WEST VIRGINIA ADVANCE DIRECTIVE

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West Virginia Center for End-of-Life Care

Frequently Asked Questions about the Combined Living Will/Medical Power of Attorney

- ***Can I combine my living will and medical power of attorney in one form?***
  Yes. If you do not want CPR, feeding tubes, breathing machines, or other life-prolonging interventions if you become terminally ill or permanently unconscious, then you can use one document that combines both the living will and the medical power of attorney forms.

- ***Can I still make my own healthcare decisions once I have completed a combined form?***
  Yes. Your combined form will does not take effect until you cannot make decisions for yourself. The living will portion of the combined form takes effect when you are terminally ill or permanently unconscious. As long as you can make your own decisions, the form is NOT in effect.

- ***Can any person create a combined form?***
  Yes. Any adult (including a mature or emancipated minor) who has the ability to make decisions for him or herself can complete a combined form.

- ***Do I need a lawyer to create a combined form?***
  No. A combined form can be completed without the help of a lawyer.

- ***Will another state honor my combined form?***
  Laws differ somewhat from state to state, but in general, a patient's expressed wishes will be honored.

- ***What should I do with my combined form after I sign it?***
  After your form is signed, witnessed and notarized, keep the original document in a safe location where it can be easily found. A photo copy of your combined form is legally valid. You are encouraged to send a copy of your combined form to the West Virginia e-Directive Registry. See instructions below.

A complete listing of all Frequently Asked Questions relating to the Combined Living Will/ Medical Power of Attorney can be found by clicking on the FAQS link on this page.

So that your combined form can be found in a medical emergency, you are encouraged to submit your form to the WV e-Directive Registry by FAXing it to 844-616-1415, mailing a copy to the WV e-Directive Registry, 1195 Health Sciences North, Morgantown, WV 26506, or scanning and submitting it online at http://www.wvendoflife.org. The combined living/medical power of attorney on this site contains an Opt-In box. If you would like to have your combined form included in the Registry, you must INITIAL the box giving your permission.

Print Form

Opt In ☐ **INITIAL box if you agree to have this advance directive submitted to the WV *e-Directive* Registry, and released to treating health care providers. Complete information to RIGHT.**

REGISTRY FAX: 844-616-1415

Last Name/First/Middle _____
Address _____
City/State/Zip _____
Date of Birth (mm/dd/yyyy) _____/_____/_____
Last 4 SSN ___ ___ ___ ___ **Gender M**___ **F**___

STATE OF WEST VIRGINIA
COMBINED
MEDICAL POWER OF ATTORNEY
AND LIVING WILL

The Person I Want to Make Health Care Decisions
For Me When I Can't Make Them for Myself
And
The Kind of Medical Treatment I Want and Don't Want
If I Have a Terminal Condition or Am In a Persistent Vegetative State

Dated: _____ , 20 ____

I, _____ , hereby

_____

(*Insert your name and address*)

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:

_____

_____

(*Insert the name, address, area code and telephone number of the person you wish to designate as your representative*)

The person I choose as my successor representative is:

If my representative is unable, unwilling or disqualified to serve, then I appoint

_____

_____

(Insert the name, address, area code and telephone number of the person you wish to designate as your successor representative)

Principal Name (person for whom form is being completed):_____

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.

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 shall act consistently with my special directives or limitations as stated below.

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:

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

_____ DATE _____
Signature of the Principal

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.

Witness _____ DATE _____

Witness _____ DATE _____

STATE OF _____

COUNTY OF _____

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

CRITICAL STEP:
SHARE YOUR COMPLETED DOCUMENT!

Your document is only helpful if people know where to find it when it is needed. It's important to discuss the decisions outlined in your document with anyone you designate to act on your behalf in a health emergency. Here's a quick guide to sharing your document once it has been completed and satisfies the legal requirements for your state (if applicable).

WHO NEEDS A COPY OF YOUR DOCUMENT?

- Anyone assigned a decision-making role in the document
- A spouse or significant other
- A trusted family member or friend
- Any doctors you see on a regular basis
- Any hospital or facility in which you regularly receive care
- A lawyer and/or estate planner, if you have one

HOW TO SHARE YOUR DOCUMENT

1) **Use Cake!** Upload your document to a free Cake account for safekeeping. Share 24/7 secure document access with anyone that has an email address*

   Create your free Cake account: www.joincake.com/share-free

2) **Or, print** and provide copies to everyone who needs one

WHY PLAN & SHARE WITH CAKE?

- Get a personalized checklist that guides you through each step
- Make healthcare, financial, funeral, and legacy decisions
- Create, upload, and print all your end-of-life documents
- Share 24/7 document access with anyone that has an email address*

Create your free Cake account: www.joincake.com/share-free

** Some healthcare providers may require a paper copy of your document to be able to enter it into their records.*