SOUTH CAROLINA
Advance Directive
Planning for Important Health Care Decisions

CaringInfo
1731 King St., Suite 100, Alexandria, VA 22314
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.**

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 forms are completed and signed, photocopy the forms and give them 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 forms are 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 SOUTH CAROLINA ADVANCE DIRECTIVE

This packet contains two legal documents that protect 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 either, or both, depending on your advance-planning needs.

South Carolina Health Care Power of Attorney. This document lets you name an adult, your "agent," to make decisions about your health care—including decisions about life-sustaining procedures—if you can no longer speak for yourself. The 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 health care decisions, not only at the end of life.

Your health care power of attorney goes into effect when your doctor, and one other doctor or your agent certify that you are unable to appreciate the nature and implications of your condition and proposed health care, to make a reasoned decision concerning the proposed health care, or to communicate that decision in an unambiguous manner.

South Carolina Declaration of a Desire for a Natural Death, or Declaration, is your state's living will. Your declaration 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 terminally ill or in a persistent vegetative state.

Your living will goes into effect when your doctor and one other doctor certify that you are no longer able to make or communicate your health care decisions and you are terminally ill or in a persistent vegetative state.

These forms do 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: These documents will be legally binding only if the person completing them is an individual of sound mind who is 18 years or older.

COMPLETING YOUR SOUTH CAROLINA ADVANCE DIRECTIVE

How do I make my South Carolina Documents legal?

In order to make your **South Carolina Health Care Power of Attorney** legal, you must sign and date it or acknowledge your signature in the presence of two witnesses. These witnesses **cannot** be:

- your agent or alternate agent;
- related to you by blood, marriage, or adoption;
- your attending physician or an employee of your attending physician;
- directly financially responsible for your medical care;
- entitled to any portion of your estate after your death either under a will or by operation of law;
- a beneficiary of your life insurance policy; or
- anyone with a claim against your estate upon your death.

In addition, at least one of your witnesses must **not** be an employee of a health facility in which you are a patient.

If you are unable to sign, you may direct someone to sign on your behalf and in your presence.

In order to make your **South Carolina Declaration of a Desire for a Natural Death** legal, you must sign it in the presence of two witnesses and have it notarized. Your notary may act as one of your witnesses. These witnesses **cannot** be:

- related to you by blood, marriage, or adoption;
- your attending physician or an employee of your attending physician;
- directly financially responsible for your medical care;
- entitled to any portion of your estate after your death either under a will or by operation of law;
- a beneficiary of your life insurance policy; or
- anyone with a claim against your estate upon your death.

In addition, at least one of your witnesses must **not** be an employee of a health facility in which you are a patient. Finally, if you are a resident in a hospital or nursing facility, one of the witnesses must be an ombudsman designated by the State Ombudsman, Office of the Governor.

Whom should I appoint as my agent?

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

Your agent must be at least 18 and **cannot** be:

- a health care provider, or an employee of a provider, with whom the you have a provider-patient relationship, or
- an employee of a nursing care facility in which the principal resides, or
- a spouse of the health care provider or employee.

You may appoint one of the people above as your agent if he or she is your relative.

Can I add personal instructions to my advance 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."

If you complete both documents included in this packet, be sure that the instructions you give match. Any agent you appoint in your health care power of attorney is bound by the choices you make in your declaration.

What if I change my mind?

You may revoke your health care power of attorney by notifying your health care provider or agent in writing or orally. You can also revoke by executing a new health care power of attorney, if that document states an intention to revoke your earlier health care power of attorney.

You may revoke your declaration by destroying it (or directing someone to destroy it in your presence), by a signed and dated written revocation, by an oral expression to your physician, or by executing a new declaration. You may also appoint an agent in your declaration with the power to revoke it on your behalf.

What other important facts should I know?

You may appoint an agent in your declaration. Unlike an agent appointed under your durable power of attorney for health care, an agent appointed through your declaration is only empowered to enforce or revoke your declaration, and may not make other medical treatment decisions.

No instruction by your agent or in your declaration to withhold or withdraw life-sustaining procedures will be honored in the event you are pregnant.

NOTICE

HEALTH CARE POWER OF ATTORNEY

INFORMATION ABOUT THIS DOCUMENT

THIS IS AN IMPORTANT LEGAL DOCUMENT. BEFORE SIGNING THIS DOCUMENT, YOU SHOULD KNOW THESE IMPORTANT FACTS:

1. THIS DOCUMENT GIVES THE PERSON YOU NAME AS YOUR AGENT THE POWER TO MAKE HEALTH CARE DECISIONS FOR YOU IF YOU CANNOT MAKE THE DECISION FOR YOURSELF. THIS POWER INCLUDES THE POWER TO MAKE DECISIONS ABOUT LIFE-SUSTAINING TREATMENT. UNLESS YOU STATE OTHERWISE, YOUR AGENT WILL HAVE THE SAME AUTHORITY TO MAKE DECISIONS ABOUT YOUR HEALTH CARE AS YOU WOULD HAVE.

2. THIS POWER IS SUBJECT TO ANY LIMITATIONS OR STATEMENTS OF YOUR DESIRES THAT YOU INCLUDE IN THIS DOCUMENT. YOU MAY STATE IN THIS DOCUMENT ANY TREATMENT YOU DO NOT DESIRE OR TREATMENT YOU WANT TO BE SURE YOU RECEIVE. YOUR AGENT WILL BE OBLIGATED TO FOLLOW YOUR INSTRUCTIONS WHEN MAKING DECISIONS ON YOUR BEHALF. YOU MAY ATTACH ADDITIONAL PAGES IF YOU NEED MORE SPACE TO COMPLETE THE STATEMENT.

3. AFTER YOU HAVE SIGNED THIS DOCUMENT, YOU HAVE THE RIGHT TO MAKE HEALTH CARE DECISIONS FOR YOURSELF IF YOU ARE MENTALLY COMPETENT TO DO SO. AFTER YOU HAVE SIGNED THIS DOCUMENT, NO TREATMENT MAY BE GIVEN TO YOU OR STOPPED OVER YOUR OBJECTION IF YOU ARE MENTALLY COMPETENT TO MAKE THAT DECISION.

4. YOU HAVE THE RIGHT TO REVOKE THIS DOCUMENT, AND TERMINATE YOUR AGENT'S AUTHORITY, BY INFORMING EITHER YOUR AGENT OR YOUR HEALTH CARE PROVIDER ORALLY OR IN WRITING.

5. IF THERE IS ANYTHING IN THIS DOCUMENT THAT YOU DO NOT UNDERSTAND, YOU SHOULD ASK A SOCIAL WORKER, LAWYER, OR OTHER PERSON TO EXPLAIN IT TO YOU.

6. THIS POWER OF ATTORNEY WILL NOT BE VALID UNLESS TWO PERSONS SIGN AS WITNESSES. EACH OF THESE PERSONS MUST EITHER WITNESS YOUR SIGNING OF THE POWER OF ATTORNEY OR WITNESS YOUR ACKNOWLEDGMENT THAT THE SIGNATURE ON THE POWER OF ATTORNEY IS YOURS.

NOTICE (CONTINUED)

THE FOLLOWING PERSONS MAY NOT ACT AS WITNESSES:

A. YOUR SPOUSE; YOUR CHILDREN, GRANDCHILDREN, AND OTHER LINEAL DESCENDANTS; YOUR PARENTS, GRANDPARENTS, AND OTHER LINEAL ANCESTORS; YOUR SIBLINGS AND THEIR LINEAL DESCENDANTS; OR A SPOUSE OF ANY OF THESE PERSONS.

B. A PERSON WHO IS DIRECTLY FINANCIALLY RESPONSIBLE FOR YOUR MEDICAL CARE.

C. A PERSON WHO IS NAMED IN YOUR WILL, OR, IF YOU HAVE NO WILL, WHO WOULD INHERIT YOUR PROPERTY BY INTESTATE SUCCESSION.

D. A BENEFICIARY OF A LIFE INSURANCE POLICY ON YOUR LIFE.

E. THE PERSONS NAMED IN THE HEALTH CARE POWER OF ATTORNEY AS YOUR AGENT OR SUCCESSOR AGENT.

F. YOUR PHYSICIAN OR AN EMPLOYEE OF YOUR PHYSICIAN.

G. ANY PERSON WHO WOULD HAVE A CLAIM AGAINST ANY PORTION OF YOUR ESTATE (PERSONS TO WHOM YOU OWE MONEY).

IF YOU ARE A PATIENT IN A HEALTH FACILITY, NO MORE THAN ONE WITNESS MAY BE AN EMPLOYEE OF THAT FACILITY.

7. YOUR AGENT MUST BE A PERSON WHO IS 18 YEARS OLD OR OLDER AND OF SOUND MIND. IT MAY NOT BE YOUR DOCTOR OR ANY OTHER HEALTH CARE PROVIDER THAT IS NOW PROVIDING YOU WITH TREATMENT; OR AN EMPLOYEE OF YOUR DOCTOR OR PROVIDER; OR A SPOUSE OF THE DOCTOR, PROVIDER, OR EMPLOYEE; UNLESS THE PERSON IS A RELATIVE OF YOURS.

8. YOU SHOULD INFORM THE PERSON THAT YOU WANT HIM OR HER TO BE YOUR HEALTH CARE AGENT. YOU SHOULD DISCUSS THIS DOCUMENT WITH YOUR AGENT AND YOUR PHYSICIAN AND GIVE EACH A SIGNED COPY. IF YOU ARE IN A HEALTH CARE FACILITY OR A NURSING CARE FACILITY, A COPY OF THIS DOCUMENT SHOULD BE INCLUDED IN YOUR MEDICAL RECORD.

PRINT YOUR NAME

PRINT THE NAME, HOME ADDRESS, AND TELEPHONE NUMBERS OF YOUR AGENT

PRINT THE NAME, ADDRESS AND TELEPHONE NUMBER OF YOUR ALTERNATE AGENT(S)

1. DESIGNATION OF HEALTH CARE AGENT

I, _____, hereby appoint:
(Principal)

_____
(Agent's Name)

_____
(Address's Address)

_____

Telephone: Home: _____ Work: _____ Mobile: _____ as my agent to make health care decisions for me as authorized in this document.

2. Successor Agent: If an agent named by me dies, becomes legally disabled, resigns, refuses to act, becomes unavailable, or if an agent who is my spouse is divorced or separated from me, I name the following as successors to my agent, each to act alone and successively, in the order named:

a. First Alternate Agent:

Address: _____

_____

Telephone: Home: _____ Work: _____ Mobile: _____

b. Second Alternate Agent:

Address: _____

_____

Telephone: Home: _____ Work: _____ Mobile: _____

Unavailability of Agent(s): If at any relevant time the agent or successor agents named here are unable or unwilling to make decisions concerning my health care, and those decisions are to be made by a guardian, by the Probate Court, or by a surrogate pursuant to the Adult Health Care Consent Act, it is my intention that the guardian, Probate Court, or surrogate make those decisions in accordance with my directions as stated in this document.

2. EFFECTIVE DATE AND DURABILITY

By this document I intend to create a durable power of attorney effective upon, and only during, any period of mental incompetence, except as provided in Paragraph 3 below.

3. HIPAA AUTHORIZATION

When considering or making health care decisions for me, all individually identifiable health information and medical records shall be released without restriction to my health care agent(s) and/or my alternate health care agent(s) named above including, but not limited to, (i) diagnostic, treatment, other health care, and related insurance and financial records and information associated with any past, present, or future physical or mental health condition including, but not limited to, diagnosis or treatment of HIV/AIDS, sexually transmitted disease(s), mental illness, and/or drug or alcohol abuse and (ii) any written opinion relating to my health that such health care agent(s) and/or alternate health care agent(s) may have requested. Without limiting the generality of the foregoing, this release authority applies to all health information and medical records governed by the Health Insurance Portability and Accountability Act of 1996 (HIPAA), 42 USC 1320d and 45 CFR 160-164; is effective whether or not I am mentally competent; has no expiration date; and shall terminate only in the event that I revoke the authority in writing and deliver it to my health care provider.

AGENT'S POWERS

4. AGENT'S POWERS

I grant to my agent full authority to make decisions for me regarding my health care. In exercising this authority, my agent shall follow my desires as stated in this document or otherwise expressed by me or known to my agent. In making any decision, my agent shall attempt to discuss the proposed decision with me to determine my desires if I am able to communicate in any way. If my agent cannot determine the choice I would want made, then my agent shall make a choice for me based upon what my agent believes to be in my best interests. My agent's authority to interpret my desires is intended to be as broad as possible, except for any limitations I may state below.

AGENT'S POWERS CONTINUED

Accordingly, unless specifically limited by the provisions specified below, my agent is authorized as follows:

A. To consent, refuse, or withdraw consent to any and all types of medical care, treatment, surgical procedures, diagnostic procedures, medication, and the use of mechanical or other procedures that affect any bodily function, including, but not limited to, artificial respiration, nutritional support and hydration, and cardiopulmonary resuscitation;

B. To authorize, or refuse to authorize, any medication or procedure intended to relieve pain, even though such use may lead to physical damage, addiction, or hasten the moment of, but not intentionally cause, my death;

C. To authorize my admission to or discharge, even against medical advice, from any hospital, nursing care facility, or similar facility or service;

D. To take any other action necessary to making, documenting, and assuring implementation of decisions concerning my health care, including, but not limited to, granting any waiver or release from liability required by any hospital, physician, nursing care provider, or other health care provider; signing any documents relating to refusals of treatment or the leaving of a facility against medical advice, and pursuing any legal action in my name, and at the expense of my estate to force compliance with my wishes as determined by my agent, or to seek actual or punitive damages for the failure to comply.

E. The powers granted above do not include the following powers or are subject to the following rules or limitations:

ADD INSTRUCTIONS HERE ONLY IF YOU WANT TO LIMIT YOUR AGENT'S AUTHORITY

(attach additional pages if needed)

ORGAN DONATION

INITIAL TO INDICATE WHETHER YOU WANT YOUR AGENT TO BE ABLE TO DONATE YOUR ORGANS

5. ORGAN DONATION (INITIAL ONLY ONE)

My agent may ___; may not ___ consent to the donation of all or any of my tissue or organs for purposes of transplantation.

6. EFFECT ON DECLARATION OF A DESIRE FOR A NATURAL DEATH (LIVING WILL)

I understand that if I have a valid Declaration of a Desire for a Natural Death, the instructions contained in the Declaration will be given effect in any situation to which they are applicable. My agent will have authority to make decisions concerning my health care only in situations to which the Declaration does not apply.

7. STATEMENT OF DESIRES CONCERINING LIFE SUSTAINING TREATEMENT

With respect to any Life-Sustaining Treatment, I direct the following:

(INITIAL ONLY ONE OF THE FOLLOWING 3 PARAGRAPHS)

INITIAL ONLY ONE

(1) ___ GRANT OF DISCRETION TO AGENT. I do not want my life to be prolonged nor do I want life-sustaining treatment to be provided or continued if my agent believes the burdens of the treatment outweigh the expected benefits. I want my agent to consider the relief of suffering, my personal beliefs, the expense involved and the quality as well as the possible extension of my life in making decisions concerning life-sustaining treatment.

OR

(2) ___ DIRECTIVE TO WITHHOLD OR WITHDRAW TREATMENT. I do not want my life to be prolonged and I do not want life-sustaining treatment:

a. if I have a condition that is incurable or irreversible and, without the administration of life-sustaining procedures, expected to result in death within a relatively short period of time; or

b. if I am in a state of permanent unconsciousness.

OR

(3) ___ DIRECTIVE FOR MAXIMUM TREATMENT. I want my life to be prolonged to the greatest extent possible, within the standards of accepted medical practice, without regard to my condition, the chances I have for recovery, or the cost of the procedures.

8. STATEMENT OF DESIRES REGARDING TUBE FEEDING

With respect to Nutrition and Hydration provided by means of a nasogastric tube or tube into the stomach, intestines, or veins, I wish to make clear that in situations where life sustaining treatment is being withheld or withdrawn pursuant to Item 7,

(INITIAL ONLY ONE OF THE FOLLOWING THREE PARAGRAPHS)

INITIAL ONLY ONE

(A) ___ GRANT OF DISCRETION TO AGENT. I do not want my life to be prolonged by tube feeding if my agent believes the burdens of tube feeding outweigh the expected benefits. I want my agent to consider the relief of suffering, my personal beliefs, the expense involved, and the quality as well as the possible extension of my life in making this decision.

OR

(B) ___ DIRECTIVE TO WITHHOLD OR WITHDRAW TUBE FEEDING. I do not want my life prolonged by tube feeding.

OR

(C) ___ DIRECTIVE FOR PROVISION OF TUBE FEEDING. I want tube feeding to be provided within the standards of accepted medical practice, without regard to my condition, the chances I have for recovery, or the cost of the procedure, and without regard to whether other forms of life-sustaining treatment are being withheld or withdrawn.

IF YOU DO NOT INITIAL ANY OF THE STATEMENTS IN PARAGRAPH 8, YOUR AGENT WILL NOT HAVE AUTHORITY TO DIRECT THAT NUTRITION AND HYDRATION NECESSARY FOR COMFORT CARE OR ALLEVIATION OF PAIN BE WITHDRAWN.

9. ADMINISTRATIVE PROVISIONS

A. I revoke any prior Health Care Power of Attorney and any provisions relating to health care of any other prior power of attorney.

B. This power of attorney is intended to be valid in any jurisdiction in which it is presented.

10. ADDITIONAL INSTRUCTIONS

I provide the following additional instructions for the guidance of my agent:

(attach additional pages if needed)

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

SOUTH CAROLINA HEALTH CARE POWER OF ATTORNEY
PAGE 9 OF 9

DATE AND PRINT YOUR ADDRESS

BY SIGNING HERE I INDICATE THAT I UNDERSTAND THE CONTENTS OF THIS DOCUMENT AND THE EFFECT OF THIS GRANT OF POWERS TO MY AGENT.

I sign my name to this Health Care Power of Attorney on this _____ day of _____, 20___. My current home address is:

_____

SIGN AND PRINT YOUR NAME

Principal's Signature: _____

Print Name of Principal: _____

WITNESS STATEMENT

I declare, on the basis of information and belief, that the person who signed or acknowledged this document (the principal) is personally known to me, that he/she signed or acknowledged this Health Care Power of Attorney in my presence, and that he/she appears to be of sound mind and under no duress, fraud, or undue influence. I am not related to the principal by blood, marriage, or adoption, either as a spouse, a lineal ancestor, descendant of the parents of the principal, or spouse of any of them. I am not directly financially responsible for the principal's medical care. I am not entitled to any portion of the principal's estate upon his decease, whether under any will or as an heir by intestate succession, nor am I the beneficiary of an insurance policy on the principal's life, nor do I have a claim against the principal's estate as of this time. I am not the principal's attending physician, nor an employee of the attending physician. No more than one witness is an employee of a health facility in which the principal is a patient. I am not appointed as Health Care Agent or Successor Health Care Agent by this document.

WITNESSES MUST SIGN, DATE, AND PRINT THEIR TELEPHONE NUMBERS AND ADDRESSES HERE

Witness No. 1

Signature: _____ Date: _____

Print Name: _____ Telephone: _____

Address: _____

Witness No. 2

Signature: _____ Date: _____

Print Name: _____ Telephone: _____

Address: _____

_____

STATE OF SOUTH CAROLINA
COUNTY OF _____

A NOTARY PUBLIC MUST COMPLETE THIS PORTION OF THE FORM

The foregoing instrument was acknowledged before me by Principal on

_____, 20_____.
Notary Public for South Carolina

_____
My Commission Expires: _____

Courtesy of CaringInfo
1731 King St., Suite 100, Alexandria, VA 22314
www.caringinfo.org, 800/658-8898

DECLARATION OF A DESIRE FOR A NATURAL DEATH

STATE OF SOUTH CAROLINA COUNTY OF _____

PRINT NAME, ADDRESS, AND DATE

I, _____ (print your name), Declarant, being at least eighteen years of age and a resident of and domiciled in the City of _____, County of _____, State of South Carolina, make this Declaration this ___ day of _____, 20___.

I willfully and voluntarily make known my desire that no life-sustaining procedures be used to prolong my dying if my condition is terminal or if I am in a state of permanent unconsciousness, and I declare:

If at any time I have a condition certified to be a terminal condition by two physicians who have personally examined me, one of whom is my attending physician, and the physicians have determined that my death could occur within a reasonably short period of time without the use of life-sustaining procedures or if the physicians certify that I am in a state of permanent unconsciousness and where the application of life-sustaining procedures would serve only to prolong the dying process, I direct that the procedures be withheld or withdrawn, and that I be permitted to die naturally with only the administration of medication or the performance of any medical procedure necessary to provide me with comfort care.

INSTRUCTIONS CONCERNING ARTIFICIAL NUTRITION AND HYDRATION

INITIAL ONE OF THE FOLLOWING STATEMENTS

If my condition is terminal and could result in death within a reasonably short time,

INITIAL ONLY ONE

_____ I direct that nutrition and hydration BE PROVIDED through any medically indicated means, including medically or surgically implanted tubes.

_____ I direct that nutrition and hydration NOT BE PROVIDED through any medically indicated means, including medically or surgically implanted tubes.

INITIAL ONE OF THE FOLLOWING STATEMENTS

If I am in a persistent vegetative state or other condition of permanent unconsciousness,

INITIAL ONLY ONE

_____ I direct that nutrition and hydration BE PROVIDED through any medically indicated means, including medically or surgically implanted tubes.

_____ I direct that nutrition and hydration NOT BE PROVIDED through any medically indicated means, including medically or surgically implanted tubes.

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

In the absence of my ability to give directions regarding the use of life-sustaining procedures, it is my intention that this Declaration be honored by my family and physicians and any health facility in which I may be a patient as the final expression of my legal right to refuse medical or surgical treatment, and I accept the consequences from the refusal.

I am aware that this Declaration authorizes a physician to withhold or withdraw life-sustaining procedures. I am emotionally and mentally competent to make this Declaration.

Other Instructions:

_____
_____
_____
_____
_____
_____
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_____
_____
_____
_____
_____
_____
_____

(attach additional pages if needed)

APPOINTMENT OF AN AGENT (OPTIONAL)

1. You may give another person authority to revoke this declaration on your behalf. If you wish to do so, please enter that person's name in the space below.

PROVIDE NAME, ADDRESS AND TELEPHONE NUMBER OF AGENT(S) (OPTIONAL)

Name of Agent with Power to Revoke: _____

Address: _____

Telephone Number: _____

2. You may give another person authority to enforce this declaration on your behalf. If you wish to do so, please enter that person's name in the space below.

Name of Agent with Power to Enforce: _____

Address: _____

Telephone Number: _____

REVOCATION

REVOCATION PROCEDURES

THIS DECLARATION MAY BE REVOKED BY ANY ONE OF THE FOLLOWING METHODS. HOWEVER, A REVOCATION IS NOT EFFECTIVE UNTIL IT IS COMMUNICATED TO THE ATTENDING PHYSICIAN.

(1) BY BEING DEFACED, TORN, OBLITERATED, OR OTHERWISE DESTROYED, IN EXPRESSION OF YOUR INTENT TO REVOKE, BY YOU OR BY SOME PERSON IN YOUR PRESENCE AND BY YOUR DIRECTION. REVOCATION BY DESTRUCTION OF ONE OR MORE OF MULTIPLE

THE ORIGINAL DECLARATIONS;

(2) BY A WRITTEN REVOCATION SIGNED AND DATED BY YOU EXPRESSING YOUR INTENT TO REVOKE;

(3) BY YOUR ORAL EXPRESSION OF YOUR INTENT TO REVOKE THE DECLARATION. AN ORAL REVOCATION COMMUNICATED TO THE ATTENDING PHYSICIAN BY A PERSON OTHER THAN YOU IS EFFECTIVE ONLY IF:

(a) THE PERSON WAS PRESENT WHEN THE ORAL REVOCATION WAS MADE;

(b) THE REVOCATION WAS COMMUNICATED TO THE PHYSICIAN WITHIN A REASONABLE TIME;

(c) YOUR PHYSICAL OR MENTAL CONDITION MAKES IT IMPOSSIBLE FOR THE PHYSICIAN TO CONFIRM THROUGH SUBSEQUENT CONVERSATION WITH YOU THAT THE REVOCATION HAS OCCURRED.

TO BE EFFECTIVE AS A REVOCATION, THE ORAL EXPRESSION CLEARLY MUST INDICATE YOUR DESIRE THAT THE DECLARATION NOT BE GIVEN EFFECT OR THAT LIFE-SUSTAINING PROCEDURES BE ADMINISTERED;

(4) IF YOU, IN THE SPACE ABOVE, HAVE AUTHORIZED AN AGENT TO REVOKE THE DECLARATION, THE AGENT MAY REVOKE ORALLY OR BY A WRITTEN, SIGNED, AND DATED INSTRUMENT. AN AGENT MAY REVOKE ONLY IF YOU ARE INCOMPETENT TO DO SO. AN AGENT MAY REVOKE THE DECLARATION PERMANENTLY OR TEMPORARILY.

(5) BY YOUR EXECUTING ANOTHER DECLARATION AT A LATER TIME.

SIGN AND DATE

_____ _____
Signature of Declarant Date

WITNESS AFFIDAVIT

PRINT STATE AND COUNTY

STATE OF _____ COUNTY OF _____

PRINT NAMES OF WITNESSES AND DATE

We, _____ and _____, the undersigned witnesses to the foregoing Declaration, dated the ___ day of _____, 20___, at least one of us being first duly sworn, declare to the undersigned authority, on the basis of our best information and belief, that the Declaration was on that date signed by the declarant as and for his DECLARATION OF A DESIRE FOR A NATURAL DEATH in our presence and we, at his request and in his presence, and in the presence of each other, subscribe our names as witnesses on that date. The declarant is personally known to us, and we believe him to be of sound mind. Each of us affirms that he is qualified as a witness to this Declaration under the provisions of the South Carolina Death With Dignity Act in that he is not related to the declarant by blood, marriage, or adoption, either as a spouse, lineal ancestor, descendant of the parents of the declarant, or spouse of any of them; nor directly financially responsible for the declarant's medical care; nor entitled to any portion of the declarant's estate upon his decease, whether under any will or as an heir by intestate succession; nor the beneficiary of a life insurance policy of the declarant; nor the declarant's attending physician; nor an employee of the attending physician; nor a person who has a claim against the declarant's decedent's estate as of this time. No more than one of us is an employee of a health facility in which the declarant is a patient. If the declarant is a resident in a hospital or nursing care facility at the date of execution of this Declaration, at least one of us is an ombudsman designated by the State Ombudsman, Office of the Governor.

WITNESSES SIGN HERE

Signature: _____ Date: _____

Print Name: _____

Signature: _____ Date: _____

Print Name: _____

A NOTARY MUST COMPLETE THIS PORTION OF THE FORM

Subscribed before me by _____, the declarant, and subscribed and sworn to before me by _____, the witnesses, this ___ day of _____, 20_____.

_____
Signature
Notary Public for _____

My commission expires: _____ SEAL

Courtesy of CaringInfo
1731 King St., Suite 100, Alexandria, VA 22314
www.caringinfo.org, 800/658-8898

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

1. Your *South Carolina Health Care Power of Attorney and Declaration* are important legal documents. Keep the originals signed document in a secure but accessible place. Do not put the original documents 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 originals 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 South Carolina document.

7. Be aware that your South Carolina 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.

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