



1-877-209-8086

<https://wvendlife.org>

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

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 If you regain decision-making ability, the medical power of attorney is no longer in effect, and you will be able to speak for yourself again.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 is a living will?**

A living will is a legal document, a type of advance directive, that tells your doctor how you want to be treated if you are terminally ill and cannot make decisions for yourself. A living will states that life-prolonging medical interventions that would serve solely to prolong your dying should not be used. A living will only applies if you are terminally ill AND too sick to make decisions for yourself.

- **Can I combine my living will and medical power of attorney in one form?**

Yes. You can use one document that combines both the living will and the medical power of attorney forms. This is called the Combined Medical Power of Attorney and Living Will and is contained in this packet.

- **Can I still make my own health care decisions once I have completed a combined medical power of attorney and living will form?**

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

- **Can any person create a combined medical power of attorney and living will form?**

Yes. Any adult (including mature or emancipated minors) who has the ability to make decisions for themselves can complete a combined medical power of attorney and living will form.

- **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 combined medical power of attorney and living will 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://WVENDOFLIFE.ORG/REGISTRY](https://wvendoflife.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

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

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. Such authority shall include, but not be limited to, decisions regarding the withholding or withdrawal of life-prolonging interventions, subject to the special directives and limitations as stated below:

1. IN A TERMINAL CONDITION: If I am very sick and unable to communicate my wishes for myself and I am certified by one physician, who has personally examined me, to have a terminal condition, I direct that life-prolonging intervention that would serve solely to prolong the dying process be withheld or withdrawn. Thus, if a physician has determined that I am in a terminal condition, I understand that completing this form would mean that I refuse cardiopulmonary resuscitation (CPR). It also means that I refuse or request the removal of a breathing machine (ventilator), dialysis, and medically administered food and fluids, such as might be provided intravenously or by feeding tube. 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. Nevertheless, oral food and fluids, such as may be provided by spoon or by straw, shall be offered as desired and can be tolerated.

2. OTHER LIVING WILL SPECIAL DIRECTIVES OR LIMITATIONS ON THIS POWER: Comments about 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.

In exercising the authority under this medical power of attorney, my representative shall act consistently with my special directives or limitations as stated in this advance directive.

3. NOT IN A TERMINAL CONDITION: MEDICAL POWER OF ATTORNEY 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.

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.

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 for or at the direction of the principal. I am at least 18 years of age and am not related to the principal by blood or marriage, nor entitled to any portion of the estate of the principal to the best of my knowledge under any will of principal or codicil thereto, nor directly financially responsible for principal's medical care. I am not the principal's attending physician or the principal's medical power of attorney representative or successor medical power of attorney representative under a medical power of attorney.

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