ARIZONA
Advance Directive
Planning for Important Health Care Decisions

Caring Connections
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CARING CONNECTIONS

Caring Connections, 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 Caring Connections 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.

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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 form is completed and signed, photocopy the form and give it 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 form is available in the event of an emergency.

5. Arizona maintains an Advance Directive Registry. By filing your advance directive with the registry, your health care provider and loved ones may be able to find a copy of your directive in the event you are unable to provide one. You can read more about the registry, including instructions on how to file your advance directive, at https://www.azsos.gov/adv_dir/.

6. 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 Arizona 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.

Your *Arizona Health Care Directive* goes into effect when your doctor determines that you are no longer able to make or communicate your health care decisions.

This form does not contain a *Mental Health Care Power of Attorney*. The Arizona Attorney General's office provides more information on these documents, including a form and instructions, at http://www.azag.gov/life_care/index.html. However, if you do not have a mental health care power of attorney, your general health care power of attorney may make decisions about mental health treatment on your behalf if you are found to be incapable of making decisions, *except* that your agent cannot consent to your admission at a Level One Behavioral Facility unless expressly authorized to do so.

Note: This document will be legally binding only if the person completing the document is a competent adult who is at least 18 years of age.

Instructions for Completing Your Arizona Health Care Directive

How do I make my *Arizona 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:

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

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.

Either option is available using this form.

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.

Instructions for Completing Your Arizona Health Care Directive (continued)

Can I add personal instructions to my *Living Will*?

One of the strongest reasons for naming an agent is to have someone who can respond flexibly as your medical 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."

Whom should I appoint as my agent?

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

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.

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

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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 http://www.azag.gov/life_care/. We suggest you speak to your physician for more information. Caring Connections does not distribute these forms.

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INITIAL ANY AND ALL PARAGRAPHS THAT REFLECT YOUR WISHES AND CROSS THROUGH STATEMENTS THAT DO NOT REFLECT YOUR WISHES

YOU MAY ADD ADDITIONAL STATEMENTS THAT REFLECT YOUR WISHES ON THE NEXT PAGE

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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.**

_____ 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.

______ 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:

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INSTRUCTIONS

AUTOPSY (OPTIONAL)

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

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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.

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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)

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FUNERAL AND BURIAL DISPOSITION (OPTIONAL)

INITIAL THE STATEMENTS THAT REFLECT YOUR WISHES

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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.

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

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

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EXECUTION

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

(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

(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.)

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

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.

SIGN AND DATE THE DOCUMENT

____
(signature of principal)

______________________ _________________
(date) (time)

WITNESSING PROCEDURE

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 MUST SIGN AND PRINT HIS OR HER ADDRESS

Witness: ________________________________ Date:______________

Address: ____

____

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

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:______________

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INSTRUCTIONS

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.

SIGN AND DATE THE DOCUMENT

____

(signature of principal)

______________________ ________________

(date) (time)

State of Arizona

County of _______________________________

The foregoing instrument was signed or acknowledged before me this _________ day of _______________________, ____________, by

______________________________ (principal).

NOTARY WILL FILL OUT THIS PART OF THE FORM

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:

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

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.

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Notary: _______________________________ Date:_____________

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

1. Your *Arizona Health Care Directive* is an important legal document. Keep the original signed document in a secure but accessible place. Do not put the original document 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 original 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. Arizona maintains an Advance Directive Registry. By filing your advance directive with the registry, your health care provider and loved ones may be able to find a copy of your directive in the event you are unable to provide one. You can read more about the registry, including instructions on how to file your advance directive, at https://www.azsos.gov/adv_dir/.

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.

6. If you want to make changes to your documents after they have been signed and witnessed, you must complete a new document.

7. Remember, you can always revoke your Arizona document.

8. Be aware that your Arizona 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.

   The directives 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 http://www.azag.gov/life_care/. We suggest you speak to your physician for more information. **Caring Connections does not distribute these forms.**