

WEST VIRGINIA

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.

INTRODUCTION TO YOUR WEST VIRGINIA ADVANCE HEALTH CARE DIRECTIVE

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.

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

You may complete Part I, Part II, or both, depending on your advance- planning needs. **You must complete Part III.**

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

How do I make my West Virginia Advance Health Care 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 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.

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.

You can appoint a second person as your alternate representative. An alternate representative will step in if the person you name as representative 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?

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 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.

You retain the primary authority for your healthcare decisions as long as you are able to make your wishes known.

Agent Limitations

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

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.

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.

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

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.

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

ATTACH
ADDITIONAL PAGES
IF NEEDED

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

This image shows a single sheet of white paper with horizontal blue ruling lines. The lines are evenly spaced and run across the width of the page. There are no margins, text, or other markings on the paper.

© 2005 National Alliance for Care at Home. 2023 Revised.

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

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

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

© 2005 National
Alliance for Care at
Home. 2023 Revised.

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

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

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

© 2005 National
Alliance for Care at
Home. 2023 Revised.

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
www.caringinfo.org