Combined Living Will and Health Care Power of Attorney

INSTRUCTIONS

1. Before completing your LIVING WILL and HEALTH CARE POWER OF ATTORNEY, you should discuss your instructions with your health care agent (if any), family members, your doctor, priest, deacon, chaplain, or anyone else who may become responsible for your care. This form was developed by Pennsylvania's Catholic Bishops to offer ethical and religious guidance. Consult with an attorney if you have legal questions about your LIVING WILL and HEALTH CARE POWER OF ATTORNEY. **This form is not intended to take the place of specific legal advice.**

2. You should periodically review this LIVING WILL and HEALTH CARE POWER OF ATTORNEY with those same people to insure that this directive always reflects your wishes.

3. You can revoke this directive at any time in any manner. The revocation is effective as soon as you, or someone who witnesses your revocation, communicate it to your attending physician or other health care provider. If you decide to revoke this LIVING WILL and HEALTH CARE POWER OF ATTORNEY make sure that your doctor and any health care agent you appoint receive notice of the revocation.

4. Two witnesses who are at least 18 years of age are required by Pennsylvania law. If someone signs this form on your behalf, that person may not also be a witness. Someone who will inherit property from you; is a creditor of yours, or is an employee of your health care provider should not sign as a witness.

ADVANCE HEALTH CARE DIRECTIVE

I. PREAMBLE

Our Christian heritage holds that life is the gift of a loving God.

I understand and believe, as a Catholic, that I may never choose to directly cause or hasten my death. I believe that euthanasia is the deliberate act of taking the life of another, whether by active intervention or by omitting an action with the intention of causing death. I believe that euthanasia constitutes an unwarranted destruction of human life and is never morally permissible.

I also believe that suicide (and assisted suicide) are never morally permissible.

I understand that I have the right to make decisions about my health care. There may come a time when I am unable, due to physical or mental incapacity, to understand, make or communicate my own health care decisions. In such circumstances, those caring for me will need direction concerning my care and will turn to someone who knows my values and health care wishes. I am, therefore, signing the attached LIVING WILL and HEALTH CARE POWER OF ATTORNEY [which is my advance directive for health care] to provide the guidance and authority needed to implement decisions for me, and especially if I have an end-stage medical condition or am permanently unconscious (as those terms are defined in Pennsylvania law).

II. HEALTH CARE POWER OF ATTORNEY

I
_____(name)

of _____ County, Pennsylvania, am a Catholic from the Diocese of

_____ and believe that life is a precious gift from God. I believe that God intended for my life to be lived for His glory and my salvation. I know too that my earthly goal is to be united with God for eternal life. Therefore, I do not need to resist death if medical treatment is futile or disproportionately burdensome. My duly appointed health care agent may refuse medical treatments, as long as doing so is consistent with the authoritative teaching of the Catholic Church such as that set forth in documents such as *The Gospel of Life* (Pope John Paul II, March 25, 1995); *Declaration on Euthanasia* (Congregation for the Doctrine of the Faith, 1980); *Patients in a "Permanent" Vegetative State* (Pope John Paul II, March 20, 2004); *Nutrition and Hydration: Moral Considerations* (The Catholic Bishops of Pennsylvania, Revised Edition, 1999); *Ethical and Religious Directives for Catholic Health Care Services* (U.S. Conference of Catholic Bishops, 2001);and *Responses to Certain Questions Concerning Artificial Nutrition and Hydration* (Congregation for the Doctrine of the Faith, 2007).

Medical treatments may be foregone, or withdrawn, if they do not offer me reasonable hope of benefit or are disproportionately burdensome, meaning the treatments will impose serious risks, excessive pain, excessive expense on the family or the community, or other extreme burden. My health care agent (or health care representative as designated by the law) is to presume in favor of providing me with nutrition and hydration, including medically assisted nutrition and hydration if they are capabale of sustaining my life. [1]

This health care power of attorney will take effect when, and only when, I lack the ability to understand, make or communicate a choice regarding a health or personal care decision and that inability is verified by my attending physician.

My health care agent may not delegate the authority to make decisions to anyone else, unless I specifically authorize that by additional written instructions which I set forth below.

I recognize that the civil law gives my health care agent certain powers. These powers are to be exercised according to my wishes and religious beliefs as expressed above.

POWERS OF HEALTH CARE AGENT UNDER PENNSYLVANIA LAW

1. To authorize or direct withholding or withdrawal of medical care and surgical procedures.

2. To authorize my admission to or discharge from a medical, nursing, residential or similar facility, and to make arrangements for my care, including hospice and/or palliative care.

3. To hire and discharge medical, social service and other support personnel responsible for my care.

4. To authorize, withhold or withdraw nutrition (food) or hydration (water) medically supplied by tube through my nose, stomach, intestines, arteries or veins.

5. To request that a physician responsible for my care issue a do-not-resuscitate (DNR) order, including an out-of-hospital DNR order as authorized in law, and sign any required documents and consents.

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1 Effective immediately and continuously until my death, or revocation by a writing signed by me or someone authorized by law to revoke this document, I authorize all health care providers or other covered entities to disclose to my health care agent, upon the agent's request, any information, oral or written, regarding my physical or mental health. The information includes, but is not limited to, medical and hospital records and what is otherwise private, privileged, protected or personal health information (such as that described or defined in the Health Insurance Portability and Accountability Act of 1996 (Public Law 104-91, 100 Stat. 1936) and the regulations promulgated thereunder and any other State or local laws and rules).

III. DECLARATION OF LIVING WILL

I direct that those responsible for my care to make health care decisions according to the principles and authoritative teachings of my Catholic faith and what they know about my stated wishes. I hereby declare and make known my instructions and wishes for my future health care.

This LIVING WILL shall take effect when my attending physician determines that I am incompetent which means that I lack sufficient capacity to understand the potential material benefits, risks and alternatives involved in a specific proposed health care decision; I am unable to make the health care decision on my behalf; or I am unable to communicate a decision about my health care.

For the LIVING WILL to be effective, my attending physician must also verify that:

1. I have an end-stage medical condition, that is, I have an incurable and irreversible medical condition in an advanced state which will result in death despite the introduction or continuation of medical treatment;or

2. I am permanently unconscious, which is a total and irreversible loss of consciousness and capacity for interaction with the environment.

To inform those responsible for my care of my specific wishes, I direct that the following health care decisions be implemented. I affirm that the statements and principles listed in the Preamble and in my HEALTH CARE POWER OF ATTORNEY which are part of this form apply, as well, to this LIVING WILL.

I ask that if I fall terminally ill, I be told so I might prepare myself for death. If I am unable to understand, communicate or make decisions for myself, I direct that a Catholic priest be contacted to attend to my spiritual needs so I may receive the Sacraments of Reconciliation and the Anointing of the Sick, Viaticum, and be supported by prayer.

If my doctor determines that I have an end-stage medical condition and my death is imminent, I direct that treatment that will only maintain a precarious and burdensome prolonging of my life be foregone or withdrawn. However, treatment should not be withdrawn if my health care agent (or in the absence of a health care agent, my health care representative) judges there are special and significant reasons why it should continue.

I believe that I do not have to use ethically extraordinary or disproportionate medical treatments for sustaining life if they are excessively burdensome or do not offer any reasonable hope of benefit. I understand that this belief is consistent with authoritative Catholic teaching.

I direct that, regardless of my physical or mental condition, all ordinary medical care necessary to relieve pain and make me comfortable (including medically assisted nutrition and hydration) be provided if it offers a reasonable hope of benefit and is not excessively burdensome.

If I am unable (even with assistance) to take food and drink orally, I desire that medically assisted nutrition and hydration be provided to me so long as it is capable of sustaining my life. Even if I am permanently unconscious, medically assisted nutrition and hydration should be continued. It should be discontinued if it is futile (no longer able to sustain my life). It should be discontinued if it imposes disproportionate burdens to me (serious risk, excessive pain, excessive expense on the family or the community, or some other extreme burden) or if death is both inevitable and so imminent that continuing medically assisted nutrition and hydration is judged futile.

I direct that I receive appropriate medication to alleviate my pain, even though the administration of such medications may indirectly hasten my death. Pain medication should never be administered with the purpose of hastening my death.

I also direct that I not receive ethically extraordinary treatments, unless my health care agent (or representative) judges that there are special and significant reasons why I should receive them. Rather than listing for my agent all specific forms of medical treatment, which I would or would not want, I direct that the directions and principles I have adopted by using this form guide him or her.

Additional Provisions for a Woman: I direct that if I am pregnant all medically indicated measures and medically assisted nutrition and hydration be provided to sustain my life, regardless of my physical or mental condition, if these measures could sustain the life of my unborn child until birth.

IV. FURTHER COMMENTS

I also note the following:

_____

_____

_____

_____

_____

_____

_____

APPOINTMENT OF HEALTH CARE AGENT

I appoint the following named individual as my health care agent:

_____
NAME / RELATIONSHIP

_____
ADDRESS

TELEPHONE NUMBER: Home _____

Work _____

Cell _____

E-MAIL _____

IF I DO NOT NAME A HEALTH CARE AGENT, I UNDERSTAND THAT HEALTH CARE PROVIDERS WILL ASK MY FAMILY OR SOME ADULT WHO KNOWS MY PREFERENCES AND VALUES TO DETERMINE MY WISHES FOR TREATMENT.

If the person I named above as health care agent is not readily available, I appoint the person or persons named below to serve in the order listed.

FIRST ALTERNATE HEALTH CARE AGENT

_____
NAME / RELATIONSHIP

_____
ADDRESS

TELEPHONE NUMBER: Home _____

Work _____

Cell _____

E-MAIL _____

SECOND ALTERNATE HEALTH CARE AGENT

_____

NAME / RELATIONSHIP

_____

ADDRESS

TELEPHONE NUMBER: Home _____

Work _____

Cell _____

E-MAIL _____

Having carefully read this document, I sign it this _____ day of _____, 20_____, revoking all previous health care powers of attorney and health care treatment instructions.

_____

Sign full name here

WITNESS: _____

WITNESS: _____

Two witnesses at least 18 years of age are required by Pennsylvania law. If someone signs this document at your direction and on your behalf, that person may not be a witness too. To limit questions which might arise, the witnesses should not be anyone who will inherit property from you, be creditors or be employed by any of your health care providers.

NOTARIZATION (OPTIONAL)

This form does not need to be notarized under Pennsylvania law, but if it is witnessed and notarized, it is more likely to be accepted under the laws of some other states.

On this _____ day of _____, 20_____, before me personally appeared the aforesaid declarant and principal to me known to be the person described in and who executed the foregoing document and acknowledged that he/she signed the document as his/her free act and deed.

IN WITNESS WHEREOF, I have hereunto set my hand and affixed my official seal in

_____ County, State of _____, the day and year first above written.

_____

NOTARY PUBLIC

My Commission expires _____