LIFE CARE PLANNING

Provided by the Office of Arizona Attorney General

Mark Brnovich

MAKE YOUR CHOICES KNOWN

WHAT IS LIFE CARE PLANNING?

The process of deciding your medical wishes and who you want to carry them out, in case you are unable to do so.

To communicate your wishes you need to fill out State of Arizona advance directives, included in the packet provided by the Arizona Attorney General's Office.

Having your wishes clearly stated helps those close to you avoid the pain of trying to assume what you would or would not want done.

WHY IS LIFE CARE PLANNING IMPORTANT?

Through increased awareness and access to information, Arizonans of all ages can make their choices known about who will manage their medical affairs in the event of an emergency.

None of us knows what life has in store, so taking steps now to inform our loved ones of our end of life wishes can make all the difference.

WHY DOES THE AGO OFFER THESE FORMS?

The Arizona Attorney General's Office (AGO) wants to make sure that all Arizonans have access to these free legal documents, all of which are based on Arizona Law.

The AGO is just one of several entities to provide forms and information on life care planning.

The AGO does not recommend any particular choices but urges you to think about these choices, discuss them with your loved ones, and complete the right documents for your situation.

INFORMATION ON LIFE CARE PLANNING

- **Talking with others about your wishes**
  - You should consider the people you can begin your life care planning conversations with. Your medical care is about you - start the conversations with those who can help you consider what medical treatments you may or may not want if you become incapacitated, or as you approach the end of your life.
    - Your Health Care Agent (the person you select to make health care decisions for you)
    - Your Spouse, Children, Other Relatives, and Trusted Close Friends
    - Your Doctor, Clergyperson, and Others

INFORMATION ON LIFE CARE PLANNING

- **What to do with these documents:**
  1. Fill out all forms that apply to you and express your wishes for your end of life care.
  2. Keep the originals in a safe and easily accessible place.
  3. Register your documents on the Arizona Health Care Directives Registry. *(Optional)*
  4. Replacing Existing Directives – if needed.

INFORMATION ON LIFE CARE PLANNING

- **Life care planning in other states**
  - If you have advance directives from another state, district, or territory of the U.S., Arizona Revised Statutes §§ 36-3208 *et seq* says it is:
    - *"valid in this state if it was valid in the place where and at the time when it was adopted and only to the extent that it does not conflict with the criminal laws of this state."*
  - If you have Arizona advance directives, you will need to check with the Attorney General's Office in other states to determine if they accept Arizona's documents.

DOCUMENTS INCLUDED IN THE PACKET

- Information on Life Care Planning
- Checklist
- Registration Agreement
- Health Care Power of Attorney
- Living Will
- Mental Health Care Power of Attorney
- Pre-hospital Medical Care Directive

REGISTRATION AGREEMENT

The Registration Agreement is provided in case you want to submit your documents to the State registry.

The State Registry allows medical professionals statewide to access your directives.

This document was created by the Secretary of State's Office and is included in the packet with the documents you can register.

Arizona Health Care Directives Registry
ARIZONA SECRETARY OF STATE
1700 W. Washington Street, 7th Floor, Phoenix, AZ 85007-2888
(602) 542-6187
(800) 458-5842 (within Arizona)
Website: www.azsos.gov

FOR OFFICE USE ONLY

REGISTRATION AGREEMENT

About this agreement:
This agreement shall be used for the registration of a Health Care Directive in the State of Arizona under the authority of A.R.S. § 36-3291 - 3297

This form/agreement must be written legibly or computer generated. For your convenience, this form has been designed to be filled out and printed online at the website referenced above.

Fees: None
Processing time-frame: three weeks

How to complete this form:
- Read this agreement carefully, and fill in all blank spaces
- Attach a copy of your witnessed or notarized Health Care Directive to this Agreement
- DO NOT send your original Health Care Directive Form
- Sign and date this Agreement
- Return by mail to:
  Arizona Secretary of State
  1700 W. Washington Street, 7th Fl., Phoenix, AZ 85007

Return in person: Tucson: 400 W. Congress, Ste. 141
Phoenix: 1700 W. Washington, Ste. 220

Last Name	First Name	Middle Name
Address		
City	State	Zip
Phone	Birth Date (month/day/year)	Last 4 digits of Social Security Number
Printed name as you want it listed on your membership card		

Address to return documents and wallet card (**IF DIFFERENT FROM ADDRESS ABOVE**)

Name		
Address		
City	State	Zip

I want to:
- ☐ Store a health care directive(s) in the Registry
- ☐ Replace a health care directive(s) now in the Registry with a new one
- ☐ Add an additional document to my currently stored directive(s)
- ☐ Remove my health care directive(s) from the Registry
- ☐ Request a replacement wallet card (no change to health care directive(s) in Registry)
- ☐ Change Registration Agreement information (such as new a address)

You must complete and sign the Agreement on Page 2 of this form.

AD0001

Page 1 of 2

HEALTH CARE POWER OF ATTORNEY

- Allows you to select a person or persons to make future health care decisions for you when you are unable to do so.
- This form does not go into effect until you can no longer make your own decisions, and if you recover, your agent can no longer make health care decisions for you.

* The person you choose should be someone who has your best interests at heart and who will make decisions based on your wishes, whether they agree with them or not. In some instances, family members may not be the most appropriate choice.

HEALTH CARE POWER OF ATTORNEY

- **Decisions to be made in this form:**
  - Funeral and burial choice
  - Autopsy choice
  - Organ donation
- **Additional forms to think about:**
  - Do you have a living will?
  - Do you have a POLST?
  - Do you have a DNR?

HIPAA PERMITS DISCLOSURE OF POLST ORDERS TO HEALTH CARE PROVIDERS AS NECESSARY FOR TREATMENT
SEND FORM WITH PATIENT WHENEVER TRANSFERRED OR DISCHARGED

Medical Record # (Optional)

National POLST Form: A Portable Medical Order

Health care providers should complete this form only after a conversation with their patient or the patient's representative. The POLST decision-making process is for patients who are at risk for a life-threatening clinical event because they have a serious life-limiting medical condition, which may include advanced frailty (www.polst.org/guidance-appropriate-patients-pdf).

Patient Information. **Having a POLST form is always voluntary.**

This is a medical order, not an advance directive. For information about POLST and to understand this document, visit: www.polst.org/form	Patient First Name: ____________________ Middle Name/Initial: ____________ Preferred name: ____________ Last Name: ____________________ Suffix (Jr, Sr, etc): ________ DOB (mm/dd/yyyy): ___/___/_____ State where form was completed: Arizona Gender: ☐ M ☐ F ☐ X Social Security Number's last 4 digits (optional): xxx-xx-__ __ __ __

A. Cardiopulmonary Resuscitation Orders. Follow these orders if patient has no pulse and is not breathing.

Pick 1		
	☐ **YES CPR: Attempt Resuscitation, including mechanical ventilation, defibrillation and cardioversion.** (Requires choosing Full Treatments in Section B)	☐ **NO CPR: Do Not Attempt Resuscitation.** (May choose any option in Section B)

B. Initial Treatment Orders. Follow these orders if patient has a pulse and/or is breathing.

Reassess and discuss interventions with patient or patient representative regularly to ensure treatments are meeting patient's care goals. Consider a time-trial of interventions based on goals and specific outcomes.

LIVING WILL

- Allows you to choose now which medical procedures and interventions you want or do not want performed if you are unable to make your own decisions.
- This form helps to provide guidance to your loved ones and doctors about what you wish to be done.
- If you have a Health Care Power of Attorney, you should attach the living will to it.

LIVING WILL

Some general statements about your health care choices are listed below. If you agree with one of the statements, you should initial that statement. Read all of these statements carefully BEFORE you initial your preferred statement. You can also write your own statement concerning life-sustaining treatment and other matters relating to your health care. 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, that would serve only to artificially delay the moment of my death.

***Comfort care is treatment given in an attempt to protect and enhance the quality of life without artificially prolonging life.*

_____ 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:

_____ a. Cardiopulmonary resuscitation (CPR). For example: the use of drugs, electric shock and artificial breathing.

_____ b. Artificially administered food and fluids.

_____ c. To be taken to a hospital if at all avoidable.

_____ 3. Regardless of any other directions I have given in this Living Will, 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. Regardless of any other directions I have given in this Living Will, 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. I want my life to be prolonged to the greatest extent possible (If you initial here, you should not initial any of the others).

MENTAL HEALTH CARE POWER OF ATTORNEY

- Allows you to appoint an agent to make future mental health care decisions for you in the event that you become incapable of making those decisions for yourself.
- The decision about whether you are incapable can only be made by a specialist in neurology or an Arizona licensed psychiatrist or psychologist who will evaluate whether you can give informed consent.
- Be sure you understand the importance of this document.

MENTAL HEALTH CARE POWER OF ATTORNEY

- This form allows you to list out all of the mental health treatments that you authorize your agent to make on your behalf.
- It also allows you to list out all mental health treatments that you expressly DO NOT AUTHORIZE.
- This form can also be revoked at any time if you are able to give informed consent.

PREHOSPITAL MEDICAL CARE DIRECTIVE (DNR)

PREHOSPITAL MEDICAL CARE DIRECTIVE
(DO NOT RESUSCITATE or DNR)

(IMPORTANT – THIS DOCUMENT MUST BE ON PAPER WITH ORANGE BACKGROUND)

MAKE SURE YOU DISPLAY THIS FORM AS VISIBLY AS POSSIBLE FOR FIRST RESPONDERS

GENERAL INFORMATION AND INSTRUCTIONS: A Prehospital Medical Care Directive is a document signed by you and your doctor that informs emergency medical technicians (EMTs) or hospital emergency personnel not to resuscitate you. Sometimes this is called a DNR – Do Not Resuscitate. If you have this form, EMTs and other emergency personnel will not use equipment, drugs, or devices to restart your heart or breathing, but they will not withhold medical interventions that are necessary to provide comfort care or to alleviate pain.

You can either attach a picture to this form OR complete the personal information.

Please take the time to fill out a Health Care Power of Attorney form. That way, if you are unable to communicate your wishes, your agent can sign this form on your behalf, if that is your wish.

This form must be signed by you, in front of your witness or notary. Your Health Care Provider and your witness or notary must also sign this form.

DO NOT have the documents signed by both a witness and a notary, just pick one. If you do not know a notary or cannot pay for one, a witness is legally accepted.

Witnesses or notary public CANNOT be anyone who is:
(a) under the age of 18
(b) related to you by blood, adoption, or marriage
(c) entitled to any part of your estate
(d) appointed as your agent
(e) involved in providing your health care at the time this form is signed

IMPORTANT: Under Arizona law a Prehospital Medical Care Directive or DNR must be on letter sized paper or wallet sized paper on an orange background to be valid.

- Allows you to inform EMTs that you do not wish to be resuscitated.
- However, EMTs will not withhold medical interventions that are necessary to provide comfort care or to alleviate pain.
- By law in Arizona, this form must be printed with an orange background.

PREHOSPITAL MEDICAL CARE DIRECTIVE (DNR)

- Should be displayed AS VISIBLE AS POSSIBLE so that first responders can see it upon entering your home.
- Either attach a picture to this form OR complete the personal information.
- Must be signed by you, in front of your witness or notary. Your Health Care Provider and your witness or notary must also sign form.

PREHOSPITAL MEDICAL CARE DIRECTIVE

In the event of cardiac or respiratory arrest, I refuse any resuscitation measures including cardiac compression, endotracheal intubation and other advanced airway management, artificial ventilation, defibrillation, administration of advanced cardiac life support drugs and related emergency medical procedures.

Patient's Printed Name: ____________________

Patient's Signature: ____________________ Date: __________

***If I am unable to communicate my wishes, and I have designated a Health Care Power of Attorney, my elected Health Care agent shall sign:**

Health Care Power of Attorney Printed Name: ____________________

Health Care Power of Attorney Signature: ____________________

PROVIDE THE FOLLOWING INFORMATION OR ATTACH A RECENT PHOTO:

Date of Birth __________
Sex __________
Race __________
Eye Color __________
Hair Color __________

INFORMATION ABOUT MY DOCTOR AND HOSPICE (if I am in Hospice):

Physician: ____________________ Telephone: __________
Hospice Program, if applicable (name): ____________________

SIGNATURE OF DOCTOR OR OTHER HEALTH CARE PROVIDER

I have explained this form and its consequences to the signer and obtained assurance that the signer understands that death may result from any refused care listed above.

Signature of a Licensed Health Care Provider: ____________________
Date: __________

SIGNATURE OF WITNESS OR NOTARY (NOT BOTH)

I was present when this form was signed (or marked). The patient then appeared to be of sound mind and free from duress.

Witness Signature: ____________________ Date: __________

NOTORIAL JURAT:

STATE OF ARIZONA) ss
COUNTY OF __________)

____
Patient's Name/Health Care Power of Attorney Name

Subscribed and sworn (or affirmed) before me this __________ day of __________, 20 _____

Notary Public Signature: ____________________ My Commission Expires: __________

PREHOSPITAL MEDICAL CARE DIRECTIVE (DNR)

FREQUENTLY ASKED QUESTIONS

- **Where can I find these forms?**
  - You can find them on the AGO website www.azag.gov/seniors/life-care-planning. You can also request copies from AGO Community Outreach at (602) 542-2123 or CommunityOutreach@azag.gov
- **At what age should I think about filling out these documents?**
  - Now, so long as you are at least 18 years of age. It is never too early to be prepared.
- **Should I complete a DNR?**
  - If it is truly your wish or the wish of your loved one to not be resuscitated, take the necessary steps to ensure that your wishes are honored.

FREQUENTLY ASKED QUESTIONS

- **If I do not fill out these forms who will make medical decisions for me?**

  If you do not appoint an agent and there is no court appointed guardian, health care providers will contact "surrogates", in this order, who will have the authority to make health care decisions for you.

  - Your spouse, unless you and your spouse are legally separated.
  - Your adult child. If there is more than one adult child, the health care providers will seek the consent of a majority of the children who are available for consultation.
  - Your parent.
  - Your domestic partner if no other person has assumed any financial responsibility for you.
  - Your brother or sister.
  - Your close friend.

FREQUENTLY ASKED QUESTIONS

- **Should I have a witness or a notary sign these documents?**
  - Both are legal options. Notaries will sometimes charge for services.

- **Witnesses or notary public CANNOT be:**
  - (a) Under the age of 18.
  - (b) Related to you by blood, adoption, or marriage.
  - (c) Entitled to any part of your estate.
  - (d) Appointed as your agent.
  - (e) Involved in providing your health care at the time the form is signed.

FREQUENTLY ASKED QUESTIONS

- **Will I need a lawyer to fill out these forms?**
  - NO. But if you wish to consult with a lawyer or you need to find an attorney, you can reach out to these legal services for help:
    - **Arizona State Bar** – **(602) 252-4804 or www.azbar.org**
      For help finding an attorney within your budget, area, and skill in the type of help needed.
    - **24-Hour Senior HELP LINE**
      Within Maricopa County – **(602) 264-HELP / (602) 264-4357**
      Outside Maricopa County – toll free - **1-888-264-2258**
      Research the closest regional Area Agency on Aging office or go to **www.des.az.gov** and search Area Agency on Aging locations.
    - **Elder Law Hotline** – **1 (800) 231-5441**
      Free legal advice, information, and referrals provided to Arizona residents 60 years of age or older, or to family members calling on behalf of a senior. Advice, information, and referrals provided on a wide variety of legal matters important to seniors.

THANK YOU

Please contact us with any questions or to request a **FREE** Life Care Planning Packet.

Community Outreach and Education

(602) 542-2123

Or

CommunityOutreach@azag.gov