



1-877-209-8086

<https://wvendlife.org>

Frequently Asked Questions about the Medical Power of Attorney

This booklet is based on the revised West Virginia Health Care Decisions Act passed by the West Virginia Legislature in March 2022 and effective June 2022. The Center hopes that this booklet will help West Virginians with advance care planning. The Center's website at <https://wvendlife.org> contains a copy of the West Virginia Health Care Decisions Act and additional downloadable forms. The information provided on this website does not, and is not intended to, constitute legal advice; instead, all information, content, and materials available on this site are for general informational purposes only. For legal advice, please consult your attorney.

Revised June 2022

- **What is a medical power of attorney?**

A medical power of attorney is a legal document, a type of advance directive, that allows you to name a person to make health care decisions for you if you are unable to make them for yourself. The medical power of attorney only goes into effect if you are too sick to make decisions for yourself. If you regain decision-making ability, the medical power of attorney is no longer in effect, and you will be able to speak for yourself again.

The medical power of attorney allows your representative to respond to medical situation that you might not have anticipated and to make decisions for you based on knowledge of your values and wishes. Medical power of attorney representatives (the people you select to make decisions for you) can never override your written, expressed wishes.

- **What if I already have a living will? Do I need to create a medical power of attorney?**

Most West Virginians create both a medical power of attorney and a living will. Since the medical power of attorney is a more flexible document and allows you to name someone to make decisions for you, it is advisable to create a medical power of attorney even if you have already signed a living will.

The representative you appoint as your medical power of attorney representative can help ensure that the preferences expressed in your living will are carried out. Some people, however, do not have someone whom they trust or who knows their values and preferences. These people should consider creating a living will.

If you choose to sign both documents, you should see that they are stored in the same place to help assure that your representative will know to respect all of your wishes. Alternatively, you may choose to complete a combined living will and medical power of attorney document.

- **Can I still make my own health care decisions once I have created a medical power of attorney?**

Yes. Your medical power of attorney does not become effective until you are unable to make decisions for yourself. As long as you can speak for yourself, you have the right to make your own decisions.

- **If I decide to create a medical power of attorney, how should I choose my representative?**

Choose someone who knows your values and wishes, and whom you trust to make decisions for you. Do the same for a successor representative. Have a conversation with both representatives to be sure they understand your wishes and agree to be your representative.

You may, but do not have to, choose a family member to be your representative. Regardless of your choice, your representative should be someone who will be available if needed and who will decide matters the way you would decide.

Name only one person each as your representative and your successor representative. Do not choose your health care provider or another person who is likely to be your future health care provider as your representative or successor representative.

- **What if I change my mind about who I want to be my representative or about the kind of treatment I want?**

It is common for wishes to change over time as different events and priorities occur in your life. You should review your advance directives periodically to make sure they still reflect your wishes. The best way to change your advance directive is to create a new one. The new document will automatically cancel the old one. Be sure to notify all people who have copies of your advance directive that you completed a new one. Collect and destroy all copies of the old version. Send the new version to the e-Directive Registry so that your current one is available to treating health care providers.

Remember to submit your new advance directive to the WV e-Directive Registry by faxing it to 844-616-1415 or mailing a copy to the WV e-Directive Registry, 64 Medical Center Drive, PO Box 9022 Health Sciences North, Morgantown, WV 26506-9022

- **Do I need a lawyer to create a medical power of attorney?**

No. Anyone can complete a WV advance directive without the assistance of a lawyer. Visit the Center's website, <https://wvendlife.org>, or call the Center at 877-209-8086 to obtain free WV advance directive forms.

- **Will another state honor my medical power of attorney?**

Laws differ somewhat from state to state, but in general, a patient's expressed wishes will be honored state-to-state. It is highly recommended that you contact your non-WV health care providers to ask if they will honor your WV advance directive.

In WV, it is legally required for health care providers to honor non-WV advance directives and medical orders as of June 7, 2022 as long as the forms were completed correctly per that state's laws.

- **What should I do with my medical power of attorney after I sign it?**

After your advance directive is signed, witnessed, and notarized, keep the original document in a safe location where it can be easily found. A photo copy of your advance directive is legally valid. You are encouraged to submit your form to the WV e-Directive Registry by faxing it to 844-616-1415 or mailing a copy to the WV e-Directive Registry, 64 Medical Center Drive, PO Box 9022 Health Sciences North, Morgantown, WV 26506-9022.

Full Name (Last, First, Middle): _____

Address: _____

City/State/Zip: _____

Date of Birth (mm/dd/yyyy): _____/_____/_____

Last 4 SSN: _____ Sex: M_____ F_____

WV e-Directive Registry Opt In

[HTTPS://WVENDOLIFE.ORG/REGISTRY](https://wvendlife.org/registry)

The WV e-Directive Registry makes your forms immediately available to your health care providers in emergencies. If you agree to have this form and any other submitted forms included in the WV e-Directive registry and released to treating health care providers, please mark below.

YES, I OPT IN

NO, I DON'T OPT IN

Registry toll-free number: 877-209-8086

Registry FAX: 844-616-1415

**STATE OF WEST VIRGINIA
MEDICAL POWER OF ATTORNEY**

The Person I Want to Make Health Care Decisions For Me When I Can't Make Them for Myself

Dated: _____, 20_____

I, _____
(Insert your name and address)

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 (One person):

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

The person I choose as my successor representative is (One person):

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. **Please insert only one name.**)

Principal Name: _____

(Insert your name)

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. This 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.

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 I want or refuse certain treatments

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 (*Sign your name*)

Address of the Principal (*Write your full address*)

I did not sign the principal's signature above. I am at least 18 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, nor 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

Insert Notary Stamp Above