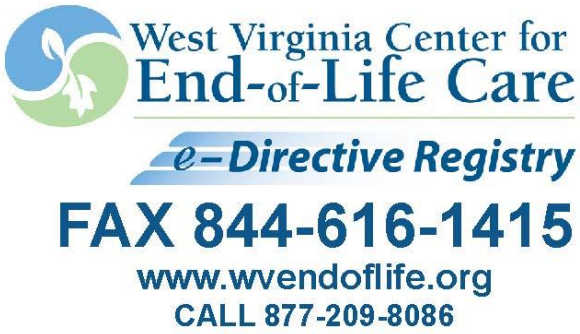
West Virginia Center for End-of-Life Care

1-877-209-8086

https://wvendoflife.org

Frequently Asked Questions and Forms

Advance Directives for Health Care Decision-Making in West Virginia



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://wvendoflife.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

About this booklet

This “Frequently Asked Questions booklet” is provided free of charge to you by the WV Center for End-of-Life Care. This booklet contains frequently asked questions about advance care planning and blank advance directive forms.

West Virginia law recognizes four types of written advance directives for health care decision-making: the living will (1), the medical power of attorney (2), the combined medical power of attorney and living will (3), and the mental health advance directive (4).

You can remain in charge of your health care, even after you can no longer make decisions for yourself, by creating a document called an “advance directive.”

This booklet presents information about these directives and includes the appropriate forms. Both forms have a special section for you to write in specific comments about circumstances, if any, in which you would not want CPR, a feeding tube, dialysis, treatment with a breathing machine, or other preferences. You should discuss these comments with your family and doctors so they can better understand what is important to you in receiving medical treatment. Should you wish to have both forms in one document, there is also a combined living will/medical power of attorney form in this booklet.

You can use these documents to let your family and doctor know your decisions for health care if you become unable to decide for yourself. You can appoint someone you know and trust as your medical power of attorney representative to ensure that your choice or decision is honored.

About the WV Center for End-of-Life Care…

The West Virginia Center for End-of-Life Care (the Center) is a nonprofit organization established by the WV legislature in 2002. The Center is here to help you with all your advance care planning needs. The nationally-recognized Center provides coordination, education, and resources to ensure your wishes are known and respected. Whatever your wishes are, the Center is committed to serving you throughout your entire advance care plan process.

The Center has been recognized for excellence in advance care planning organizations by The New York Times, the AARP, the National Quality Forum, the Institute of Medicine of the National Academies, the U.S. Government Accountability Office, and the Office of the National Coordinator for Health Information Technology.

About the WV e-Directive Registry…

The Center established the WV e-Directive Registry. With the permission of patients, this nationally recognized electronic Registry securely stores patients' medical advance care planning forms to be accessed by health care professionals for care coordination and respect of patients’

wishes. The e-Directive Registry allows these forms to be available 24/7 in the event of an emergency. The e-Directive Registry is the nation's most comprehensive database of its kind. The e-Directive Registry is password-protected, HIPAA-compliant, and the single-source of truth for the state of WV.

This database is free to all users and is the official statewide database for advance care planning forms. The e-Directive Registry was created to be a resource for West Virginians to help ease the advance care planning process and ensure your wishes are available in all medical situations.

The advance directive forms contained in this booklet contain an Opt-In box. If you would like to have your advance directive forms included in the Registry, you must INDICATE in the box giving your permission to do so and fax the forms to the Registry at 844-616-1415 or mail a copy of your forms to the Registry at PO Box 9022, Morgantown, WV 26506. If your advance directive form is older and does not contain the Opt-In box at the top left corner, you can complete the WV e-Directive Registry Sign-Up form contained in this booklet and fax or mail it along with your older forms.

Your health care provider might submit your forms to the WV e-Directive Registry on your behalf as well. If this occurs and your form has not been opted-in, your form will not be available to your health care providers through the Registry. Only opted-in forms are available on the Registry.

You can submit your advance directive, do-not-resuscitate (DNR) card, or POST form to the e-Directive Registry by faxing your forms to 844-616-1415 or mailing them to PO Box 9022, 64 Medical Center Drive, Morgantown, WV 26506.

For more information on the WV e-Directive Registry, use your mobile phone's camera to scan the QR code above to view a brief (3.5 minute) video on the WV e-Directive Registry or follow this link:

https://wvendoflife.org/registry/.

Frequently Asked Questions about Advance Care Planning

1. What is advance care planning and why is it important?

As an adult, you have the right to make your own health care decisions. Your health care provider(s) must tell you about any proposed procedure or treatment, its risks and benefits, and any predictable discomfort, complications, or risks. You have the right to know about alternative treatments and their risks and benefits. You have the right to ask questions, and then you have the right to decide whether you want the treatment or not. You have the right to accept or refuse any medical or surgical treatment.

Imagine that you are in a hospital and are confused or can't speak for yourself. Your advance care plan can help tell your health care provider(s) the types and kinds of treatment you would or would not want. Advance care planning is the process of documenting your wishes for medical care in advance of becoming too ill to speak for yourself. The advance care plan can be made up advance directives and medical orders. Advance directives are one important part of the advance care planning process which can be completed without the help of an attorney or health care provider. Medical orders are forms which can only be completed with your health care provider. There are no medical orders provided in this booklet.

2. What forms can I obtain from the WV Center for End-of-Life Care for advance care planning?

The Center maintains the official West Virginia versions of the living will, medical power of attorney, combined living will and medical power of attorney, and mental health advance directive forms. The Center also has the Frequently Asked Questions packet with all of these advance directive forms included (this booklet). The Center offers two medical orders – the DNR card and POST form – as well, but these forms must be obtained from your health care provider directly.

3. I am a young person in good health. Do I really need to create a formal advance directive?

Yes. Advance care planning, or the process of creating advance directives and/or medical orders (when appropriate), is recommended for everyone age 18 years and older, including mature minors and emancipated minors. Advance care planning allows you to outline what you do and do not want in your medical care in the event you are unable to speak for yourself. We never know when an accident or serious illness will leave us

incapable of making our own health care decisions. It is best to plan and prepare for these decisions early.

4. Can any person create an advance directive?

Yes. Any adult (including a mature or emancipated minor) who has the capacity to make decisions for themselves can create an advance directive.

5. Do I need a lawyer to create an advance directive?

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

6. Who should witness my signature on my advance directive?

Your witnesses must be at least 18 years of age and not related to you by blood or marriage. Choose individuals who will not inherit any of your property. Do not choose the person you named as your medical power of attorney representative or your successor representative or your health care provider as your witness.

7. How can I find a Notary Public to complete my medical power of attorney form?

Businesses such as banks, insurance agents, government offices, hospitals, doctors' offices, and automobile associations have or can direct you to a notary public. Contact your local National 2-1-1 hotline by calling 211 for more assistance and location of a Notary Public. The Center also has a notary available via appointment only.

8. Do I have to sign an advance directive to receive health care treatment?

No. A health care provider cannot require you to complete an advance directive or medical order in order for you to receive services. Completing an advance directive or medical order is always voluntary.

9. Will another state honor my advance directive? Will WV honor my advance directive from another state?

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.

10. How can I be sure that the wishes expressed in my advance directive will be followed?

Give your doctor a current copy of your advance directive. Bring a copy with you if you are admitted to a health care facility. Tell people where you keep your advance directive. Fax or mail a copy of your advance directive to the WV e-Directive Registry at 844-616-1415 or 64 Medical Center Drive, PO Box 9022 Health Sciences North, Morgantown, WV 26506-9022, so that your wishes will be known in a medical emergency.

11. What should I do with my advance directive 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.

12. Can I still make my own health care decisions once I have created an advance directive?

Yes. Your living will does not become effective until you are terminally ill AND too sick to make decisions for yourself. 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.

13. What if I live or receive medical care outside of West Virginia?

We recommend completing both the WV forms as well as the state-approved forms for your other state. Laws vary from state to state, so it is not guaranteed that other states will honor your WV forms. However, all non-WV forms must be honored in WV as of June 7, 2022 as long as the forms were completed correctly by state law. Please contact your local, non-West Virginian state agency to locate non-WV advance directive forms.

14. Are there any advance directives in WV specifically related to mental/psychiatric health?

Yes. The WV Mental Health Advance Directive (MHAD, pronounced like "mad") is a legal advance directive that allows individuals with mental illness(es) to state their mental health treatment preferences in advance of a crisis. The MHAD provides a way to protect a person's autonomy and ability to self-direct care for treatment of mental health disorders similar to other advance directives used to direct care for medical disorders in palliative care and end-of-life care

15. I completed advance directives and/or medical orders previously. Do I have to do anything else?

It is highly recommended that advance directives and medical orders are reviewed regularly to ensure they still match your wishes for medical care. You also want to make sure there are no inconsistencies between your forms.

Once you've ensured your forms accurately reflect your wishes, you are highly encouraged to submit the forms to the WV e-Directive Registry by faxing it to 844-616-1415 or mailing a copy to PO Box 9022, Morgantown, WV 26506.

16. How can I get more copies of the advance directives forms and this booklet?

You may call the West Virginia Center for End-of-Life Care toll-free at 1-877-209-8086. If you have Internet access, go to https://wvendoflife.org and click on For Patients OR Meet the Forms. You can print off forms from the website. You may also photocopy the forms in this booklet.

Frequently Asked Questions about Advance Directives

1. 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.

2. What are life-prolonging medical interventions?

Life-prolonging interventions are any medical treatment that serves only to prolong the dying process. If you complete a living will or combined medical power of attorney and living will, you are directing your health care providers to withhold life-prolonging interventions if you have a terminal condition. These forms state that you wish to die naturally and only be kept comfortable.

Life-prolonging interventions include cardiopulmonary resuscitation (CPR), breathing machines (ventilator), dialysis, and medically administered food and fluids.

3. 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.

4. How is the medical power of attorney different from the living will?

A living will only applies if you are terminally ill AND too sick to make decisions for yourself. A living will only tells your health care provider what you do not want unless you write in other specific instructions. A living will is a written record of decisions that you have made yourself.

The medical power of attorney allows you to choose someone else to make health care decisions for you if you are too sick to make them for yourself. This person is called your medical power of attorney representative. A medical power of attorney allows you to give specific instructions to your representative about the type of care you would want to receive. The medical power of attorney allows your representative to respond to medical situations that you might not have anticipated and to make decisions for you with knowledge of your values and wishes.

On all WV advance directive forms, you can write specific wishes in the Special Directives and Limitations section of the form. Your medical power of attorney representative can never override the wishes you write in this section.

5. 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.

6. 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.

7. 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.

8. 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.

9. What instructions should I give my representatives concerning my health care?

You may give very general instructions and preferences or be quite specific. It would be helpful to your representatives to have directions from you about medical conditions in which you would NOT want life prolonging intervention, particularly medically administered food and water (tube feedings), cardiopulmonary resuscitation (CPR), and the use of machines to help you breathe (ventilators). You should also tell your representative if you want to be an organ and tissue donor.

Many people choose to write their representatives a letter stating their personal values and wishes, their feelings about life and death, and any specific instructions, and to attach a copy of this letter to their medical power of attorney.

Talk with your representatives about your choices and personal values and beliefs. Make sure they know what is important to you. This information will help them make the decisions that you would make if you were able to speak for yourself.

10. Can I write my wishes for funeral arrangements on my advance directive?

Yes, you can make decisions about funeral arrangements or cremation. The way to do so is to write instructions in the Special Directives or Limitations section of your advance directive.

11. What should I NOT put in the Special Directives or Limitations section of my advance directive?

It is strongly recommended that you do not put requests for cardiopulmonary resuscitation (CPR, also referred to as "chest compressions") or do-not-resuscitate (DNR) status in your advance directive. What unfortunately tends to happen is that forms with these wishes don't get updated as wishes change. If you change your mind regarding CPR or DNR and lose the ability to speak for yourself, your health care providers will honor your written wishes even if they haven't been updated. This could result in you receiving unwanted treatment.

Living Will (specifically) – Requests for cardiopulmonary resuscitation (CPR) or breathing machines are inconsistent with the purpose of the living will and will be held to be invalid. West Virginia Code §16-30-4(g)

Combined Medical Power of Attorney and Living Will (specifically) – As of June 7, 2022, the combined medical power of attorney and living will form has two qualifying sections for special directives and limitations. The first section is where you can write the wishes you want followed if you are terminally ill and the living will is in effect. In this section, it is inconsistent to request CPR or breathing machines. The second section is where you can write the wishes you want followed if you are not terminally ill and the living will portion of the form is not in effect. In this section, you can write any wish you want including CPR and breathing machines.

It is still recommended to not write CPR or DNR in any special directive section, however.

12. What if my doctor or my family does not agree with my treatment choices or health care decisions?

You should talk with your family and health care providers about your decisions and personal values and beliefs. If others understand your choices and the reasons for them, there is less of a chance that they will challenge them later.

If you have made your wishes known in an advance directive and a disagreement does occur, your doctor and your representative must respect your wishes. You have a right to refuse or consent to health care. If your doctor cannot comply with your wishes, they must transfer your care to another doctor.

The consent or refusal of your medical power of attorney representative is as meaningful and valid as your own. The wishes of other family members will not override your own clearly expressed choices or those made by your representative on your behalf.

13. Should I complete a new living will or medical power of attorney if I completed one before June 7, 2022?

On June 7, 2022, the WV Health Care Decisions Act was updated and made several changes to the living will and medical power of attorney forms. The new law removes persistent vegetative state from the living will and the combined medical power of attorney and living will. Forms prior to June 7, 2022 include persistent vegetative state as a qualifying condition for the living will and combined medical power of attorney and living will.

The new law also updates the language and redefines key terms in all major advance directives. The living will and combined medical power of attorney and living will forms have added directions specifying that oral food and fluids should always be offered as desired and tolerated. Also, the new law provides three separate sections for special directives and limitations in the combined medical power of attorney and living will form to allow for better understanding of your wishes.

Forms completed prior to June 7, 2022 do not include these important changes. You are not required to update your forms to the new version, however, it is strongly recommended that you take this new law as an opportunity to update and review your advance directives as needed.

For more frequently asked questions and information, please visit https://wvendoflife.org or call toll-free 877-209-8086.

Full Name (Last, First, Middle): _____

Address: _____

City/State/Zip: _____

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

WV e-Directive Registry Opt In 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
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

Full Name (Last, First, Middle): _____

Address: _____

City/State/Zip: _____

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

WV e-Directive Registry Opt In 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
LIVING WILL

The Kind of Medical Treatment I Want and Don't Want if I Have a Terminal Condition

Living will made this _____day of _____.
(insert calendar day) (insert month and year)

I, _____,
(Insert your name and address)

being of sound mind, willfully and voluntarily declare that I want my wishes to be respected if I am very sick and unable to communicate my wishes for myself. In the absence of my ability to give directions regarding the use of life-prolonging intervention, it is my desire that my dying may not be prolonged under the following circumstances:

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. I understand that by signing this document I am agreeing to the REMOVAL or REFUSAL of cardiopulmonary resuscitation (CPR), 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.

I give the following SPECIAL DIRECTIVES OR LIMITATIONS: Comments about funeral arrangements, autopsy, mental health treatment, 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.

_____

_____

_____

It is my intention that this living will be honored as the final expression of my legal right to refuse medical or surgical treatment and accept the consequences resulting from such refusal.

I understand the full import of this living will.

_____ 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

Full Name (Last, First, Middle): _____

Address: _____

City/State/Zip: _____

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

WV e-Directive Registry Opt In 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

Mental Health Advance Directive Fact Sheet

A mental health advance directive (MHAD), also known as a psychiatric advance directive, is a legal tool that allows persons with mental illness to state their preferences for treatment in advance of a crisis. MHAD provides a way to protect a person's autonomy and ability to self-direct care for treatment of mental health disorders similar to medical powers of attorneys, living wills and other medical advance care planning documents used to direct care for medical disorders in palliative care and end-of-life care.

Benefits of a MHAD

- Persons with mental health disorders who have lost decision-making capacity can receive preferred treatment even though they do not meet involuntary commitment criteria.
- Persons in the middle of an acute mental illness episode who have lost decision-making capacity and have a Ulysses agreement in their MHAD can receive treatment even if they are conscious, unruly, and refusing treatment.
- MHADs can guide treatment for patients whose acute episodes of mental illness otherwise might land them in an emergency department or in jail.
- MHADs can improve patient-provider communication and create cost savings by…
    - Decreasing emergency transports
    - Decreasing need for police involvement
    - Reducing number of mental health hygiene hearings
    - Reducing number of emergency department visits
    - Reducing number of long stays in emergency departments which tie up emergency department resources

Legal Status of MHAD

- MHADs are legal in West Virginia because they fall within the "substantially in compliance" provision of the West Virginia Health Care Decisions Act, §16-30-1 *et seq:* "An expressed directive contained in a living will or medical power of attorney or by any other means the health care provider determines to be reliable shall be followed."
- MHADs are also to be followed according to the West Virginia Code of State Regulations 64CSR74 which states in '64-74-5.5 "An advance psychiatric directive shall be honored…"
- MHADs can be submitted to the West Virginia e-Directive Registry as well as given to treating health care providers and the patient's mental health care representative.

Full Name (Last, First, Middle): _____

Address: _____

City/State/Zip: _____

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

WV e-Directive Registry Opt In 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
MENTAL HEALTH ADVANCE DIRECTIVE

The Types of Treatment I Do and Do Not Want and The Person I want to Make Mental Health Treatment Decisions for Me When I Can't Make Them for Myself

Dated: _____, 20_____

I am giving the following DIRECTIVES (instructions) about treatment that I do and do not want (NOTE: the below are suggestions of things about which you might want to give directives; you may give directives about other types of treatment in addition to or instead of those below):

- the medications I consent to (types and dosage),
- the medications to which I do not give consent (allergies or side effects),
- instructions about short-term inpatient treatment,
- a physician or mental health therapist whom I would like to treat me,
- a facility where I would like to receive treatment,
- instructions about transport to a provider or facility,
- instructions about electroconvulsive treatment (ECT) shock therapy,
- persons to be notified of my mental health treatment,
- persons to be allowed to visit me, and
- instructions about alternative outpatient treatments I would like.

My failure to provide directives does not mean that I want or refuse certain treatments.

Directive with Regard to Revocation – changing my mind
(initial only one of the boxes below)

☐ My wish is that, in accordance with state law, this mental health advance directive may be revoked by me at any time.

☐ My wish is that I may revoke (change my mind about) this mental health advance directive only at times that I have the capacity to make my own mental health care decisions. I understand that I am choosing to give up the right to revoke my mental health advance directive whenever I do not have decision-making capacity and that I will regain that right whenever I recover decision-making capacity.

Crisis Response (completion optional)

The following signs and symptoms may indicate that I am in a mental health crisis:

_____

_____

_____

_____

_____

I request the following interventions/activities in a mental health crisis regardless of setting (community, outpatient or inpatient) which may reduce my symptoms, make me more comfortable, and keep me safe:

_____

_____

_____

_____

_____

In a psychiatric emergency, PLEASE AVOID the following interventions that make me feel worse:

_____

_____

_____

_____

_____

Are you in recovery for, or do you have a substance use disorder (addiction)?_____

If yes, which substances are you most likely to use when your substance disorder is active?

_____

_____

_____

_____

_____

Temporary Custody of Dependents (only applies when I lack the capacity to make my own mental health care decisions and choose to say whom I would want to watch my dependents)

I have the following dependent(s), which may include children, support service animal, pets, etc.:

_____

_____

_____

_____

_____

In the event that I am unable to care for my dependent(s), I direct that the following person have temporary custody of my dependent(s) (only applies when I lack capacity):

Name: _____

Address: _____

_____

Phone Numbers: _____

Dependent(s): _____

For the following reason(s): _____

_____

_____

_____

_____

_____

Name: _____

Address: _____

_____

Phone Numbers: _____

Dependent(s): _____

For the following reason(s): _____
_____

_____

_____

_____

_____

Person(s) to be notified at the time of discharge from a mental health care facility (completion optional)

Name(s): _____

Address(es):_____

_____

Phone Number(s):_____

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

I, _____,
(Insert your name and address)

hereby appoint as my representative to act on my behalf to give, withhold, or withdraw informed consent to mental health care decisions in the event that I am not able to do so myself.

The person I choose as my mental health care 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 mental health 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.)

☐ I do not wish to appoint a mental health care representative. *(Mark this box to select this choice)*

This appointment shall be for the purpose of mental health care decisions. Mental health care means treatment of "mental illness" as defined at West Virginia Code §27-1-2 with psychoactive medication, admission to and retention in a mental health care facility, electroconvulsive treatment and outpatient services. 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 mental health care if my representative determines that I, if able to do so, would consent to, refuse or withdraw such treatment. The authority of the mental health care representative ceases when I have regained capacity to make mental health care decisions.

I appoint this representative because I believe this person understands my wishes and values and will make the mental 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 mental health care decision should be made on my behalf during any period when I am unable to make such decisions.

In exercising the authority under this mental health advance directive, my representative shall act consistently with my special directives as stated in this advance directive.

THIS MENTAL HEALTH ADVANCE DIRECTIVE SHALL BECOME EFFECTIVE ONLY UPON MY INCAPACITY TO GIVE, WITHHOLD OR WITHDRAW INFORMED CONSENT TO MY OWN MENTAL

HEALTH CARE. INCAPACITY IS TO BE DETERMINED BY A QUALIFIED PHYSICIAN AND A SECOND QUALIFIED PHYSICIAN OR QUALIFIED PSYCHOLOGIST.

_____ 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