ARIZONA
Advance Directive
Planning for Important Healthcare Decisions

Courtesy of CaringInfo
www.caringinfo.org

CaringInfo, a program of the National Alliance for Care at Home (the Alliance), is a national consumer engagement initiative to improve care and the experience of caregiving during serious illness and at the end of life. As part of that effort, CaringInfo provides detailed guidance for completing advance directive forms in all 50 states, the District of Columbia, and Puerto Rico.

This package includes:

- 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.

BEFORE YOU BEGIN

Check to be sure that you have the materials for each state in which you may receive healthcare. Because documents are state-specific, having a state-specific document for each state where you may spend significant time can be beneficial. A new advance directive is not necessary for ordinary travel into other states. The advance directives in this package will be legally binding only if the person completing them is a competent adult who is 18 years of age or older, or an emancipated minor.

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, scan, or take a photo of 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.

5. You may also want to save a copy of your form in your electronic healthcare record, or 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.

6. The Arizona State Registry, AzHDR, enables you to store your advance directive electronically. You can obtain a copy of the AzHDR Registration Agreement (in English or Spanish) and other information at Help Me Register-B – Arizona Healthcare Directives Registry (azhdr.org).

INTRODUCTION TO YOUR ARIZONA ADVANCE HEALTH CARE DIRECTIVE

This packet contains the **Arizona Advance Health Care Directive**, 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.

The first part of this document is a **Health Care Power of Attorney** that permits the appointment of an adult as Agent. This section lets you name an adult agent to make decisions about your medical care, including decisions about life-sustaining treatment, if you can no longer speak for yourself.

The second part of this document is a **Living Will**. It lets you discuss your wishes about medical care in the event that you develop a terminal condition or are permanently unconscious and can no longer make your own medical decisions. Your living will may control or guide your agent's decisions regarding your health care treatment.

The third part of this document records your wishes regarding an autopsy not required by law. Under certain circumstances, Arizona law will require an autopsy, regardless of your wishes.

The fourth part of this document allows you to make a donation of your organs or to refuse to allow your organs to be used following your death.

The fifth part of this document is a Physician Affidavit. You may wish to ask questions of your physician regarding your end-of-life decisions. If so, it is a good idea to ask your physician to complete the affidavit and keep a copy for his or her file.

The sixth part of this document allows you to record your choices regarding your funeral and burial decisions.

How do I make my Arizona Advance Health Care Directive legal?

The law requires that you sign and date your Arizona Health Care Directive in the presence of at least one (1) adult witness. You can do this in either of two ways:

Option 1: Sign and date your document in the presence of at least one witness, who must also sign the document and affirm that (a) he/she was present when you dated and signed the

document, (b) you appeared to be of sound mind and free from duress at the time you signed the document, and (c) he/she does not fall into any of the categories of people who cannot be a witness.

Your witness **cannot** be:

- related to you by blood, marriage, or adoption,
- entitled to any part of your estate, by will or operation of law, at the time the document is signed,
- appointed as your agent, or
- involved with the provision of your health care at the time the document is signed.

OR

Option 2. Have your signature witnessed by a notary public who is neither your agent nor a person involved with the provision of your health care at the time the document is signed. The notary must also affirm that (a) he/she was present when you dated and signed the document, (b) you appeared to be of sound mind and free from duress at the time you signed the document. The notary cannot be appointed as your agent, or involved with the provision of your health care at the time the document is signed.

If you are physically unable to sign your Arizona Health Care Directive, your witness or notary must add and sign a statement that you have indicated to him or her that the health care directive expresses your wishes and that you wish to adopt the documents.

Whom should I appoint as my agent?

Your agent is the person you appoint to make decisions about your healthcare 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 healthcare 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.

Should I add personal instructions to my advance directive?

Yes! One of the most important reasons to execute an advance directive is to have your voice heard. When you name an agent and clearly communicate to them what you want and don't want, they are in the strongest position to advocate for you. Because the future is unpredictable, be careful that you do not unintentionally restrict your agent's power to act in your best interest. Be especially careful with the words "always" and "never." In any event, be sure to talk with your agent and others about your future healthcare and describe what you consider to be an acceptable "quality of life."

When does my agent's authority become effective?

Your **Arizona Health Care Directive** goes into effect when your doctor determines that you are no longer able to make or communicate your healthcare decisions. You retain the primary authority for your healthcare decisions as long as you are able to make your wishes known.

Agent Limitations

Your agent, if you appoint one, cannot consent to your admission at an inpatient psychiatric facility unless expressly authorized to do so.

Your agent will be bound by the current laws of Arizona as they regard pregnancy and termination of pregnancies.

What if I change my mind?

If you wish to revoke your Arizona Health Care Directive, you may do so by:

- a written revocation,
- orally notifying your agent or health care provider of your revocation,
- executing a new Health Care Power of Attorney, or
- any other act that demonstrates your intent to revoke your document.

Mental Health Issues

These forms do not *expressly* address mental illness, although you can state your wishes and grant authority to your agent regarding mental health issues. The National Resource Center on Psychiatric Advance Directives maintains a website (https://nrc-pad.org/) with links to each state's psychiatric advance directive forms. If you would like to make more detailed advance care plans regarding mental illness, you could talk to your physician and an attorney about a durable power of attorney tailored to your needs.

What other important facts should I know?

Be aware that your advance directive will not be effective in the event of a medical emergency, except to identify your agent. Ambulance and hospital emergency department personnel are required to provide cardiopulmonary resuscitation (CPR) unless you have a separate physician's order, which are typically called "prehospital medical care directives" or "do not resuscitate orders." DNR forms may be obtained from your state health department or department of aging (https://www.hhs.gov/aging/state-resources/index.html). Another form of orders regarding CPR and other treatments are state-specific POLST (portable orders for life sustaining treatment) (https://polst.org/form-patients/). Both a POLST and a DNR form MUST be signed by a healthcare provider and MUST be presented to the emergency responders when they arrive. These directives instruct ambulance and hospital emergency personnel not to attempt CPR (or to stop it if it has begun) if your heart or breathing should stop.

INSTRUCTIONS

PRINT YOUR NAME

PRINT THE

NAME, HOME ADDRESS, HOME AND WORK TELEPHONE NUMBERS OF YOUR AGENT

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

1. HEALTH CARE POWER OF ATTORNEY

I, _____, as principal,
(name)

designate

_____
(name of agent)

_____
(address)

_____(home telephone number)

_____(work telephone number)

as my agent for all matters relating to my health care, including, without limitation, full power to give or refuse consent to all medical, surgical, hospital and related health care. This power of attorney is effective on my inability to make or communicate health care decisions. All of my agent's actions under this power during any period when I am unable to make or communicate health care decisions or when there is uncertainty whether I am dead or alive have the same effect on my heirs, devisees and personal representatives as if I were alive, competent and acting for myself.

If my agent is unwilling or unable to serve or continue to serve, I hereby appoint

_____
(alternate agent)

_____
(address)

_____(home telephone number)

_____(work telephone number)

as my agent.

INSTRUCTIONS

INITIAL THE STATEMENT THAT APPLIES IN EACH PARAGRAPH

I have _____ I have not _____ completed the living will (Part 2 of the Health Care Directive form) for purposes of providing specific direction to my agent in situations that may occur during any period when I am unable to make or communicate health care decisions or after my death. My agent is directed to implement those choices I have initialed in the living will.

I have _____ I have not _____ completed a prehospital medical care directive pursuant to section 36-3251, Arizona Revised Statutes.

Note: A prehospital medical care directive must be in the form required by the Arizona Department of Health Services, and must be signed by you, your physician, and a witness. A form can be found online at https://www.azag.gov/seniors/life-care-planning. We suggest you speak to your physician for more information. Caring Info does not distribute these forms.

2. LIVING WILL (OPTIONAL)

Some general statements concerning your health care options are outlined below. If you agree with one of the statements, you should initial that statement. Read all of these statements carefully before you initial your selection. You can also write your own statement concerning life-sustaining treatment and other matters relating to your health care under the section titled "Other or additional statements of desires." **You may initial any combination of paragraphs 1, 2, 3 and 4 but if you initial paragraph 5 the others should not be initialed.**

INITIAL ANY AND ALL PARAGRAPHS THAT REFLECT

YOUR WISHES AND CROSS THROUGH STATEMENTS THAT DO NOT REFLECT YOUR WISHES

_____1. If I have a terminal condition I do not want my life to be prolonged and I do not want life-sustaining treatment, beyond comfort care (treatment given to protect and enhance my quality of life), that would serve only to artificially delay the moment of my death.

_____2. If I am in a terminal condition or an irreversible coma or a persistent vegetative state that my doctors reasonably feel to be irreversible or incurable, I do want the medical treatment necessary to provide care that would keep me comfortable, but I do not want the following

- cardiopulmonary resuscitation, for example, the use of drugs, electric shock and artificial breathing; or
- artificially administered nutrition and hydration; or
- to be taken to a hospital if at all avoidable.

_____3. Notwithstanding my other directions, if I am known to be pregnant, I do not want life-sustaining treatment withheld or withdrawn if it is possible that the embryo/fetus will develop to the point of live birth with the continued application of life-sustaining treatment.

YOU MAY ADD ADDITIONAL

STATEMENTS THAT REFLECT YOUR WISHES ON THE NEXT PAGE

_____4. Notwithstanding my other directions I do want the use of all medical care necessary to treat my condition until my doctors reasonably conclude that my condition is terminal or is irreversible and incurable or I am in a persistent vegetative state.

_____5. Regardless of my condition, I want my life to be prolonged to the greatest extent possible.

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

Other or additional statements of desires:

INSTRUCTIONS

AUTOPSY (OPTIONAL)

IF YOU CHOOSE TO INITIAL A STATEMENT, INITIAL ONLY ONE STATEMENT THAT REFLECTS YOUR WISHES

3. AUTOPSY (Optional)
(UNDER ARIZONA LAW AN AUTOPSY MAY BE REQUIRED IN CERTAIN CIRCUMSTANCES)

If one of the statements below reflects your wishes, initial on the line next to that statement. If you choose to initial a statement, initial only one statement. You do not have to initial any of the statements.

_____ 1. I do not consent to an autopsy in any situation in which an autopsy is not otherwise required by law.

_____ 2. I consent to an autopsy.

_____ 3. My agent may give consent to or refuse an autopsy.

ORGAN DONATION

4. ORGAN DONATION (OPTIONAL)

(Under Arizona 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. You may also authorize your agent to do so or a member of your family may make a gift unless you give them notice that you do not want a gift made. In the space below you may make a gift yourself or state that you do not want to make a gift. If you do not complete this section, your agent will have the authority to make a gift of a part of your body pursuant to law. The donation elections you make below survive your death.)

If any of the statements below reflects your desire, initial on the line next to that statement. 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 Arizona law.

INITIAL THE

STATEMENTS

THAT REFLECT YOUR WISHES

_____ 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:

_____ Pursuant to Arizona 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.

PHYSICIAN AFFIDAVIT (OPTIONAL)

YOUR DOCTOR SHOULD COMPLETE THIS SECTION

5. PHYSICIAN AFFIDAVIT (OPTIONAL)

(Before initialing any choices in your Health Care Directive you may wish to ask questions of your physician regarding a particular treatment alternative. If you do speak with your physician it is a good idea to ask your physician to complete this affidavit and keep a copy for his or her file.)

I, Dr. _____,
have reviewed this guidance document and have discussed with

_____
any questions regarding the probable medical consequences of the treatment choices provided above. This discussion with the principal occurred on _____.
(date)

I have agreed to comply with the provisions of this directive.

_____
(signature of physician)

FUNERAL AND BURIAL DISPOSITION (OPTIONAL)

INITIAL THE STATEMENTS THAT REFLECT YOUR WISHES

6. FUNERAL AND BURIAL DISPOSITION (OPTIONAL)

If any of the statements below reflects your desire, initial on the line next to that statement. You do not have to initial any of the statements.

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

_____ Upon my death, I direct my body to be buried (as opposed to cremated).

_____ Upon my death, I direct my body to be buried in _____.

_____ Upon my death, I direct my body to be cremated.

_____Upon my death, I direct my body to be cremated, with my ashes to be _____ .

_____ My agent may make all funeral and burial disposition decisions.

EXECUTION

This Health Care Directive will not be valid unless it is EITHER:

IF YOU CHOOSE TO SIGN WITH A WITNESS, USE ALTERNATIVE 1, BELOW

(A) Signed by at least one qualified adult witness who is present when you sign and who affirms that you appear to be of sound mind and are under no duress. The witness cannot be related to you by blood, marriage, or adoption, entitled to any part of your estate at the time the document is signed, appointed as your agent, or involved with the provision of your health care at the time the document is signed. (Use Alternative 1, below, if you decide to have your signature witnessed.)

OR

IF YOU CHOOSE TO HAVE YOUR SIGNATURE NOTARIZED, USE ALTERNATIVE 2, BELOW

(B) Witnessed by a notary public who is neither your agent nor a person involved with the provision of your health care at the time the document is signed. The notary must also affirm that (a) he/she was present when you dated and signed the document, (b) you appeared to be of sound mind and free from duress at the time you signed the document. (Use Alternative 2, below, if you decide to have your signature notarized.)

(C) NOTE: If the principal is physically unable to sign the Health Care Directive, the witness or notary must add a statement that "The principal has directly indicated to me that this Health Care Directive expresses his or her wishes and that the principal intends to adopt this Health Care Directive at this time."

INSTRUCTIONS

SIGN AND DATE THE DOCUMENT

WITNESSING PROCEDURE

WITNESS MUST SIGN AND PRINT HIS OR HER ADDRESS

WITNESS MUST SIGN THIS STATEMENT IF PRINCIPAL IS PHYSICALLY UNABLE TO SIGN

OPTION 1: Sign before a Witness

This health care directive is made under Section 36-3221, Arizona Revised Statutes, and continues in effect for all who may rely on it except those to whom I have given notice of its revocation.

_____
(signature of principal)

_____ _____
(date) (time)

I affirm that this was signed or acknowledged and dated in my presence, and that the person signing this document (the principal) appears to be of sound mind and under no duress. I am not designated to make medical decisions on the principal's behalf. I am not directly involved with the provision of health care to the principal. I am not entitled to any portion of the principal's estate upon his or her decease, whether under any will or by operation of law. I am not related to the principal by blood, marriage, or adoption.

Witness: _____ Date:_____

Address: _____

_____

Note: If the principal is physically unable to sign the Health Care Directive, the Witness must sign the following statement:

> The principal has directly indicated to me that this Health Care Directive expresses his or her wishes and that the principal intends to adopt this Health Care Directive at this time.

Witness: _____ Date:_____

INSTRUCTIONS

SIGN AND DATE THE DOCUMENT

NOTARY WILL FILL OUT THIS PART OF THE FORM

NOTARY MUST SIGN THIS STATEMENT IF PRINCIPAL IS PHYSICALLY UNABLE TO SIGN

OPTION 2: Sign Before a Notary

This health care directive is made under Section 36-3221, Arizona Revised Statutes, and continues in effect for all who may rely on it except those to whom I have given notice of its revocation.

_____
(signature of principal)

_____ _____
(date) (time)

State of Arizona
County of _____

The foregoing instrument was signed or acknowledged before me this _____ day of _____, _____, by

_____ (principal).

The person signing this document (the principal) appears to be of sound mind and is under no duress. I am not designated to make medical decisions on the principal's behalf. I am not directly involved with the provision of health care to the principal.

_____
NOTARY PUBLIC
Print Name: _____

My Commission Expires:

Note: If the principal is physically unable to sign the Health Care Directive, the Notary must sign the following statement:

> The principal has directly indicated to me that this Health Care Directive expresses his or her wishes and that the principal intends to adopt this Health Care Directive at this time.

Notary: _____ Date:_____