signed this document on behalf of and at the direction of a principal, if applicable.

Witness One Signature: ____

Witness One Printed Name: ______________________________________

Witness One Address: ____

____

Witness One Phone: ____

Witness Two. In my presence on _____________________ (date) FirstName LastName acknowledged his/her/their signature on this document or acknowledged that he/she/they authorized the person signing this document to sign on his/her/their behalf. I certify the following:

- I am at least 18 years of age.
- I am not the individual who signed this document on behalf of and at the direction of a principal, if applicable.

Witness Two Signature: ____

Witness Two Printed Name: ______________________________________

Witness Two Address: ____

____

Witness Two Phone: ____