Completing your living will and medical power of attorney

Completing Your Living Will

Print your name on the first blank line. “I, MY NAME, want everyone who cares for me to know what I want when I cannot speak for myself.”

Section 1: What kind of quality of life is unacceptable to you? When would you want your family and doctors to stop or withdraw treatment?

Section 2: There may be some procedures you would not want under any circumstances. If you have decided you would never want one of the treatments listed, check that box. If you have not decided yet, or want your doctor to try these treatments, leave the box blank.

Section 3: Think about the statement: “When I am near death, it is important that...” You may write anything you want here. Some say, “I want hospice care. I want to die at home. I want family near me. I want to be cremated when I die.” You may leave these lines blank if you wish.

It is not necessary to have this form notarized in Arizona, but there is a space for a notary if you wish.

Incomplete Your Medical Power of Attorney form to a completed and signed English version of this form. Give copies to your family, close friends and doctor. Take copies to the hospital if you become ill and need treatment.

1510 E. Flower St. Phoenix, AZ 85014 (602) 530-6900 FAX (602) 530-6901 hov.org

A legacy of caring since 1977
Completing Your Medical Power of Attorney

Print your name in the first blank line. “I, MY NAME, as principal, designate…”

Print the name of the person you choose to be your Medical Power of Attorney on the next blank line. “OTHER PERSON’S NAME, as my agent for all matters…”

Initial if you give your agent the power to admit you to an inpatient or psychiatric program if ordered by your doctor.

Initial if you want to make it clear that this document may not be revoked if you are incapacitated.

Print the address and phone number of your chosen Medical Power of Attorney on the next blank line. ADDRESS AND PHONE

You may choose an alternate Medical Power of Attorney in case the first person is not available or unable to make decisions for you. “SECOND PERSON’S NAME as my agent…”

Print that person’s ADDRESS and PHONE. If you do not choose an alternate, leave the lines blank.

Sign this form in front of a witness who is not related to you by blood, marriage or adoption. The witness cannot be a beneficiary to your estate or be directly involved in your healthcare.

It is not necessary to have this form notarized in Arizona, but there is space for a notary if you wish.

Attach this form and your Living Will form to a completed and signed English version of this form. Give copies to your family, close friends and doctor. Take copies to the hospital if you become ill and need treatment.
HEALTH CARE DIRECTIVE (LIVING WILL)

I, , want everyone who cares for me to know what health care I want, when I cannot let others know what I want.

SECTION 1:

I want my doctor to try treatments that may get me back to an acceptable quality of life. However, if my quality of life becomes unacceptable to me and my condition will not improve (is irreversible), I direct that all treatments that extend my life be withdrawn.

A quality of life that is unacceptable to me means (check all that apply):

☐ Unconscious (chronic coma or persistent vegetative state)

☐ Unable to communicate my needs

☐ Unable to recognize family or friends

☐ Total or near total dependence on others for care

☐ Other: ________________________________

☐ Even if I have the quality of life described above, I still wish to be treated with food and water by tube or intravenously (IV).

☐ If I have the quality of life described above, I do NOT wish to be treated with food and water by tube or intravenously (IV).

SECTION 2: (You may leave this section blank.)

Some people do not want certain treatments under any circumstance, even if they might recover. Check the treatments below that you do not want under any circumstances:

☐ Cardiopulmonary Resuscitation (CPR)
☐ Ventilation (breathing machine)
☐ Feeding tube
☐ Dialysis
☐ Other: ________________________

غير ذلك: ________________________

التقسيم الثالث:

SECTION 3:

When I am near death, it is important to me that:

_________________________________________________________________________________________________________
_________________________________________________________________________________________________________
_________________________________________________________________________________________________________

Such as hospice care, place of death, funeral arrangements, cremation or burial preferences.

BM E SURE TO SIGN THE REVERSE SIDE OF THIS FORM

• If you only want a Health Care (Medical) Power of Attorney, draw a large X through this page.

• Tell the people who have made decisions for you, your doctor(s), your family and friends. Give each of them a copy of this form.

• Take a copy of this with you whenever you go to the hospital or on a trip.

• You should review this form often.

• You can cancel or change this form at any time.

For more information, contact Health Care Decisions: (602) 222-2229 or hov.org/healthcare-decisions

hov.org/healthcare-decisions

احرص على توقيع الجانب الخلفي لهذا النموذج

BE SURE TO SIGN THE REVERSE SIDE OF THIS FORM

إذا كنت تريد فقط إعطاء تركيل رسمي للرعاية الصحية (الطبية)، فارسم علامة X كبيرة على هذه الصفحة.

تحدد عن هذا النموذج مع شخص تختاره لاتخاذ القرارات بالنيابة عنك، مثل طبيبك (أطبائك)، وأفراد عائلتك وأصدقائك. أعط كلا منهم نسخة من هذا النموذج.

• If you only want a Health Care (Medical) Power of Attorney, draw a large X through this page.

• Talk about this form with the person you have chosen to make decisions for you, your doctor(s), your family and friends. Give each of them a copy of this form.

• Take a copy of this with you whenever you go to the hospital or on a trip.

• You should review this form often.

• You can cancel or change this form at any time.

hov.org/healthcare-decisions

For more information, contact Health Care Decisions: (602) 222-2229 or hov.org/healthcare-decisions
By initialing here, this Health Care Directive including Mental Health Care Power of Attorney may not be revoked if I am incapacitated.

By initialing here, I specifically consent to giving my agent the power to admit me to an inpatient or partial psychiatric hospitalization program if ordered by my physician. If my agent is unwilling or unable to serve or continue to serve, I hereby appoint: ____________________________ as my agent.

Print alternate agent ADDRESS and PHONE: __________________________________________

I intend for my agent to be treated as I would regarding the use and disclosure of my individually identifiable health information or other medical records. This release authority applies to any information governed by the Health Insurance Portability and Accountability Act of 1996 (aka HIPAA), 42 USC 1420D and 45 CFR 160-164.
SIGN HERE for the Health Care (Medical) Power of Attorney and/or the Health Care Directive forms

Please ask one person to witness your signature who is not related to you or financially connected to you or your estate.

Signature __________________________ Date __________________________

The above named person is personally known to me, and I believe him/her to be of sound mind and to have completed this document voluntarily. I am at least 18 years old, not related to him/her by blood, marriage or adoption, and not an agent named in this document. I am not to my knowledge a beneficiary of his/her will or any codicil, and I have no claim against his/her estate. I am not directly involved in his/her health care.

Witness __________________________________________ Date __________________________

This document may be notarized instead of witnessed.

On this ________ day of __________________, in the year of __________, personally appeared before me the person signing, known by me to be the person who completed this document and acknowledged it as his/her free act and deed. IN WITNESS THEREOF, I have set my hand and affixed my official seal in the County of __________.

State of __________, on the date written above.

Notary Public __________________________________________

For more information, contact Health Care Decisions: (602) 222-2229 or hov.org/healthcare-decisions