PENNSYLVANIA
Advance Directive
Planning for Important Healthcare Decisions

Caring Connections
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Caring Connections, a program of the National Hospice and Palliative Care Organization (NHPCO), is a national consumer engagement initiative to improve care at the end of life.

Caring Connections tracks and monitors all state and federal legislation and significant court cases related to end-of-life care to ensure that our advance directives are up to date.

It's About How You LIVE

It's About How You LIVE is a national community engagement campaign encouraging individuals to make informed decisions about end-of-life care and services. The campaign encourages people to:

Learn about options for end-of-life services and care
Implement plans to ensure wishes are honored
Voice decisions to family, friends and healthcare providers
Engage in personal or community efforts to improve end-of-life care

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Using these Materials

BEFORE YOU BEGIN

1. Check to be sure that you have the materials for each state in which you may receive healthcare.

2. These materials include:
   - Instructions for preparing your advance directive, please read all the instructions.
   - Your state-specific advance directive forms, which are the pages with the gray instruction bar on the left side.

ACTION STEPS

3. You may want to photocopy these forms before you start so you will have a clean copy if you need to start over.

4. When you begin to fill out the forms, refer to the gray instruction bars - they will guide you through the process.

5. Talk with your family, friends, and physicians about your advance directive. Be sure the person you appoint to make decisions on your behalf understands your wishes.

6. Once the form is completed and signed, photocopy the form and give it to the person you have appointed to make decisions on your behalf, your family, friends, healthcare providers and/or faith leaders so that the form is available in the event of an emergency.

INTRODUCTION TO YOUR PENNSYLVANIA ADVANCE DIRECTIVE

This packet contains a legal document that protects your right to refuse medical treatment you do not want, or to request treatment you do want, in the event you lose the ability to make decisions yourself.

The **Pennsylvania Directive** is your state's living will. It lets you state your wishes about medical care in the event that you develop a terminal condition or enter a state of permanent unconsciousness and can no longer make your own medical decisions. The Living Will becomes effective when your doctor receives a copy of it and determines that you are incompetent and in an end-state medical condition or a state of permanent unconsciousness. In your Directive you can name another person, called a healthcare agent, to make decisions about your medical care—including decisions about life support—when you can no longer speak for yourself.

Note: This document will be legally binding only if the person completing it is an individual of sound mind who is 18 years or older, or if a minor, is married, emancipated or a high school graduate.

COMPLETING YOUR PENNSYLVANIA DECLARATION

How do I make my Pennsylvania Directive legal?

In order to make your Directive legally binding, you must date and sign it, or direct another to sign it, in the presence of two witnesses who must also sign the document to show that you knowingly and voluntarily signed the document. Both of your witnesses must be 18 years or older and, if you are unable to sign your Directive, neither witness can be the person who signed the Directive on your behalf.

Note: You do not need to notarize your Pennsylvania Directive.

Whom should I appoint as my healthcare agent?

Your healthcare agent is the person you appoint to make decisions about your medical care if you become unable to make those decisions yourself. Your healthcare agent should be an adult, and can be a family member or a close friend whom you trust to make serious decisions. The person you name as your healthcare agent should clearly understand your wishes and be willing to accept the responsibility of making medical decisions for you. (A healthcare agent may also be called a “surrogate,” “attorney-in-fact,” or “proxy.”)

You can appoint a second or third person as your alternate healthcare agent. The alternate will step in if the first person you name as surrogate is unable, unwilling or unavailable to act for you.

Can I add personal instructions to my Directive?

Yes. You can add personal instructions in the part of the document called “Other directions.”

If you have appointed a healthcare agent, it is a good idea to write a statement such as, “Any questions about how to interpret or when to apply my Directive are to be decided by my agent.”

COMPLETING YOUR PENNSYLVANIA DIRECTIVE (CONTINUED)

What if I change my mind?

You may revoke your Pennsylvania Directive at any time and in any manner. Your revocation becomes effective when you, or a witness to your revocation, notify your doctor or other healthcare provider. Once your doctor is notified, he or she must then make the revocation a part of your medical record.

What other important facts should I know?

A pregnant patient's Pennsylvania Directive will not be honored, due to restrictions in the state law, unless life-sustaining treatment will not permit the development and live birth of the unborn child, will be physically harmful to the pregnant woman, or will cause her pain that cannot be alleviated by medication.

Your Directive goes into effect when a copy is provided to your attending physician and your attending physician determines that a healthcare provider has documented that despite being provided appropriate medical information, communication supports and technical assistance, you are unable to understand the potential material benefits, risks and alternatives involved in a specific proposed healthcare decision, you are unable to make that healthcare decision on your own behalf, and you are unable to communicate that healthcare decision to any other person; and you are determined to be in an end-stage medical condition or permanently unconscious. Your attending physician must promptly certify in writing that you have an end-stage medical condition or are permanently unconscious.

INSTRUCTIONS	

DURABLE HEALTH CARE
POWER OF ATTORNEY

PRINT YOUR NAME AND COUNTY

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

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 (Public Law 104-191, 110 Stat. 1936), the regulations promulgated there under 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.

The remainder of 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.

MY HEALTH CARE AGENT HAS ALL OF THE FOLLOWING POWERS SUBJECT TO THE HEALTH CARE TREATMENT INSTRUCTIONS THAT FOLLOW IN NUMBER 3 ON PAGE 13 (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.

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PRINT THE NAME, RELATIONSHIP AND ADDRESS OF YOUR AGENT

PRINT PHONE NUMBER AND EMAIL ADDRESS OF YOUR AGENT

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.

APPOINTMENT OF HEALTH CARE AGENT

I appoint the following health care agent:

Health care agent:

_________________________ _____________________(Name and relationship)

Address: ____

____

Telephone Number: Home______________ Work_____________

E-mail: ____________________________

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. (It is helpful, but not required, to name alternative health care agents.)

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PRINT THE NAME, ADDRESS, PHONE NUMBER AND EMAIL ADDRESS OF YOUR FIRST AND SECOND ALTERNATE HEALTHCARE AGENTS

First Alternative Health Care Agent:

_______________________________ _______________________________
(Name and relationship)

Address: ____

____

Telephone Number: Home_____________ Work_____________

E-mail: _____________________________

Second Alternative Health Care Agent:

_______________________________ _______________________________
(Name and relationship)

Address: ____

____

Telephone Number: Home_____________ Work_____________

E-mail: _____________________________

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OPTIONAL GUIDANCE FOR YOUR HEALTH CARE AGENT

GUIDANCE FOR HEALTH CARE AGENT (OPTIONAL)

GOALS

If I have an end-stage medical condition or other extreme irreversible medical condition, my goals in making medical decisions are as follows (insert your personal priorities such as comfort, care, preservation of mental function, etc.):

PRINT ANY GOALS FOR YOUR HEALTH CARE AGENT

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.

SELECT ONE AND INITIAL

Initials_____I agree

Initials_____I disagree

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LIVING WILL

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 ANY TREATMENT INSTRUCTIONS WITH WHICH YOU DO NOT AGREE):

CROSS OUT ANY TREATMENT INSTRUCTIONS WITH WHICH YOU DISAGREE

1. 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.

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

3. 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)

WRITE "I DO WANT" IF YOU WISH TO RECEIVE THESE TREATMENTS

heart-lung resuscitation (CPR)________________

mechanical ventilator (breathing machine) ________________

dialysis (kidney machine) ________________

surgery________________

chemotherapy________________

radiation treatment________________

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SELECT ONE AND INITIAL

SELECT ONE AND INITIAL

Antibiotics ______________________________

Please indicate whether you want nutrition (food) or hydration (water) medically supplied by a tube into your nose, stomach, intestine, arteries, or veins if you have an end-stage medical condition or are permanently unconscious and there is no realistic hope of significant recovery.

(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.

HEALTH CARE AGENT'S USE OF INSTRUCTIONS

(INITIAL ONE OPTION ONLY)

_____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. (Indicate any exceptions) ____

If I did not appoint a health care agent, these instructions shall be followed.

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.

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ORGAN DONATION (Optional)

Under Pennsylvania law, you may make a gift of all or part of your body to a bank or storage facility or a hospital, physician or medical or dental school for transplantation, therapy, medical or dental evaluation or research or for the advancement of medical or dental science. In the space below you may make a gift yourself or state that you do not want to make a gift. An individual may revoke or amend an anatomical gift by: (1) destruction, cancellation or mutilation of this document and all executed copies thereof; (2) execution of a signed statement; (3) an oral statement made in the presence of two persons; (4) a statement during a terminal illness or injury addressed to an attending physician, or (5) a signed card or document found on his person or in his effects.

Initial the line next to the statement below that best reflects your wishes. You do not have to initial any of the statements. If you do not initial any of the statements, your agent and your family will have the authority to make a gift of all or part of your body under Pennsylvania law.

SELECT ONE AND INITIAL

_____ I do not want to make an organ or tissue donation and I do not want my agent or family to do so.

_____ I have already signed a written agreement or donor card regarding organ and tissue donation with the following individual or institution:

Name of individual/organization:_____________________________

SELECT ONE AND INITIAL

_____ Pursuant Pennsylvania law, I hereby give, effective on my death (initial one)

SELECT ONE AND INITIAL

_____ Any needed organ or parts.
_____ The following part or organs listed below:

For (initial one):
_____ Any legally authorized purpose.
_____ Transplant or therapeutic purposes only.

Note: A gift of the whole body shall be invalid unless made in writing at least fifteen days prior to the date of the death, or consent is obtained from the legal next of kin.

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PRINT THE DATE AND SIGN

SIGNATURE

Having carefully read this document, I have signed it this_____day of_____________, 20_____, revoking all previous health care powers of attorney and health care treatment instructions.

____

WITNESS PROCEDURE

YOUR TWO WITNESSES MUST SIGN HERE

(SIGN FULL NAME HERE FOR HEALTH CARE POWER OF ATTORNEY AND HEALTH CARE TREATMENT INSTRUCTIONS)

WITNESS: ____

WITNESS: ____

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

OPTIONAL NOTARIZATION

NOTARIZATION (OPTIONAL)

HAVE NOTARY FILL OUT THIS SECTION

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

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

IN WITNESS WHEREOF, I have hereunto set my hand and affixed my official seal in the County of________, State of_______ the day and year first above written.

____

Notary Public

____

My commission expires

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YOU HAVE FILLED OUT YOUR ADVANCE DIRECTIVE, NOW WHAT?

1. Your Pennsylvania Directive is an important legal document. Keep the original signed document in a secure but accessible place. Do not put the original document in a safe deposit box or any other security box that would keep others from having access to it.

2. Give photocopies of the signed original to your healthcare agent and alternate healthcare agents, doctor(s), family, close friends, clergy and anyone else who might become involved in your healthcare. If you enter a nursing home or hospital, have copies of your Directive placed in your medical records.

3. Be sure to talk to your healthcare agent and alternate, doctor(s), clergy, and family and friends about your wishes concerning medical treatment. Discuss your wishes with them often, particularly if your medical condition changes.

4. If you want to make changes to your Directive after it has been signed and witnessed, you must complete a new document.

5. Remember, you can always revoke your Pennsylvania Directive.

6. Be aware that your Pennsylvania document will not be effective in the event of a medical emergency. Ambulance personnel are required to provide cardiopulmonary resuscitation (CPR) unless they are given a separate order that states otherwise. These orders, commonly called an "out-of-hospital do-not-resuscitate orders," are designed for people whose poor health gives them little chance of benefiting from CPR. These orders must be signed by your physician and instruct ambulance personnel not to attempt CPR if your heart or breathing should stop.

   Currently not all states have laws authorizing non-hospital do-not-resuscitate orders. We suggest you speak to your physician for more information. **Caring Connections does not distribute these forms.**