Life Care Planning Packet

Advance Directives for Health Care Planning

Office of the Attorney General of Arizona
Mark Brnovich

Mail completed forms to:
Arizona Secretary of State
Attn: Advance Directive Dept.
1700 W. Washington Street
Phoenix, AZ 85007

OFFICE OF THE ARIZONA ATTORNEY GENERAL
Mark Brnovich

LIFE CARE PLANNING INFORMATION AND DOCUMENTS

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ARIZONA ADVANCE DIRECTIVE REGISTRY

The Arizona Advance Directive Registry was created in May 2004 by the Arizona State Legislature. The Registry is a database for the storage of advance directives (Living Will, Medical Power of Attorney, and Mental Health Power of Attorney). The Arizona Secretary of State oversees Registry filings, its security, and its operations. Health care providers may use the Registry to look up registered directives using the information provided to them by the registrant or the registrant's loved ones. Further information and access to the Registry is available on the Secretary of State's Web site at www.azsos.gov or by calling 602.542.6187 or toll free 800.458.5842. Please request information at the following:

Office of the Attorney General of Arizona
Mark Brnovich

2005 N Central Avenue
Phoenix, Arizona 85004

Direct Line: 602.542.2123
Toll Free: 800.352.8431
Fax: 602.364.1970
www.azag.gov

GENERAL INFORMATION AND INSTRUCTIONS

INTRODUCTION

WHAT IS LIFE PLANNING CARE?

All states have laws that allow us to **make future health care treatment decisions now** so that if we become incapacitated and unable to make these decisions later, our family and doctors will know what medical care we want or do not want. State laws also allow us to **appoint a representative to make future health care treatment decisions** for us if we become incapacitated, since we cannot predict what future decisions might be necessary. These laws are called "advance directives" or "health care directives." Because these laws are somewhat different from state to state, the federal Medicare/Medicaid agency suggests that citizens contact the state's Attorney General's Office about the laws of that state. The Life Care Planning program developed by the Office of the Attorney General follows Arizona law as to "health care directives."

Most people communicate their health care directives by completing forms, such as the Life Care Planning forms, that are tailored to prompt decisions about treatment choices that might be needed. Before you complete these or other health care forms, you should learn and think about what medical treatments you want and/or do not want in the future. Discuss your choices with your family, loved ones, physician, clergyperson, etc. Also consider who you want to appoint to make treatment decisions for you if you become incapacitated. Although you cannot anticipate all the medical situations that might arise, you can give guidance to your decision-maker, doctor, and family as to your values and choices, so they can respect your wishes if a time comes when you cannot make or express decisions for yourself.

So take a few moments to read about and then follow these easy steps to complete the Life Care Planning forms. This is a gift you can give to yourself and your family. Don't delay!

STEP ONE

UNDERSTANDING THE LAW-
OUR LEGAL RIGHT TO MAKE HEALTH CARE DECISIONS

Our constitutional rights to privacy and liberty include the right to make our own medical treatment decisions. The government also has interests in some of our medical treatment decisions, which include preserving life, safeguarding the integrity of the medical profession, preventing suicide, and protecting innocent third parties (Arizona, for example, does not approve or authorize suicide or assisted suicide). Choices within the bounds of law as to which medical treatments will be applied or denied are ordinarily made by the person receiving the treatment, through the process of informed consent.

If someone becomes unable to understand, reason or make judgments, his/her constitutional rights to make medical treatment decisions remain. A health care representative appointed by the person in writing or, if no one has been appointed, a representative appointed according to the law, will make treatment decisions as follows:

1. **Following Expressed Wishes:** The representative and physicians will be guided or controlled by medical treatment decisions that were made in writing by the person before he/she became incapacitated.
2. **Using Substitute Judgment:** The representative will make choices about treatment decisions based on what he/she believes the incapacitated person would choose; if those choices are unknown, and then the representative will decide based on what he/she knows about the incapacitated person's values and wishes.
3. **Using Good Faith to Decide Best Interests:** If the representative does not know the decisions, preferences or values of the incapacitated person as to medical treatment decisions, then he/she must decide in good faith what would be in the best interests of that person, considering (a) relief from suffering, (b) whether functioning will be preserved or restored, and (c) the quality and extent of sustained life.

STEP TWO
UNDERSTANDING SOME OF THE MEDICAL CHOICES
RELATED TO LIFE CARE PLANNING

You might want to become familiar with some of the medical subjects that relate to future medical care, especially medical treatment choices specifically mentioned in Arizona law. There are many places you can get information to help you -- from your physician, at your local library or bookstore, on the Internet, by sharing experiences of friends and family, etc. -- so this is only a beginning to get you started thinking about these important matters. At the end of this General Information section is a list of resources where you can find more information about Life Care Planning.

- **Comfort Care**

Under Arizona law, comfort care is an effort to protect or enhance quality of life without artificially prolonging life. Comfort care often means pain medication. For example, morphine and other medications may be administered to alleviate pain, and dosages can be increased as pain increases. Medications may or may not cause sleepiness, sedation, or other side effects. Talk with your doctor about your concerns as to pain relief, and what is best in a given circumstance for a suffering person.

Comfort care can also include oxygen and perhaps stopping certain medical interventions. It may involve offering but not forcing food or fluids, keeping the patient clean, cooling or warming the patient, humidifying the room, turning lights on or off, holding the patient's hand, and comforting him/her with soothing words and music.

- **Cardiopulmonary Resuscitation ("CPR") and Artificial Breathing**

CPR was developed to assist victims facing sudden death, such as heart attack or trauma, and increases the likelihood of long-term survival. Unless a doctor or other licensed health care provider authorizes a Do Not Resuscitate ("DNR") or you have a valid Prehospital Medical Care Directive, CPR is administered virtually every time a person's heart stops. Talk to your doctor to learn more about why you might choose to accept or reject CPR and the methods of CPR you want or do not want.

Ventilators put air and therefore oxygen into the lungs, and thus can save lives. Oxygen is administered for a short term by a tube through the nose or mouth and for a longer term via a tracheotomy (a hole in the throat). Talk with your doctor about the use of a ventilator.

- **Artificially Administered Food and Fluids**

Food and fluids can be artificially administered by medical procedures, including intravenous treatment or by various types of tubes inserted into the body (if food and fluid can be taken by spoon, drink, or other natural means, it is not artificially administered). Talk with your doctor about artificially administered food and fluids when a person is close to death, as compared to the use of these devices when a person is expected to recover. Also, discuss the comfort or discomfort of these procedures.

STEP THREE
TALKING WITH OTHERS
ABOUT YOUR LIFE CARE PLANNING

Now that you are familiar with a few of the issues you might need to think about, you should consider the people with whom you can begin your life care planning conversations. Your medical care is about you – so you should start the conversations with those who can help you consider what medical treatments you might want or not want if you become incapacitated, or as you approach the end of your life. Perhaps they are waiting for you to begin the discussions – so start now!

- **Your Health Care Representative**

Think about who you might want as your representative to make decisions for you if you become unable to do so for yourself. This should be a person you trust to have your interests at heart – someone who can make decisions for you in a manner that is consistent with your preferences, even if he/she disagrees.

Be sure that you speak with your representative about your choices, so that he/she can make medical decisions on your behalf in the way you would want. This is the only way you will get the benefit of having your "substituted judgment" used rather than your representative or physician's evaluation of what is in your "best interests." Remember, your representative may be asked to make many medical decisions for you if you are no longer competent to or cannot communicate your wishes. These are not only ultimate "life and death, turn-off-the-machine decisions," but also decisions about day-to-day medical care, placement in a nursing facility or hospital, administration of certain medication, etc.

- **Your Spouse, Children, Other Relatives, and Close Friends**

Consider sharing your thoughts about some or all of the above issues with your spouse and children and whoever is closest to you and most likely to be affected emotionally or otherwise by your medical condition and the decisions that must be made. Sometimes problems arise because family members do not understand what the patient would want in a given situation, or they disagree about what treatment is best for the patient. Although the designated representative is legally empowered to make decisions on behalf of the patient, uncertainties can raise concerns for the treating physicians and can result in problems, delays, misunderstandings, and even court proceedings.

This is why it is important that you discuss your beliefs, values and preferences about medical care not only with the person you choose as your health care representative but also with family, relatives, and close friends. This will give them an opportunity to learn from you what medical care you want and will make decisions easier for your representative and your physicians should the time come when you cannot make medical decisions for yourself.

- **Your Doctor, Clergyperson and Others**

You can get medical information about many issues related to the Life Care Planning forms, but only your doctor can give you the personal medical advice you need to make the best choices for you. Do not hesitate to talk with your doctor about these forms and ask for your doctor's opinion about what is best for you.

You may have religious beliefs that influence your choices. Discuss your choices with your clergyperson. You can also learn more about the positions of different faiths from religious magazines, newspapers, or Internet web pages published by various faith groups.

Finally, a lawyer, accountant, banker, or others with whom you have a relationship may also have advice for you about life care planning and choices that are best for you.

STEP FOUR
SOME QUESTIONS AND TOPICS TO CONSIDER AND DISCUSS

Now that you have a general idea of some of the topics that are important in Life Care Planning and you have identified some of the people with whom you should have these conversations, there are some questions you should consider. You do not have to discuss all these topics with everyone, and you may choose to discuss only some of these topics, or none of them. We are all different and we approach questions about disability and end of life medical care differently. There is no right or wrong way, so do what is best for you.

- **QUALITY OF LIFE AND PROLONGING LIFE**: Consider your values, beliefs, and preferences as to the length of your life in relation to the quality of your life, and whether you would or would not choose to prolong your life regardless of the quality.

  - What "quality of life" means to you: Which of the following or other factors are important to you in considering the quality of your life: The ability to think for yourself? Consciousness? The ability to communicate? The ability to take care of your personal needs? Your privacy and dignity? Mobility, independence, and/or self-sufficiency? The ability to recognize family and friends?

- Your responsibilities: Are there certain people or duties that you feel you have an obligation to live for?
- Who/what? Do your choices change if your obligations to those persons or duties are resolved? How? When?
- Your age: Does your age play a factor in any or all of your choices? Do your preferences change depending on how old you might be if these decisions must be made?
- Your religious or other beliefs: What is the importance of your religious beliefs or other values in making these determinations? Who can you talk to about this?
- Where you might be medically treated or "placed": Is your future living environment an important consideration for you? How do you feel about living in a nursing facility or other medical care facility for ongoing medical treatment?
- Finances: Is financial cost a consideration for you when you think about disability or end of life matters? What aspects of finances are you considering?

- **LIFE SUPPORT**: Consider the following common life support measures: food and/or fluids (nutrition/hydration); cardiopulmonary resuscitation (CPR) by equipment, devices, or drugs; and breathing devices such as a ventilator.

  - Under what circumstances do you want some, all, or no life support to be administered? To be withheld? To be removed or stopped? Why and which ones?
  - What about withholding or withdrawing life-sustaining treatment if you are known to be pregnant and there is the possibility that with treatment the embryo/fetus will develop to the point of a live birth?
  - What about medical care necessary to treat your condition until your doctors reasonably conclude that your condition is terminal or is irreversible and incurable or you are in a persistent vegetative state?

- **ORGAN DONATION:** You can determine if you want to donate organs or tissues, and if you do, then what organs or tissues do you want to donate, for what purposes, and to what organizations. You also have the option of whole body donation for research purposes. Or, you can leave the choice to your representative.

  - Who decides: Do you want to decide about organ/tissue donation, or do you want your representative to do so? What tissues/organs: Do you have preferences about what tissues or organs to donate -- Heart? Liver? Lungs? Kidneys? Pancreas? Whole body? Some or all of the above?
  - What purposes: Do you have preferences as to what uses might be made under Arizona law of your tissues or organs -- Transplantation? Therapy? Medical or dental education? Research or advancement of medical or dental science? Some or all of these uses?
  - What organization: Do you have preferences as to what organization should receive your tissues/organs?

- **AUTOPSY**: Under Arizona law an autopsy may be required when a person dies who was not under the current care of a physician for a potentially fatal illness, and/or the physician is unavailable or unwilling to sign a death certificate. This might happen if a person dies at home. However, if the person's doctor is willing to sign a death certificate or if the person is under the care of a hospice and its physician will sign the death certificate, an autopsy will probably not be required.

  If there is no legal reason to require an autopsy, you can decide whether upon your death you want an autopsy or not, or whether you want your representative to choose for you. There is usually a charge for voluntary autopsy. After the autopsy is completed the body is transported to the mortuary for burial or cremation. This can be a sensitive topic at the time of death, and you can help your family and loved ones by making your preferences clear.

  - Who decides: Do you want to decide about an autopsy if it is optional at the time of your death, or do you want your representative to decide?
  - Autopsy: If an autopsy is not required by law when you die, do you want or not want an autopsy performed?

- **COMFORT CARE AND OTHER SUPPORT WHEN YOU AREDYING:**

  - What are your preferences and directions about pain and pain medication?
  - Do you want a comfort care medication or procedure even if it might make you drowsy, sedated, or have other effects?
  - Do you want certain people to be with you when you are dying if they can do so? Who?
  - Do you have a preference about where you want to die? At home? In a hospital? Somewhere else?
  - Do you want your church, synagogue, mosque, or place of worship advised if you are dying?
  - Do you want certain music, poetry, or religious readings? Do you want silence? Radio? Television?

- **REMEMBRANCES TO LOVED ONES, AND FUNERAL OR OTHER ARRANGEMENTS:**

  - Do you have anything you want to be remembered for, or any special words to share with anyone that you would like to write down?
  - Do you want to be buried or cremated?
  - Do you have preferences about a memorial service? What? Where?
  - Are there certain people you would like in attendance? Are there songs, readings, or rituals you want performed?

STEP FIVE
COMPLETING THE LIFE CARE PLANNINGFORMS

Now that you have thought about Life Care Planning and discussed certain topics with those who can help you complete the forms, decide which forms you want to sign, and what you want to say in each form. Then read the instructions on each form and follow all instructions exactly, especially as to signing and witnesses. Each form has different requirements for completion under Arizona law, so be sure you follow all the individual instructions on each form.

STEP SIX
KEEPING THE ORIGINALS, MAKING COPIES, AND CHANGING YOUR FORMS

You should keep the originals in a safe place that is also readily accessible, so you can review them from time to time. Give copies to your representative(s) and your doctor(s). You might also want to give copies to family members and close friends. Keep a few extra copies and be sure to take one with you if you go to a hospital or other facility for health care.

The Arizona Secretary of State maintains the Arizona Advance Directive Registry, which is a confidential database that will store a copy of your completed Life Care Planning Forms. The purpose of registering Life Care Planning forms is to create a centralized location where your relatives or the hospital or other health care facility caring for you can access the form if it is not readily available. Access to the Life Care Planning Forms in the registry is password protected.

If you wish to register your Life Care Planning Forms in the Arizona Advance Directive Registry, you should contact the Office of the Arizona Secretary of State:

Arizona Advance Directive Registry
Arizona Secretary of State
1700 West Washington, 7^{the} Floor
Phoenix, AZ 85007-2888
602-542-6187 or 800-458-5842
www.azsos.gov/adv_dir/

You may change or cancel any of these forms whenever you wish. Review your forms every year or so and consider whether to make changes based on your life circumstances. Remember to discuss changes with your representative(s), and/or doctor(s), and perhaps your family, clergyperson, etc.

- If you want to change what you said on a form, complete a new form, following all instructions. Be sure to put a date on the new form, since the most recent form will be the valid form. Try to collect and destroy the original and copies of the old form. Give copies of the new form to your representatives, doctors, and any others you want to know about your wishes.
- If you want to cancel a form entirely, try to collect and destroy the original and all copies of the form. In Arizona, you can also revoke the Durable Health Care Power of Attorney and the Durable Mental Health Care Power of Attorney verbally by telling your representative(s) and/or health care provider. Cancellation in writing is always best if you are able to do so, since writing makes your wishes clearer.

CONCLUSION

SOME FINAL INFORMATION

CITATIONS TO RELEVANT ARIZONA LAWS: You can find the relevant Arizona statutes addressing these issues as follows:

- **About Living Wills and Health Care Directives:** Arizona Revised Statutes §§ 36-3201 *et seq.*
- **About Representatives or Surrogate Decision-Makers:** Arizona Revised Statutes §§ 36-3231 *et seq.*
- **Durable Health Care Power of Attorney:** Arizona Revised Statutes §§ 36-3221 *et seq.*
- **Living Will:** Arizona Revised Statutes §§ 36-3261 *et seq.*
- **Durable Mental Health Care Power of Attorney:** Arizona Revised Statutes §§ 36-3281 *et seq.*
- **Prehospital Medical Care Directives (Do Not Resuscitate):** Arizona Revised Statutes § 36-3251.
- **Durable General Power of Attorney:** Arizona Revised Statutes §§ 14-5501 *et seq.*
- **Autopsy:** Arizona Revised Statutes §§ 11-591 *etseq.*
- **Anatomical Gifts ("Organ Donations"):** Arizona Revised Statutes §§ 36-841 *et seq.*

DIFFERENT STATES:

Even though all states have laws for "advance directives" or Life Care Planning, the laws may be somewhat different. Normally the law of the state where treatment occurs controls, not the law of the state where medical forms were signed. If you spend time in more than one state and reasonably conclude you may need medical treatment in more than one state, you might want to have your forms comply with the laws of the states where you might be treated, to the extent possible. Consider asking an attorney for help with this.

RESOURCES THAT MIGHT BE OF HELP:

- **24-hour Senior HELP LINE** (within Maricopa County) **(602) 264-HELP ((602) 264-4357)**, (toll-free outside Maricopa County) **1-888-264-2258**. A project of Region 1, Maricopa County Area Agency on Aging. There are also regional offices located in or designated to serve each Arizona county at the local level. See your local telephone book for the closest regional office.
- **Elder Law Hotline 1-800-231-5441**: Free legal advice, information, and referrals to Arizona residents 60 years of age or older; family members can call on behalf of a senior. Attorneys do not provide services in criminal matters, nor do they represent clients in court proceedings. They do give advice, information, and referrals on a wide variety of legal matters important to seniors. Funded by the Arizona Supreme Court and operated by Southern Arizona Legal Aid, Inc.
- **Adult Protective Services:** 24-hour toll-free hotline, **1-877-SOS-ADULT (1-877-767-2385),** TDD: 1-877-815-8390 (Department of Economic Security, Aging and Adult Administration)

- **Hospice:** Hospice is for patients who have a terminal illness and have decided to shift the focus of care from cure to comfort. (The word "hospice" is derived from a medieval word meaning a place of shelter for travelers on difficult journeys.) For information and referrals call the Arizona Hospice and Palliative Care Organization at (480) 967-9424, check www.Arizonahospice.org.

WALLET-SIZED NOTICE:

Complete the wallet-sized "Notice In Case of Accident or Other Emergency," cut it out, and keep it in your wallet with your driver's license and insurance cards so that law enforcement and medical personnel will know that you have completed health care forms.

NOTICE IN CASE OF ACCIDENT OR OTHER EMERGENCY:
Name:
Date:

I have signed the following forms: (check)

- o Durable Health Care Power of Attorney
- o Living Will
- o Prehospital Medical Directive (Do Not Resuscitate)
- o Durable Mental Health Care Power of Attorney
- o Durable General Power of Attorney (Financial)

Please contact the following for a copy:

Name:
Telephone:

FREQUENTLY ASKED QUESTIONS

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FREQUENTLY ASKED QUESTIONS

1. What can I do to make sure that the Schiavo situation does not happen to me and to my family?

Terri Schiavo was in her 20s when she had her catastrophic collapse. Unfortunately, she did not leave written instructions (an "advance directive") expressing how she would like to be cared for if something happened to her. Because she did not leave instructions, the courts had to intervene to determine what she would want. Further complicating matters, her family did not agree on what her wishes would be, causing an incredibly painful situation for all involved. By taking the proper steps now, you can ensure that your wishes are known. Those steps include completing advanced directives, such as a Living Will and/or a Health Care Power of Attorney, and then discussing your choices with your loved ones so they can understand and support your wishes if you are unable to communicate for yourself.

2. Where can I find these documents?

The Attorney General's Office is just one of several sources from which to obtain forms and information on life care planning and advance directives. The forms made available by the Attorney General's Office are free of charge and comply with Arizona law. These forms and information can be found on the Attorney General's website, www.azag.gov. However, please note that advance directives do not require any particular form, and information and forms are also available from medical, religious, aging assistance, and legal organizations.

3. What are the different documents?

For example, let's look at a Durable Health Care Power of Attorney? The Durable Health Care Power of Attorney is a document lets you choose another person, called an "agent," to make health care decisions if you can no longer make those decisions for yourself. Unless the document includes specific limits, the agent will have broad authority to make any health care decision you could normally make for yourself. This could include a decision about whether or not to continue tube feeding. In this packet you will also find a Durable Mental Health Care Power of Attorney, a Living Will, a Letter to My Agent, and a Pre-Hospital Medical Directive.

4. What is a Living Will?

A Living Will is a written statement that expresses your wishes about medical treatment that would delay death from a terminal condition. It also applies to situations of persistent vegetative state or irreversible coma. A Living Will would speak for you in the event that you were unable to communicate. It gives direction and guidance to others, but is not as broadly applicable as a Durable Health Care Power of Attorney. For example, a Living Will does not permit health care providers to stop tube feeding - only an agent appointed by a Durable Health Care Power of Attorney or a court-

appointed guardian may make such a decision.

5. Can I sign both a Living Will and a Durable Health Care Power of Attorney?

Yes, but if you sign both you must attach a copy of your Living Will to the Durable Health Care Power of Attorney.

6. What if I don't sign anything? Who will make decisions for me if I am unable to communicate?

Health care providers (for example, doctors and nurses) will first try to find out if a you appointed an agent pursuant to a Durable Health Care Power of Attorney. It is also possible that a court will appoint a guardian to act as your surrogate. If you did not leave a Durable Health Care Power of Attorney and there is no court appointed guardian, the health care providers will contact the following people, in this order, who will have the authority to make health care decisions for the you (following the your wishes, if known). These people are called "surrogates."

1. Your spouse, unless you and your spouse are legally separated.
2. Your adult child. If there is more than one adult child, the health care providers will seek the consent of a majority of the children who are available for consultation.
3. Your parent.
4. Your domestic partner if no other person has assumed any financial responsibility for you.
5. Your brother or sister.
6. Your close friend.

If none of the above persons can be located, health care providers may make decisions on your behalf with the input of an ethics committee or a second physician. Again, only agents and guardians may make the decision to withdraw the artificial administration of food or fluid once it has begun. A surrogate decision-maker may not make such a decision under Arizona law.

7. Should I complete a Do Not Resuscitate "DNR" Form?

If you are healthy and strong, you may not wish to complete a DNR. You can express your wishes about how you wish to be cared for should you become seriously ill without completing a DNR. DNRs are most appropriate for people who would probably not do well with CPR (cardiopulmonary resuscitation) because they are very sick, terminally ill or otherwise extremely weak. In any case, you will need to discuss the DNR with your doctor, who will also need to sign the form.

8. At what age should I think about filling out these documents?

Now, so long as you are at least 18 years of age. It is never too early to think about these things and make preparations.

9. What should I do once I've filled out the documents?

First, it is important that you talk about the documents and your wishes with your family, your agent and your physician. An agent needs to know what your feelings are in order to act on your behalf. You also need to make sure that the appropriate people have copies of the documents. To register a copy of your documents, please send them to the Secretary of State. Information on how to register your Advance Directive and other Life Care Planning materials can be found on the Secretary of State's Web site at http://www.azsos.gov/

10. Do I have to use a lawyer to complete these forms?

No. You do not have to have a lawyer's help to fill out these documents, but you may wish to consult with a lawyer if you have questions. If you do not know an attorney in your area, the State Bar of Arizona provides information on attorney referral services for persons of varying income levels. Additionally, these legal services can help provide free

legal services to those in need:

Arizona State Bar	Community Legal Services
602.252.4804	602.258.3434
www.azbar.org	www.vlparizona.org

11. Do I have to use a notary or have a witness to complete these forms?

Yes. The Durable Health Care Power of Attorney, Living Will and Durable Mental Health Care Power of Attorney must be signed by EITHER a witness OR a notary. Please note that the witness must be at least 18, cannot be family (related by blood, adoption or marriage), cannot be in your will to receive part of your estate, cannot be appointed as your representative, and cannot be a health care giver. A witness CAN be a neighbor, a friend, or an acquaintance who is an adult, but a witness cannot be provided for in your will and cannot not be caring for you or representing you.

12. How does HIPAA apply to my Life Care Planning forms?

There is a difference of opinion as to whether HIPAA (Health Insurance Portability and Accountability Act of 1996) applies to life care planning documents, such as those provided here by the Attorney General's Office.

In an abundance of caution, we have placed a HIPAA release under the "Signature and Verification" section of both the Health Care and Mental Health Power of Attorney forms, just above the space for your signature. This release should reassure anyone concerned about HIPAA issues, especially medical personnel, that they may provide information about your care to your representative(s).

13. What else should I know?

These documents are meant for you to express your wishes, whatever they may be, so you receive the treatment you want if you can no longer communicate. The Attorney General's Office is not recommending any particular choices but does urge you to think about these choices, discuss them with your loved ones, and complete the appropriate documents for your situation. Hopefully, having your wishes clearly expressed to your loved ones and in these documents will help those close to you avoid the anguish suffered by the Schiavo family.

The primary role of the Attorney General’s Office is to provide legal representation to the State of Arizona, its agencies, and State officials acting in their official capacities. The Office is not authorized to advise or represent private citizens on personal legal matters. If you need help with a personal legal matter—such as filing a lawsuit, creating a will, or defending against a criminal charge—you may want to contact a private attorney.

LIFE CARE PLANNING FORMS

Checklist:

- ❑ Registration Agreement *
- ❑ Durable Medical Health Care Power of Attorney *
- ❑ Durable Mental Health Care Power of Attorney *
- ❑ Living Will *
- ❑ Letter to my Representative
- ❑ Prehospital Medical Care Directive (Do Not Resuscitate)*

Indicates forms that can be registered with the Secretary of State's Office

To register your completed documents, make photo copies and send the copies to:

Arizona Secretary of State
Attn: Advance Directive Dept.
1700 W. Washington Street
Phoenix, AZ 85007

Arizona Health Care Directives Registry
ARIZONA SECRETARY OF STATE
1700 W. Washington Street, 7th Floor, Phoenix, AZ 85007-2888
(602) 542-6187
(800) 458-5842 (within Arizona)
Website: www.azsos.gov

FOR OFFICE USE ONLY - REV. 06/22/16

REGISTRATION AGREEMENT

About this agreement:
This agreement shall be used for the registration of a Health Care Directive in the State of Arizona under the authority of A.R.S. § 36-3291 - 3297

This form/agreement must be written legibly or computer generated. For your convenience, this form has been designed to be filled out and printed online at the website referenced above.

Fees: None
Processing time-frame: three weeks

How to complete this form:
- Read this agreement carefully, and fill in all blank spaces
- Attach a copy of your witnessed or notarized Health Care Directive to this Agreement
- DO NOT send your original Health Care Directive Form
- Sign and date this Agreement
- Return by mail to:
  Arizona Secretary of State
  1700 W. Washington Street, 7th Fl., Phoenix, AZ 85007
  Return in person: Tucson: 400 W. Congress, Ste. 141
  Phoenix: 1700 W. Washington, Ste. 220

Last Name	First Name	Middle Name

Address

City	State	Zip

Phone	Birth Date (month/day/year)	Last 4 digits of Social Security Number

Printed name as you want it listed on your membership card

Address to return documents and wallet card (IF DIFFERENT FROM ADDRESS ABOVE)

Name

Address

City	State	Zip

I want to:

- ☐ Store a health care directive(s) in the Registry
- ☐ Replace a health care directive(s) now in the Registry with a new one
- ☐ Add an additional document to my currently stored directive(s)
- ☐ Remove my health care directive(s) from the Registry
- ☐ Request a replacement wallet card (no change to health care directive(s) in Registry)
- ☐ Change Registration Agreement information (such as new a address)

You must complete and sign the Agreement on Page 2 of this form.

Arizona Health Care Directives Registry
ARIZONA SECRETARY OF STATE
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FOR OFFICE USE ONLY - REV. 09/28/09

REGISTRATION AGREEMENT

I am providing this personal information, along with a copy of my advance directive, with the understanding that this information will be stored in the Arizona Health Care Directive Registry. I certify that the advance directive that accompanies this Agreement is my currently effective advance directive, and was duly executed, witnessed and acknowledged in accordance with the laws of the State of Arizona.

I understand this authorization is voluntary. This authorization to store my advance directive in the Arizona Health Care Directives Registry will remain in force until revoked by me. I understand that I may revoke this authorization at any time by giving written notice of my revocation to the Contact Office listed below. I understand that revocation of this authorization will NOT affect any action you took in reliance on this authorization before you received my written notice of revocation.

Contact Office: Office of the Arizona Secretary of State
Telephone: 602-542-6187 E-mail: AD@azsos.gov
Address: 1700 W. Washington Street, 7th Floor, Phoenix, AZ, 85007

Your registration form will be processed within three (3) weeks. You will receive further information in the mail. In order to complete the registration of your health care directive(s) you are required to reply to the letter that you will receive.

For further assistance please contact the Arizona Secretary of State at (602) 542-6187 or visit us online at: www.azsos.gov

Signature of person completing this agreement	Date
Printed Name	

OFFICE OF THE ARIZONA ATTORNEY GENERAL
Mark Brnovich

STATE OF ARIZONA
DURABLE HEALTH CARE POWER OF ATTORNEY

Instructions and Form

GENERAL INSTRUCTIONS: Use this Durable Health Care Power of Attorney form if you want to select a person to make future health care decisions for you so that if you become too ill or cannot make those decisions for yourself the person you choose and trust can make medical decisions for you. Talk to your family, friends, and others you trust about your choices. Also, it is a good idea to talk with professionals such as your doctor, clergyperson and a lawyer before you sign this form.

Be sure you understand the importance of this document. If you decide this is the form you want to use, complete the form. **Do not sign this form until** your witness or a Notary Public is present to witness the signing. There are further instructions for you about signing this form on page three.

1. Information about me (the Principal):

My Name: _____ My Age: _____
My Address: _____ My Date of Birth: _____
_____ My Telephone: _____

2. Selection of my health care representative and alternate ("agent" or "surrogate")

I choose the following person to act as my representative to make health care decisions for me:

Name: _____ Home Phone: _____
Address: _____ Work Phone: _____
_____ Cell Phone: _____

I choose the following person to act as an alternate representative to make health care decisions on my behalf if the first representative is unavailable, unwilling, or unable to make decisions for me:

Name: _____ Home Phone: _____
Address: _____ Work Phone: _____
_____ Cell Phone: _____

3. I AUTHORIZE if I am unable to make medical care decisions for myself:

I authorize my health care representative to make health care decisions for me when I cannot make or communicate my own health care decisions due to mental or physical illness, injury, disability, or incapacity. I want my

representative to make all such decisions for me except those decisions that I have expressly stated in Part 4 below that I do not authorize him/her to make. If I am able to communicate in any manner, my representative should discuss my health care options with me. My representative should explain to me any choices he or she made if I am able to understand. I further authorize my representative to have all access to and copies of my "personal protected health care information and medical records". This appointment is effective unless and until it is revoked by me or by an order of a court.

The types of health care decisions I authorize to be made on my behalf include but are not limited to the following:

- To consent or to refuse medical care, including diagnostic, surgical, or therapeutic procedures;
- To authorize the physicians, nurses, therapists, and other health care providers of his/her choice to provide care for me, and to obligate my resources or my estate to pay reasonable compensation for these services;
- To approve or deny my admittance to health care institutions, nursing homes, assisted living facilities, or other facilities or programs. By signing this form I understand that I allow my representative to make decisions about my mental health care except that he or she cannot have me admitted to a structured treatment setting with 24-hour-a-day supervision and an intensive treatment program – called a "level one" behavioral health facility – using just this grant of authority;
- To have access to and control over my medical records and to have the authority to discuss those records with health care providers.

4. DECISIONS I EXPRESSLY DO NOT AUTHORIZE my Representative to make for me:

I do not want my representative to make the following health care decisions for me (describe or write in "not applicable"):

5. My specific desires about autopsy:

NOTE: Under Arizona law, an autopsy is not required unless the county medical examiner, the county attorney, or a superior court judge orders it to be performed. See the General Information document for more information about this topic. Initial or put a check mark by one of the following choices.

_____Upon my death I DO NOT consent to a voluntary autopsy.
_____Upon my death I DO consent to a voluntary autopsy.
_____My representative may give or refuse consent for an autopsy.

6. My specific desires about organ donation ("anatomical gift"):

NOTE: Under Arizona law, you may donate all or part of your body. If you do not make a choice, your representative or family can make the decision when you die. You may indicate which organs or tissues you want to donate and where you want them donated. Initial or put a check mark by A or B below. If you select B, continue with your choices.

____ **A.** I DO NOT WANT to make an organ or tissue donation, and I do not want this donation authorized on my behalf by my representative or my family.

____ **B.** I DO WANT to make an organ or tissue donation when I die. Here are my directions:

1. What organs/tissues I choose to donate: (Select a or below)

☐ **a.** Whole body
☐ **b.** Any needed parts or organs:
☐ **c.** These parts or organs only:
1) _____
2) _____
3) _____

2. What purposes I donate organs/tissue for: (Select a, b, or c below)

☐ **a. Any** legally authorized purpose (transplantation, therapy, medical and dental evaluation, education or research, and/or advancement of medical and dental science).
☐ **b.** Transplant or therapeutic purposes only.
☐ **c.** Research Only
☐ **d.** Other: _____

3. Which organization or person I want my parts or organs to go to:

☐ **a.** I have already signed a written agreement or donor card regarding organ and tissue donation with the following individual or institution:(name) _____
_____

☐ **b.** I would like my tissues or organs to go to the following individual or institution:
_____

☐ **c**. I authorize my representative to make this decision.

7. Funeral and Burial Disposition (Optional):

My agent has authority to carry out all matters relating to my funeral and burial disposition wishes in accordance with this power of attorney, which is effective upon my death. My wishes are reflected below:

NOTE: If you choose whole body donation, cremation is the only burial disposition available.

Place your initials by those choices you wish to select.

_____ Upon my death, I direct my body to be buried. (As opposed to cremated)
_____ Upon my death, I direct my body to be buried in _____
_____. (Optional directive)
_____ Upon my death, I direct my body to be cremated.
_____ Upon my death, I direct my body to be cremated with my ashes to be _____
_____. (Optional directive)
_____ My agent will make all funeral and burial disposition decisions. (Optional directive)

8. About a Living Will

NOTE: If you have a Living Will and a Durable Health Care Power of Attorney, **you must attach** the Living Will to this form. A Living Will form is available on the Attorney General (AG) web site. Initial or put a check mark by box A or B.

_____ **A.** I have SIGNED AND ATTACHED a completed Living Will in addition to this Durable Health Care Power of Attorney to state decisions I have made about end of life health care if I am unable to communicate or make my own decisions at that time.
_____ **B.** I have NOT SIGNED a Living Will.

9. About a Prehospital Medical Care Directive or Do Not Resuscitate Directive:

NOTE: A form for the Prehospital Medical Care Directive or Do Not Resuscitate Directive is available on the AG Web site. Initial or put a check mark by box A or B.

____ A. I and my doctor or health care provider HAVE SIGNED a Prehospital Medical Care Directive or a Do Not Resuscitate Directive on Paper with ORANGE background in the event that 911 of Emergency Medical Technicians or hospital emergency personnel are called and my heart or breathing has stopped.

____ B. I have NOT SIGNED a Prehospital Medical Care Directive or Do Not Resuscitate Directive.

10. HIPAA WAIVER OF CONFIDENTIALITY FOR MY AGENT/REPRESENTATIVE

_____ (Initial) I intend for my agent to be treated as I would with respect to my rights regarding the use and disclosure of my individually identifiable health information or medical records. This release authority applies to information governed by the Health Insurance Portability and Accountability Act (HIPAA) of 1996, 42 USC 1320d, 45 CFR 160-164.

SIGNATURE OR VERIFICATION

A. I am signing this Durable Health Care Power of Attorney as follows:

My Signature:_____ Date: _____

B. I am physically unable to sign this document, so a proxy is verifying my desires as follows:

Proxy Verification: I believe that this Durable Health Care Power of Attorney accurately expresses the wishes communicated to me by the principal of this document. He/she intends to adopt this Durable Health Care Power of Attorney at this time. He/she is physically unable to sign or mark this document at this time, and I verify that he/she directly indicated to me that the Durable Health Care Power of Attorney expresses his/her wishes and that he/she intends to adopt the Durable Health Care Power of Attorney at this time.

Proxy Name (printed):_____

Signature:_____Date:_____

SIGNATURE OF WITNESS:

NOTE: At least one adult witness, not to include the proxy above, OR a Notary Public must witness the signing of this document and then sign it. The witness or Notary Public CANNOT be anyone who is: (a) under the age of 18; (b) related to you by blood, adoption, or marriage; (c) entitled to any part of your estate; (d) appointed as your representative; or (e) involved in providing your health care at the time this form is signed. If choosing the signature of a Notary Public instead of a witness, write "N/A" on each line below and go to the next page.

A. Witness: I certify that I witnessed the signing of this document by the Principal. The person who signed this Durable Health Care Power of Attorney appeared to be of sound mind and under no pressure to make specific choices or sign the document. I understand the requirements of being a witness and I confirm the following:

- I am not currently designated to make medical decisions for this person.
- I am not directly involved in administering health care to this person.
- I am not entitled to any portion of this person's estate upon his or her death under a will or by operation of law.
- I am not related to this person by blood, marriage or adoption.

Witness Name (printed): _____

Signature:_____Date:_____

Address: _____

_____

NOTORIAL JURAT:

NOTE: The following jurat pertains to the foregoing four pages of the State of Arizona Durable Healthcare Power of Attorney dated_____, 20_____.

Notary Public (NOTE: If a witness signs your form, you SHOULD NOT have a notary sign):
STATE OF ARIZONA) ss
COUNTY OF _____)

_____
NAME OF PRINCIPAL/PROXY

Subscribed and sworn (or affirmed) before me this _____day of___, 20_____

Notary Public _____My Commission Expires: _____

OPTIONAL:
STATEMENT THAT YOU HAVE DISCUSSED YOUR HEALTH CARE CHOICES FOR THE FUTURE WITHYOUR PHYSICIAN

NOTE: Before deciding what health care you want for yourself, you may wish to ask your physician questions regarding treatment alternatives. This statement from your physician is not required by Arizona law. If you do speak with your physician, it is a good idea to have him or her complete this section. Ask your doctor to keep a copy of this form with your medical records. If choosing not to have a physician complete this section, write "N/A" on each line below.

On this date I reviewed this document with the Principal and discussed any questions regarding the probable medical consequences of the treatment choices provided above. I agree to comply with the provisions of this directive, and I will comply with the health care decisions made by the representative unless a decision violates my conscience. In such case I will promptly disclose my unwillingness to comply and will transfer or try to transfer patient care to another provider who is willing to act in accordance with the representative's direction.

Doctor Name (printed):_____

Signature:_____Date:_____

Address:_____

_____

OFFICE OF THE ARIZONA ATTORNEY GENERAL
Mark Brnovich

STATE OF ARIZONA
DURABLE MENTAL HEALTH CARE POWER OF ATTORNEY

Instructions and Form

GENERAL INSTRUCTIONS: Use this Durable Mental Health Care Power of Attorney form if you want to appoint a person to make future mental health care decisions for you if you become incapable of making those decisions for yourself. The decision about whether you are incapable can only be made by a specialist in neurology or an Arizona licensed psychiatrist or psychologist who will evaluate whether you can give informed consent. Be sure you understand the importance of this document. Talk to your family members, friends, and others you trust about your choices. Also, it is a good idea to talk with professionals such as your doctor, clergyperson, and a lawyer before you sign this form. If you decide this is the form you want to use, complete the form. Do not sign this form until your witness or a Notary Public is present to witness the signing. There are more instructions about signing this form on page 3.

1. Information about me: (I am called the "Principal")

My Name:_____ My Age: _____
My Address:_____ My Date of Birth: _____
_____ My Telephone: _____

2. Selection of my health care representative and alternate: (Also called an "agent" or "surrogate")

I choose the following person to act as my representative to make mental health care decisions for me:

Name: _____ Home Phone:_____
Address: _____ Work Phone:_____
_____ Cell Phone:_____

I choose the following person to act as an alternate representative to make mental health care decisions for me if my first representative is unavailable, unwilling, or unable to make decisions for me:

Name: _____ Home Phone:_____
Address: _____ Work Phone:_____
_____ Cell Phone:_____

3. Mental health treatments that I AUTHORIZE if I am unable to make decisions for myself:

Here are the mental health treatments I authorize my mental health care representative to make on my behalf if I become incapable of making my own mental health care decisions due to mental or physical illness, injury, disability, or incapacity. If my wishes are not clear from this Durable Mental Health Care Power of Attorney or are not otherwise known to my representative, my representative will, in good faith, act in accordance with my best interests. This appointment is effective unless and until it is revoked by me or by an order of a court. My representative is authorized to do the following which I have initialed or marked:

DURABLE MENTAL HEALTH CARE POWER OF ATTORNEY (Cont'd)

☐ **A. About my records:** To receive information regarding mental health treatment that is proposed for me and to receive, review, and consent to disclosure of any of my medical records related to that treatment.

☐ **B. About medications:** To consent to the administration of any medications recommended by my treating physician.

☐ **C. About a structured treatment setting:** To admit me to a structured treatment setting with 24hour-a-day supervision and an intensive treatment program licensed by the Department of Health Services, which is called an inpatient psychiatric facility.

☐ **D. Other:** .

4. Durable Mental health treatments that I expressly DO NOT AUTHORIZE if I am unable to make decisions for myself: (Explain or write in "None") _____

5. Revocability of this Durable Mental Health Care Power of Attorney: This mental health care power of attorney or any portion of it may not be revoked and any designated agent may not be disqualified by me during times that I am found to be unable to give informed consent. However, at all other times I retain the right to revoke all or any portion of this mental health care power of attorney or to disqualify any agent designated by me in this document.

6. Additional information about my mental health care treatment needs (consider including mental or physical health history, dietary requirements, religious concerns, people to notify and any other matters that you feel are important): _____

HIPAA WAIVER OF CONFIDENTIALITY FOR MY AGENT/REPRESENTATIVE

_____**(Initial)** I intend for my agent to be treated as I would be with respect to my rights regarding the use and disclosure of my individually identifiable health information or other medical records. This release authority applies to any information governed by the Health Insurance Portability and Accountability Act of 1996 (aka HIPAA), 42 USC 1320d and 45 CFR 160-164.

SIGNATURE OR VERIFICATION

A. I am signing this Durable Mental Health Care Power of Attorney as follows:

My Signature: _____ Date: _____

DURABLE MENTAL HEALTH CARE POWER OF ATTORNEY (Last Page)

B. I am physically unable to sign this document, so a proxy is verifying my desires as follows:

Proxy Verification: I believe that this Durable Mental Health Care Power of Attorney accurately expresses the wishes communicated to me by the Principal of this document. He/she intends to adopt this Durable Mental Health Care Power of Attorney at this time. He/she is physically unable to sign or mark this document at this time. I verify that he/she directly indicated to me that the Durable Mental Health Care Power of Attorney expresses his/her wishes and that he/she intends to adopt the Durable Mental Health Care Power of Attorney at this time.

Proxy Name (printed): _____

Signature:_____ Date: _____

SIGNATURE OF WITNESS

NOTE: At least one adult witness, not to include the proxy above, OR a Notary Public must witness the signing of this document and then sign it. The witness or Notary Public CANNOT be anyone who is: (a) under the age of 18; (b) related to you by blood, adoption, or marriage; (c) entitled to any part of your estate; (d) appointed as your representative; or (e) involved in providing your health care at the time this document is signed. If choosing the signature of a Notary Public instead of a witness, write "N/A" on each line below and go to the next page.

A. Witness: I affirm that I personally know the person signing this Durable Mental Health Care Power of Attorney and that I witnessed the person sign or acknowledge the person's signature on this document in my presence. I further affirm that he/she appears to be of sound mind and not under duress, fraud, or undue influence. He/she is not related to me by blood, marriage, or adoption and is not a person for whom I directly provide care in a professional capacity. I have not been appointed to make medical decisions on his/her behalf.

Witness Name (printed): _____

Signature:_____ Date: _____

Address: _____

NOTORIAL JURAT:

NOTE: The following jurat pertains to the foregoing two pages of the State of Arizona Durable Mental Healthcare Power of Attorney dated_____, 20_____.

Notary Public (NOTE: If a witness signs your form, you SHOULD NOT have a notary sign):

STATE OF ARIZONA) ss
COUNTY OF _____)

_____
NAME OF PRINCIPAL/PROXY

Subscribed and sworn (or affirmed) before me this _____day of___, 20_____

Notary Public_____ My Commission Expires_____

OPTIONAL: REPRESENTATIVE'S ACCEPTANCE OF APPOINTMENT

I accept this appointment and agree to serve as agent to make mental health treatment decisions for the Principal. I understand that I must act consistently with the wishes of the person I represent as expressed in this Durable Mental Health Care Power of Attorney or, if not expressed, as otherwise known by me. If I do not know the Principal's wishes, I have a duty to act in what I, in good faith, believe to be that person's best interests. I understand that this document gives me the authority to make decisions about mental health treatment only while that person has been determined to be incapacitated which means under Arizona law that a specialist in neurology or a licensed psychiatrist or psychologist has the opinion that the Principal is unable to give informed consent.

Representative Name (printed):_____

Signature:_____ Date:_____

OFFICE OF THE ARIZONA ATTORNEY GENERAL
Mark Brnovich

LIVING WILL (End of Life Care)
Instructions and Form

GENERAL INSTRUCTIONS: Use this Living Will form to make decisions now about your medical care if you are ever in a terminal condition, a persistent vegetative state or an irreversible coma. You should talk to your doctor about what these terms mean. The Living Will states what choices you would have made for yourself if you were able to communicate. It is your written directions to your health care representative if you have one, your family, your physician, and any other person who might be in a position to make medical care decisions for you. Talk to your family members, friends, and others you trust about your choices. Also, it is a good idea to talk with professionals such as your doctor, clergyperson and a lawyer before you complete and sign this Living Will.

If you decide this is the form you want to use, complete the form. **Do not sign the Living Will until** your witness or a Notary Public is present to watch you sign it. There are further instructions for you about signing on page 2.

IMPORTANT: If you have a Living Will and a Durable Health Care Power of Attorney, you must attach the Living Will to the Durable Health Care Power of Attorney.

1. **My information:** (the "Principal")

Name:_____ Age:_____
Address: _____ Date of birth: _____
_____ Phone: _____

2. My decisions about end of life care:

NOTE: Here are some general statements about choices you have as to health care you want at the end of your life. They are listed in the order provided by Arizona law. You can initial any combination of paragraphs A, B, C, and D. **If you initial Paragraph E, do not initial any other paragraphs.** Read all of the statements carefully before initialing to indicate your choice. You can also write your own statement concerning life-sustaining treatments and other matters relating to your health care at Heading 3 of this form.

_____ **A. Comfort Care Only:** If I have a terminal condition I do not want my life to be prolonged, and I do not want life- sustaining treatment, beyond comfort care, that would serve only to artificially delay the moment of my death. (NOTE: "Comfort care" means treatment in an attempt to protect and enhance the quality of life without artificially prolonging life.)

_____ **B. Specific Limitations on Medical Treatments I Want:** (NOTE: Initial or mark one or more choices, talk to your doctor about your choices.) If I have a terminal condition, or am in an irreversible coma or a persistent vegetative state that my doctors reasonably believe to be irreversible or incurable, I do want the medical treatment necessary to provide care that would keep me comfortable, but **I do not want the following:**

_____1.) Cardiopulmonary resuscitation, for example, the use of drugs, electric shock, and artificial breathing.
_____ 2.) Artificially administered food and fluids.
_____ 3.) To be taken to a hospital if it is at all avoidable.

_____ **C. Pregnancy:** Regardless of any other directions I have given in this Living Will, if I am known to be pregnant I do not want life-sustaining treatment withheld or withdrawn if it is possible that the embryo/fetus will develop to the point of live birth with the continued application of life-sustaining treatment.

_____ **D. Treatment Until My Medical Condition is Reasonably Known:** Regardless of the directions I have made in this Living Will, I do want the use of all medical care necessary to treat my condition until my doctors reasonably conclude that my condition is terminal or is irreversible and incurable, or I am in a persistent vegetative state.

_____ **E. Direction to Prolong My Life:** I want my life to be prolonged to the greatest extent possible.

3. Other Statements Or Wishes I Want Followed For End of Life Care:

NOTE: You can attach additional provisions or limitations on medical care that have not been included in this Living Will form. Initial or put a check mark by box A or B below. Be sure to include the attachment if you check B.

☐ **A.** I have not attached additional special provisions or limitations about End of Life Care I want.
☐ **B.** I have attached additional special provisions or limitations about End of Life Care I want.

SIGNATURE VERIFICATION

A. I am signing this Living Will as follows:

Signature:_____ Date:_____

B. I am physically unable to sign this Living Will, so a proxy is verifying my desires as follows:

Proxy Verification: I believe that this Living Will accurately expresses the wishes communicated to me by the principal of this document. He/she intends to adopt this Living Will at this time. He/she is physically unable to sign or mark this document at this time. I verify that he/she directly indicated to me that the Living Will expresses his/her wishes and that he/she intends to adopt the Living Will at this time.

Proxy Name (printed):_____

Signature: _____Date:_____

SIGNATURE OF WITNESS

NOTE: At least one adult witness, not to include the proxy above, OR a Notary Public must witness you signing this document. The witness or Notary Public CANNOT be anyone who is: (a) under the age of 18; (b) related to you by blood, adoption, or marriage; (c) entitled to any part of your estate; (d) appointed as your representative; or (e) involved in providing your health care at the time this document is signed. If choosing the signature of a Notary Public instead of a witness, write "N/A" on each line below and go to the next page.

A. Witness: I certify that I witnessed the signing of this document by the Principal. The person who signed this Living Will appeared to be of sound mind and under no pressure to make specific choices or sign the document. I understand the requirements of being a witness. I confirm the following:

- I am not currently designated to make medical decisions for this person.
- I am not directly involved in administering health care to this person.
- I am not entitled to any portion of this person's estate upon his or her death under a will or by operation of law.
- I am not related to this person by blood, marriage, or adoption.

Witness Name (printed):_____

Signature:_____Date: _____

Address:_____

STATE OF ARIZONA LIVING WILL ("End of Life Care") (Last Page)

NOTORIAL JURAT:

NOTE: The following jurat pertains to the foregoing two pages of the State of Arizona Living Will dated_____, 20_____.

Notary Public (NOTE: If a witness signs your form, you SHOULD NOT have a notary sign):

STATE OF ARIZONA) ss
COUNTY OF _____)

_____
NAME OF PRINCIPAL/PROXY

Subscribed and sworn (or affirmed) before me this _____day of___, 20_____

Notary Public_____ My Commission Expires_____

OFFICE OF THE ARIZONA ATTORNEY GENERAL
Mark Brnovich

LETTER TO MY REPRESENTATIVE(S)

About Powers of Attorney Forms and Responsibilities

To My Representative:
Name:_____
Address: _____
_____

To My Alternate Representative:
Name:_____
Address: _____
_____

A. What I Ask You to Do For Me: Arizona law allows me to make certain medical and financial decisions as to what I want in the future if I become unable or incapable of making certain decisions for myself. I have completed the following document(s), and I want you to be my representative or alternate representative for the following purposes. (Initial or check one or more of the following):

____1. Durable Health Care Power of Attorney
____2. Durable Mental Health Care Power of Attorney

B. Why I Named an Alternate Representative: I chose two representatives in case one of you is unable to act for me when the time arises. I ask that you accept my selection of you as my representative or alternate. If you do not return the Power of Attorney form(s) and this letter to me or inform me differently, I will assume that you have agreed to be my representative.

C. Your Responsibilities as My Representative: By selecting you, I want you to make some very important decisions for me about my future health care needs if I become unable to make these decisions for myself. I might need you to carry out my medical choices as indicated in the enclosed Powers of Attorney, even if you do not agree with them. Please read the copies of the Powers of Attorney I am giving you. You will be my voice and will make medical decisions on my behalf. Other than what I have indicated in the Powers of Attorney as to my specific directions on certain issues, I am trusting your judgment to make decisions that you believe to be in my best interests. If at any time you do not feel that you can undertake this responsibility for any reason, please let me know. If you are unsure about any of my directions, please discuss them with me. If you are not willing to serve as my representative, please tell me so I can choose someone else to help me.

As to Health Care: You are not financially responsible for paying my health care costs merely by accepting this responsibility. Under Arizona law, you are not liable for complying with my decisions as stated in the Powers of Attorney or in making other health care decisions for me if you act in good faith.

D. What Else You Should Do: Please keep a copy of my Powers of Attorney and other documents in a safe place. Please read these documents carefully and discuss my choices with me at any time. I will give copies of my health care Powers of Attorney to my physician, and I will give copies of any or all of these Powers of Attorney to my family and any other representative I may choose. I authorize you to discuss with them the Powers of Attorney, including, as applicable, my medical situation, or any medical concerns about me. Please work with them and help them to act in accordance with my desires and in my best interests. I appreciate your support, and I thank you for your willingness to help me in this way.

Signature:_____Date: _____

Printed Name:_____

PREHOSPITAL MEDICAL CARE DIRECTIVE (DO NOT RESUSCITATE)

(IMPORTANT—THIS DOCUMENT MUST BE ON PAPER WITH ORANGE BACKGROUND)

GENERAL INFORMATION AND INSTRUCTIONS: A Prehospital Medical Care Directive is a document signed by you and your doctor that informs emergency medical technicians (EMTs) or hospital emergency personnel not to resuscitate you. Sometimes this is called a DNR – Do Not Resuscitate. If you have this form, EMTs and other emergency personnel will not use equipment, drugs, or devices to restart your heart or breathing, but they will not withhold medical interventions that are necessary to provide comfort care or to alleviate pain. **IMPORTANT**: Under Arizona law a Prehospital Medical Care Directive or DNR must be on letter sized paper or wallet sized paper on an orange background to be valid.

You can either attach a picture to this form, or complete the personal information. You must also complete the form and sign it in front of a witness. Your health care provider and your witness must sign this form.

1. My Directive and My Signature:

In the event of cardiac or respiratory arrest, I refuse any resuscitation measures including cardiac compression, endotracheal intubation and other advanced airway management, artificial ventilation, defibrillation, administration of advanced cardiac life support drugs and related emergency medical procedures.

Patient Signature:_____ Date: _____

Patient's Printed Name: _____

PROVIDE THE FOLLOWING INFORMATION: **OR**

My Date of Birth
My Sex
My Race
My Eye Color
My Hair Color

ATTACH RECENT PHOTOGRAPH HERE:

2. Information About My Doctor and Hospice (if I am in Hospice)**:**

Physician:_____ Telephone:_____

Hospice Program, if applicable (name):_____

PREHOSPITAL MEDICAL CARE DIRECTIVE (DO NOT RESUSCITATE) (Last Page)

3. Signature of Doctor or Other Health Care Provider:

I have explained this form and its consequences to the signer and obtained assurance that the signer understands that death may result from any refused care listed above.

Signature of a Licensed Health Care Provider:_____ Date: _____

4. Signature of Witness to My Directive:

NOTE: At least one adult witness OR a Notary Public must witness the signing of this document. The witness or Notary Public CANNOT be anyone who is: (a) under the age of 18; (b) related to you by blood, adoption, or marriage; (c) entitled to any part of your estate; (d) appointed as your representative; or (e) involved in providing your health care at the time this form is signed.

I was present when this form was signed (or marked). The patient then appeared to be of sound mind and free from duress.

Signature:_____ Date:_____