

**PENNSYLVANIA**  
**Advance Directive**  
**Planning for Important Health Care Decisions**

*CaringInfo*  
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CaringInfo, 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.

**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:

- L**earn about options for end-of-life services and care
- I**mplement plans to ensure wishes are honored
- V**oice decisions to family, friends and health care providers
- E**ngage in personal or community efforts to improve end-of-life care

**Note:** The following is not a substitute for legal advice. While CaringInfo updates the following information and form to keep them up-to-date, changes in the underlying law can affect how the form will operate in the event you lose the ability to make decisions for yourself. If you have any questions about how the form will help ensure your wishes are carried out, or if your wishes do not seem to fit with the form, you may wish to talk to your health care provider or an attorney with experience in drafting advance directives. **If you have other questions regarding these documents, we recommend contacting your state attorney general's office.**

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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 health care.
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

1. You may want to photocopy or print a second set of these forms before you start so you will have a clean copy if you need to start over.
2. When you begin to fill out the forms, refer to the gray instruction bars — they will guide you through the process.
3. 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.
4. 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, health care providers, and/or faith leaders so that the form is available in the event of an emergency.
5. You may also want to save a copy of your form in an online personal health records application, program, or service that allows you to share your medical documents with your physicians, family, and others who you want to take an active role in your advance care planning.

## INTRODUCTION TO YOUR PENNSYLVANIA ADVANCE HEALTH CARE DIRECTIVE

This packet contains a legal document, a **Pennsylvania Advance Health Care Directive**, 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. You may complete Part II, Part III, or both depending on your advance-planning needs. You must complete Part IV.

**Part I** contains an introduction that describes the uses and effects of this form.

**Part II** contains a **Durable Health Care Power of Attorney**. This part lets you name someone to make decisions about your medical care—including decisions about life-sustaining treatment—if you can no longer speak for yourself. The durable health care power of attorney is especially useful because it appoints someone to speak for you any time you are unable to make your own medical decisions, not only at the end of life.

Your durable health care power of attorney goes into effect when your doctor determines that you are no longer able to make or communicate your health care decisions.

**Part III** contains your **Living Will**. Your living will lets you state your wishes about health care in the event that you can no longer make your own health care decisions and you are permanently unconscious or have an end-stage medical condition.

Your living will goes into effect when your doctor determines that you are no longer able to make or communicate your health care decisions, and you are permanently unconscious or have an end-stage medical condition.

**Part IV** contains the signature and witnessing provisions so that your document will be effective.

This form does not expressly address mental illness. If you would like to make advance care plans regarding mental illness, you should talk to your physician and an attorney about an advance directive tailored to your needs.

*Note: This document will be legally binding only if the person completing it is an individual of sound mind and the individual also is one of the following:*

- 1. 18 years or older;*
- 2. a high school graduate;*
- 3. married; OR*
- 4. an emancipated minor.*

## **COMPLETING YOUR PENNSYLVANIA ADVANCE HEALTH CARE DIRECTIVE**

### **How do I make my Pennsylvania Advance Health Care Directive legal?**

In order to make your advance health care directive legally binding, you must date and sign it, or direct another to do so, in the presence of two witnesses. 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.

### **Whom should I appoint as my health care agent?**

Your health care agent is the person you appoint to make decisions about your health care if you become unable to make those decisions yourself. Your health care agent may be a family member or a close friend whom you trust to make serious decisions. The person you name as your health care agent should clearly understand your wishes and be willing to accept the responsibility of making health care decisions for you.

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

Unless he or she is related to you, you may not appoint as your agent:

- Your attending physician or other health care provider, or
- The owner, operator, or employee of a health care facility where you are receiving care.

### **Can I add personal instructions to my advance health care directive?**

One of the strongest reasons for naming an agent is to have someone who can respond flexibly as your health care situation changes and deal with situations that you did not foresee. If you add instructions to this document it may help your agent carry out your wishes, but be careful that you do not unintentionally restrict your agent's power to act in your best interest. In any event, be sure to talk with your agent about your future medical care and describe what you consider to be an acceptable "quality of life."

### **What if I change my mind?**

You may revoke your Pennsylvania Advance Health Care 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 health care provider.

Unless you specify otherwise, if you have appointed your spouse as your agent, your appointment is automatically revoked if either of you file a divorce action. You may specify on page 7 of the form that you want your spouse to continue to be your agent even if a divorce action is filed if you do not want such an automatic revocation to occur.

**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.

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**PART I: INTRODUCTORY REMARKS ON  
HEALTH CARE DECISION MAKING**

You have the right to decide the type of health care you want.

Should you become unable to understand, make or communicate decisions about medical care, your wishes for medical treatment are most likely to be followed if you express those wishes in advance by:

- (1) naming a health care agent to decide treatment for you; and
- (2) giving health care treatment instructions to your health care agent or health care provider.

An advance health care directive is a written set of instructions expressing your wishes for medical treatment. It may contain a health care power of attorney, where you name a person called a "health care agent" to decide treatment for you, and a living will, where you tell your health care agent and health care providers your choices regarding the initiation, continuation, withholding or withdrawal of life-sustaining treatment and other specific directions.

You may limit your health care agent's involvement in deciding your medical treatment so that your health care agent will speak for you only when you are unable to speak for yourself or you may give your health care agent the power to speak for you immediately. This combined form gives your health care agent the power to speak for you only when you are unable to speak for yourself. A living will cannot be followed unless your attending physician determines that you lack the ability to understand, make or communicate health care decisions for yourself and you are either permanently unconscious or you have an end-stage medical condition, which is a condition that will result in death despite the introduction or continuation of medical treatment. You, and not your health care agent, remain responsible for the cost of your medical care.

If you do not write down your wishes about your health care in advance, and if later you become unable to understand, make or communicate these decisions, those wishes may not be honored because they may remain unknown to others.

A health care provider who refuses to honor your wishes about health care must tell you of his or her refusal and help to transfer you to a health care provider who will honor your wishes.

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You should give a copy of your advance health care directive (a living will, a health care power of attorney or a document like this one that contains both) to your health care agent, your physicians, family members and others whom you expect would likely attend to your needs if you become unable to understand, make or communicate decisions about medical care. If your health care wishes change, tell your physician and write a new advance health care directive to replace your old one. It is important in selecting a health care agent that you choose a person you trust who is likely to be available in a medical situation where you cannot make decisions for yourself. You should inform that person that you have appointed him or her as your health care agent and discuss your beliefs and values with him or her so that your health care agent will understand your health care objectives.

You may wish to consult with knowledgeable, trusted individuals such as family members, your physician or clergy when considering an expression of your values and health care wishes. You are free to create your own advance health care directive to convey your wishes regarding medical treatment. The following form is an example of an advance health care directive that combines a health care power of attorney with a living will.

**NOTES ABOUT THE USE OF THIS FORM**

If you decide to use this form or create your own advance health care directive, you should consult with your physician and your attorney to make sure that your wishes are clearly expressed and comply with the law.

If you decide to use this form but disagree with any of its statements, you may cross out those statements.

You may add comments to this form or use your own form to help your physician or health care agent decide your medical care.

This form is designed to give your health care agent broad powers to make health care decisions for you whenever you cannot make them for yourself. It is also designed to express a desire to limit or authorize care if you have an end-stage medical condition or are permanently unconscious. If you do not desire to give your health care agent broad powers, or you do not wish to limit your care if you have an end-stage medical condition or are permanently unconscious, you may wish to use a different form or create your own. **YOU SHOULD ALSO USE A DIFFERENT FORM IF YOU WISH TO EXPRESS YOUR PREFERENCES IN MORE DETAIL THAN THIS FORM ALLOWS OR IF YOU WISH FOR YOUR HEALTH CARE**

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AGENT TO BE ABLE TO SPEAK FOR YOU IMMEDIATELY. In these situations, it is particularly important that you consult with your attorney and physician to make sure that your wishes are clearly expressed.

This form allows you to tell your health care agent your goals if you have an end-stage medical condition or other extreme and irreversible medical condition, such as advanced Alzheimer's disease. Do you want medical care applied aggressively in these situations or would you consider such aggressive medical care burdensome and undesirable?

You may choose whether you want your health care agent to be bound by your instructions or whether you want your health care agent to be able to decide at the time what course of treatment the health care agent thinks most fully reflects your wishes and values.

If you are a woman and diagnosed as being pregnant at the time a health care decision would otherwise be made pursuant to this form, the laws of this Commonwealth prohibit implementation of that decision if it directs that life-sustaining treatment, including nutrition and hydration, be withheld or withdrawn from you, unless your attending physician and an obstetrician who have examined you certify in your medical record that the life-sustaining treatment:

- (1) will not maintain you in such a way as to permit the continuing development and live birth of the unborn child;
- (2) will be physically harmful to you; or
- (3) will cause pain to you that cannot be alleviated by medication.

A physician is not required to perform a pregnancy test on you unless the physician has reason to believe that you may be pregnant.

Pennsylvania law protects your health care agent and health care providers from any legal liability for following in good faith your wishes as expressed in the form or by your health care agent's direction. It does not otherwise change professional standards or excuse negligence in the way your wishes are carried out. If you have any questions about the law, consult an attorney for guidance.

This form and explanation is not intended to take the place of specific legal or medical advice, for which you should rely upon your own attorney and physician.

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INFORMATION  
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**PART II: DURABLE HEALTH CARE POWER OF ATTORNEY**

I, \_\_\_\_\_, of

\_\_\_\_\_ County, Pennsylvania, appoint the person named below to be my health care agent to make health and personal care decisions for me.

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.

PRINT YOUR NAME  
AND COUNTY

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MY HEALTH CARE AGENT HAS ALL OF THE FOLLOWING POWERS, SUBJECT TO ANY HEALTH CARE TREATMENT INSTRUCTIONS THAT I GIVE IN THIS DOCUMENT (CROSS OUT AND INITIAL 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.

CROSS OUT AND  
INITIAL POWERS  
YOU DO NOT WANT  
YOUR AGENT TO  
HAVE

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*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.)

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: \_\_\_\_\_

PRINT THE NAME,  
RELATIONSHIP AND  
ADDRESS OF YOUR  
AGENT

PRINT PHONE  
NUMBER AND EMAIL  
ADDRESS OF YOUR  
AGENT

PRINT THE NAME,  
RELATIONSHIP,  
ADDRESS, PHONE  
NUMBER AND EMAIL  
ADDRESS OF YOUR  
ALTERNATE HEALTH  
CARE AGENTS

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**PART III: 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):

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)

heart-lung resuscitation (CPR) \_\_\_\_\_

mechanical ventilator (breathing machine) \_\_\_\_\_

dialysis (kidney machine) \_\_\_\_\_

surgery \_\_\_\_\_

chemotherapy \_\_\_\_\_

radiation treatment \_\_\_\_\_

antibiotics \_\_\_\_\_

LIVING WILL  
INFORMATION

CROSS OUT ANY  
TREATMENT  
INSTRUCTIONS  
WITH WHICH YOU  
DISAGREE

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

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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.

*TUBE FEEDINGS*

\_\_\_\_\_ I want tube feedings to be given

OR

\_\_\_\_\_ I do not want tube feedings to be given.

*HEALTH CARE AGENT'S USE OF INSTRUCTIONS*

\_\_\_\_\_ 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 here): \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

If I have not appointed 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.

INITIAL ONLY ONE

INITIAL ONLY ONE



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**PART IV: SIGNATURE**

PRINT YOUR NAME  
AND THE DATE AND  
SIGN HERE

I, \_\_\_\_\_ (print your name),  
having carefully read this document, have signed it this \_\_\_\_ day of  
\_\_\_\_\_, 20\_\_\_\_, revoking all previous health care powers of  
attorney and health care treatment instructions.

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

WITNESS SIGNATURE: \_\_\_\_\_ Date: \_\_\_\_\_

Printed name: \_\_\_\_\_

WITNESS SIGNATURE: \_\_\_\_\_ Date: \_\_\_\_\_

Printed name: \_\_\_\_\_

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.)

YOUR TWO  
WITNESSES MUST  
SIGN AND DATE  
AND PRINT THEIR  
NAMES HERE

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## **You Have Filled Out Your Health Care Directive, Now What?**

1. Your Pennsylvania Advance Health Care 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 health care agent and alternate health care agent(s), doctor(s), family, close friends, clergy, and anyone else who might become involved in your health care. If you enter a nursing home or hospital, have photocopies of your document placed in your medical records.
3. Be sure to talk to your health care agent(s), doctor(s), clergy, family, and friends about your wishes concerning medical treatment. Discuss your wishes with them often, particularly if your medical condition changes.
4. You may also want to save a copy of your form in an online personal health records application, program, or service that allows you to share your medical documents with your physicians, family, and others who you want to take an active role in your advance care planning.
5. If you want to make changes to your documents after they have been signed and witnessed, you must complete a new document.
6. Remember, you can always revoke your Pennsylvania document.
7. Be aware that your Pennsylvania document will not be effective in the event of a medical emergency. Ambulance and hospital emergency department personnel are required to provide cardiopulmonary resuscitation (CPR) unless they are given a separate directive that states otherwise. These directives called "prehospital medical care directives" or "do not resuscitate orders" are designed for people whose poor health gives them little chance of benefiting from CPR. These directives instruct ambulance and hospital emergency personnel not to attempt CPR if your heart or breathing should stop.

Currently not all states have laws authorizing these orders. We suggest you speak to your physician if you are interested in obtaining one. **CaringInfo does not distribute these forms.**

## Congratulations!

You've downloaded **your free, state specific advance directive**.

You are taking important steps to make sure your wishes are known. Help us keep this free.

Your generous support of the National Hospice Foundation and CaringInfo allows us to continue to provide these FREE resources, tools, and information to educate and empower individuals to access advance care planning, caregiving, hospice and grief services, and information.

**I hope you will show your support for our mission and make a tax-deductible gift today.**

Since 1992, the National Hospice Foundation has been dedicated to creating FREE resources for individuals and families facing a life-limiting illness, raising awareness for the need for hospice care, and providing ongoing professional education and skills development to hospice professionals across the nation.

Your gift strengthens the Foundation's ability to provide FREE caregiver and family resources.

Support your National Hospice Foundation by returning a **generous tax-deductible gift of \$23, \$47, \$64**, or the most generous amount you can send.

**You can help** us provide resources like this advance directive FREE by sending in your gift to help others.

**Please help to make this possible with your contribution! Cut along the dotted line and use the coupon below to return a check contribution of the most generous amount you can send. Thank you.**



**YES!** I want to support the important work of the National Hospice Foundation.

**\$23** helps us provide free advance directives

**\$47** helps us maintain our free InfoLine

**\$64** helps us provide webinars to hospice

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