

# WEST VIRGINIA Advance Directive Planning for Important Health Care Decisions

*CaringInfo*  
1731 King St., Suite 100, Alexandria, VA 22314  
[www.caringinfo.org](http://www.caringinfo.org)  
800/658-8898

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:

- Learn about options for end-of-life services and care
- Implement plans to ensure wishes are honored
- Voice decisions to family, friends and health care providers
- Engage 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 WEST VIRGINIA ADVANCE DIRECTIVES

This packet contains a **West Virginia Combined Medical Power of Attorney and Living Will**, which 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 I, Part II, or both, depending on your advance-planning needs. You must complete Part III.

**Part I, Medical Power of Attorney**, lets you name an adult, called a “representative,” to make decisions about your health care—including decisions about life-prolonging intervention—if you can no longer speak for yourself. This 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.

Part I goes into effect when your doctor determines and records in your medical record that you are unable because of physical or mental impairment to appreciate the nature and implications of a health care decision, to make an informed choice regarding the alternatives presented and to communicate that choice in an unambiguous manner.

**Part II, Living Will**, lets you state your wishes about health care in the event you cannot speak for yourself and you develop a terminal condition or you are in a persistent vegetative state.

Part II goes into effect when your doctor determines that you are no longer capable of making or communicating your health care decisions and documents in your record that you are in a terminal condition or a persistent vegetative state.

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

Following your advance directive form is a **West Virginia Organ Donation Form**

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 a competent adult (at least 18 years old).*

## COMPLETING YOUR WEST VIRGINIA ADVANCE DIRECTIVE

### How do I make my West Virginia Advance Directive legal?

You must sign or, if you are unable to sign, direct someone to sign on your behalf and in your presence your *West Virginia Combined Medical Power of Attorney and Living Will* in the presence of two adult witnesses AND before a notary public. Your witnesses **cannot** be:

- a person signing the document on your behalf;
- related to you;
- any person with knowledge that they are entitled to any portion of your estate;
- directly financially responsible for the cost of your health care;
- your attending physician; or
- your health care representative or successor representative.

### Whom should I appoint as my representative?

Your representative is the person you appoint to make decisions about your health care if you become unable to make those decisions yourself. Your representative may be a family member or a close friend whom you trust to make serious decisions. The person you name as your representative 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 successor representative. The successor will step in if the first person you name as a representative is unable, unwilling, or unavailable to act for you.

The person you appoint as your representative **cannot** be:

- your treating health care provider;
- an employee of your treating health care provider, unless related to you;
- an operator of a health care facility in which you are a patient or in which you reside; or
- an employee of an operator of a health care facility in which you are a patient or in which you reside, unless related to you.

### Should I add personal instructions to my West Virginia Advance Directive?

One of the strongest reasons for naming a representative 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 representative carry out your wishes, but be careful that you do not unintentionally restrict your representative's power to act in your best interest. In any event, be sure to talk with your representative 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 Advance Directive at any time by:

- physically destroying the document or having someone destroy on your behalf at your direction and in your presence;
- signing and dating a written revocation that is given to your doctor; or
- orally revoking your document in the presence of a witness at least eighteen years of age, who must sign and date a written confirmation of your revocation.

You should be sure to notify your representative and attending physician in order to be sure that your revocation is effective.

**WEST VIRGINIA  
COMBINED MEDICAL POWER OF ATTORNEY  
AND LIVING WILL - PAGE 1 OF 4**

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**PART I. Medical Power of Attorney**

PRINT THE DATE

Dated: \_\_\_\_\_, 20\_\_\_\_

PRINT YOUR  
NAME

I, \_\_\_\_\_, hereby  
appoint as my representative to act on my behalf to give, withhold or  
withdraw informed consent to health care decisions in the event that I  
am not able to do so myself.

The person I choose as my representative is:

PRINT THE  
NAME, ADDRESS  
AND TELEPHONE  
NUMBER OF YOUR  
REPRESENTATIVE  
AND SUCCESSOR  
REPRESENTATIVE

Name: \_\_\_\_\_ Telephone: \_\_\_\_\_

Address: \_\_\_\_\_.

If my representative is unable, unwilling, or disqualified to serve, then I  
appoint as my successor representative:

Name: \_\_\_\_\_ Telephone: \_\_\_\_\_

Address: \_\_\_\_\_.

This appointment shall extend to, but not be limited to, health care  
decisions relating to medical treatment, surgical treatment, nursing care,  
medication, hospitalization, care and treatment in a nursing home or  
other facility, and home health care. The representative appointed by this  
document is specifically authorized to be granted access to my medical  
records and other health information and to act on my behalf to consent  
to, refuse or withdraw any and all medical treatment or diagnostic  
procedures, or autopsy if my representative determines that I, if able to  
do so, would consent to, refuse or withdraw such treatment or  
procedures. Such authority shall include, but not be limited to, decisions  
regarding the withholding or withdrawal of life-prolonging interventions.

I appoint this representative because I believe this person understands  
my wishes and values and will act to carry into effect the health care  
decisions that I would make if I were able to do so, and because I also  
believe that this person will act in my best interest when my wishes are  
unknown. It is my intent that my family, my physician, and all legal  
authorities be bound by the decisions that are made by the  
representative appointed by this document, and it is my intent that these  
decisions should not be the subject of review by any health care provider  
or administrative or judicial agency.

**WEST VIRGINIA  
COMBINED MEDICAL POWER OF ATTORNEY  
AND LIVING WILL - PAGE 2 OF 4**

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When making health care decisions for me, my representative should think about what action would be consistent with past conversations we have had, my treatment preferences as expressed in this document, my religious and other beliefs and values, and how I have handled medical and other important issues in the past. If what I would decide is still unclear, then my representative should make decisions for me that my representative believes are in my best interest, considering the benefits, burdens, and risks of my current circumstances and treatment options.

I give these additional instructions as further guidance for my representative:

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(attach additional pages if needed)

**THIS MEDICAL POWER OF ATTORNEY SHALL BECOME EFFECTIVE ONLY UPON MY INCAPACITY TO GIVE, WITHHOLD, OR WITHDRAW INFORMED CONSENT TO MY OWN MEDICAL CARE.**

ADD OTHER INSTRUCTIONS, IF ANY, REGARDING YOUR ADVANCE CARE PLANS

THESE INSTRUCTIONS CAN FURTHER ADDRESS YOUR HEALTH CARE PLANS, SUCH AS YOUR WISHES REGARDING HOSPICE TREATMENT, BUT CAN ALSO ADDRESS OTHER ADVANCE PLANNING ISSUES, SUCH AS YOUR BURIAL WISHES

ATTACH ADDITIONAL PAGES IF NEEDED

**WEST VIRGINIA  
COMBINED MEDICAL POWER OF ATTORNEY  
AND LIVING WILL - PAGE 3 OF 4**

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**PART II. Living Will**

It is my intent that this document be legally binding and effective and that this document be taken as a formal statement of my desire concerning the method by which any health care decisions should be made on my behalf during any period when I am unable to make such decisions.

In exercising the authority under this medical power of attorney, my representative, if I have appointed one, shall act consistently with my special directives or limitations as stated below. If I have not appointed a representative, this document shall be binding on any surrogate appointed to make health care decisions on my behalf.

I am giving the following SPECIAL DIRECTIVES OR LIMITATIONS ON THIS POWER: (Comments about tube feedings, breathing machines, cardiopulmonary resuscitation, dialysis, mental health treatment, funeral arrangements, autopsy, and organ donation may be placed here. My failure to provide special directives or limitations does not mean that I want or refuse certain treatments).

1. If I am very sick and not able to communicate my wishes for myself and I am certified by one physician who has personally examined me, to have a terminal condition or to be in a persistent vegetative state (I am unconscious and am neither aware of my environment nor able to interact with others,) I direct that life-prolonging medical intervention that would serve solely to prolong the dying process or maintain me in a persistent vegetative state be withheld or withdrawn. I want to be allowed to die naturally and only be given medications or other medical procedures necessary to keep me comfortable. I want to receive as much medication as is necessary to alleviate my pain.

2. Other directives: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

(attach additional pages if needed)

STRIKE THROUGH  
AND INITIAL ANY  
LANGUAGE WITH  
WHICH YOU  
DISAGREE

ADD OTHER  
INSTRUCTIONS, IF  
ANY, REGARDING  
YOUR ADVANCE  
CARE PLANS

THESE  
INSTRUCTIONS CAN  
FURTHER ADDRESS  
YOUR HEALTH CARE  
PLANS, SUCH AS  
YOUR WISHES  
REGARDING  
HOSPICE  
TREATMENT, BUT  
CAN ALSO ADDRESS  
OTHER ADVANCE  
PLANNING ISSUES,  
SUCH AS YOUR  
BURIAL WISHES

ATTACH  
ADDITIONAL PAGES  
IF NEEDED

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**WEST VIRGINIA  
COMBINED MEDICAL POWER OF ATTORNEY  
AND LIVING WILL - PAGE 4 OF 4**

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**PART III. Execution**

SIGN, DATE, AND  
PRINT YOUR NAME

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Printed Name: \_\_\_\_\_

I did not sign the principal's signature above. I am at least eighteen years of age and am not related to the principal by blood or marriage. I am not entitled to any portion of the estate of the principal or to the best of my knowledge under any will of the principal or codicil thereto, or legally responsible for the costs of the principal's medical or other care. I am not the principal's attending physician, nor am I the representative or successor representative of the principal.

TWO WITNESSES  
MUST SIGN, DATE,  
AND PRINT THEIR  
NAMES

Witness #1 \_\_\_\_\_ DATE \_\_\_\_\_

Print Name \_\_\_\_\_

Witness #2 \_\_\_\_\_ DATE \_\_\_\_\_

Print Name \_\_\_\_\_

**AND**

STATE OF \_\_\_\_\_

COUNTY OF \_\_\_\_\_

A NOTARY PUBLIC  
MUST COMPLETE  
THIS SECTION OF  
YOUR DOCUMENT

I, \_\_\_\_\_, a Notary Public of said  
\_\_\_\_\_ county, do certify that \_\_\_\_\_, as  
principal, and \_\_\_\_\_ and \_\_\_\_\_, as  
witnesses, whose names are signed to the writing above bearing date on the  
\_\_\_\_\_ day of \_\_\_\_\_, 20\_\_\_\_, have this day acknowledged the same  
before me.

Given under my hand this \_\_\_\_\_ day of \_\_\_\_\_, 20\_\_\_\_.

My commission expires: \_\_\_\_\_

\_\_\_\_\_  
Signature of Notary Public

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1731 King St., Suite 100, Alexandria, VA 22314  
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**WEST VIRGINIA ORGAN DONATION FORM - PAGE 1 OF 1**

ORGAN DONATION  
(OPTIONAL)

INITIAL THE OPTION  
THAT REFLECTS  
YOUR WISHES

ADD NAME OR  
INSTITUTION (IF  
ANY)

PRINT YOUR NAME,  
SIGN, AND DATE  
THE DOCUMENT

YOUR  
WITNESSES  
MUST SIGN AND  
PRINT THEIR  
ADDRESSES

AT LEAST ONE  
WITNESS MUST BE A  
DISINTERESTED  
PARTY

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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 attorney for health care, proxy, or other agent, or your family, may have the authority to make a gift of all or part of your body under West Virginia law.

\_\_\_\_\_ I do not want to make an organ or tissue donation and I do not want my attorney for health care, proxy, or other 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/institution: \_\_\_\_\_

\_\_\_\_\_ Pursuant to West Virginia law, I hereby give, effective on my death:

\_\_\_\_\_ Any needed organ or parts.

\_\_\_\_\_ The following part or organs listed below:

\_\_\_\_\_ For (initial one):

\_\_\_\_\_ Any legally authorized purpose.

\_\_\_\_\_ Transplant or therapeutic purposes only.

Declarant name: \_\_\_\_\_

Declarant signature: \_\_\_\_\_

Date: \_\_\_\_\_

The declarant voluntarily signed or directed another person to sign this writing in my presence.

Witness \_\_\_\_\_ Date \_\_\_\_\_  
Address \_\_\_\_\_

I am a disinterested party with regard to the declarant and his or her donation and estate. The declarant voluntarily signed or directed another person to sign this writing in my presence.

Witness \_\_\_\_\_ Date \_\_\_\_\_  
Address \_\_\_\_\_

*Courtesy of CaringInfo*  
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[www.caringinfo.org](http://www.caringinfo.org), 800/658-8898

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

1. Your *West Virginia Combined Medical Power of Attorney and Living Will* 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 agent and alternate agent, 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 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 West Virginia document.
7. Be aware that your West Virginia 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.

West Virginia authorizes a "Physician's Order for Scope of Treatment" or "POST" form that addresses these issues. 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     |

Return to:  
National Hospice Foundation  
PO Box 824401  
Philadelphia, PA 19182-4401

AD\_2016



OR donate online today: [www.caringinfo.org/donate](http://www.caringinfo.org/donate)