

# **LIFE CARE PLANNING**

Advance Directives for Making Your Health Care Decisions

Provided by  
**The Office of Arizona Attorney General,  
Mark Brnovich**



## **MAIL FORMS TO:**

**Arizona Secretary of State  
Advance Directive Dept.  
1700 W. Washington St., 7<sup>th</sup> Floor  
Phoenix, AZ 85007**

## **WHAT IS LIFE CARE PLANNING AND WHY IS IT SO IMPORTANT?**

Life Care Planning is the process of deciding your medical wishes and who you want to carry them out, in case you are unable to do so. The documents in this packet are meant for you to express your wishes, whatever they may be, so you receive the treatment you want if you can no longer communicate. Hopefully, having your wishes clearly stated will help those close to you avoid the pain of trying to guess what you would or would not want done.

Life Care Planning is an important task for all of us, whether young or old, healthy or facing challenges. None of us knows what life has in store, so taking steps to tell our loved ones of our wishes can make all the difference on our end of life care. 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.

## **WHY DOES THE ARIZONA ATTORNEY GENERAL OFFER THESE FORMS?**

The Arizona Attorney General's Office wants to make sure that all Arizonans have access to these free legal documents, all of which are in line with Arizona Law. The Attorney General's Office is just one of several places to get forms and information on life care planning. The Attorney General's Office is not recommending any particular choices but does urge you to think about these choices, discuss them with your loved ones, and complete the right documents for your situation.

The primary role of the Attorney General's Office is to provide legal representation to the State of Arizona, its agencies, and State officials acting in their official capacities. The Office cannot give legal advice or represent private citizens on personal legal matters. If you need help with a personal legal matter—such as filing a lawsuit, creating a will, or defending against a criminal charge—you may want to contact a private attorney.

## **TALKING WITH OTHERS ABOUT YOUR WISHES**

You should consider the people that 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 Close Friends**
- **Your Doctor, Clergy person and Others**

## DOCUMENTS INCLUDED IN THIS PACKET

- **Life Care Planning Checklist**
  - This document lists out all the forms in the packet so that you can check off which ones you have completed. If you wish to register your documents with the Arizona Health Care Directives Registry, the checklist will let you know which forms are accepted.
- **Health Care Power of Attorney**
  - This form allows you to select a person to make future medical decisions for you if you become too ill to communicate or cannot make those decisions for yourself.
- **Living Will**
  - This form allows you to list out the type of medical treatments you do or do not want for your end of life care. It should go with your Health Care Power of Attorney form so your agent knows your wishes.
- **Mental Health Care Power of Attorney**
  - This form allows you to select a person to make future mental health care decisions for you in case you become incapable of making those decisions for yourself.
- **Prehospital Medical Care Directives (Do Not Resuscitate)**
  - This form needs to be on orange paper and should be signed by you and your doctor. It informs emergency medical technicians (EMTs) or first responders not to resuscitate you. Sometimes this is called a DNR – Do Not Resuscitate. Please note this is valid prior to going to a hospital, if admitted to a hospital they may require you to fill out another form for their hospital.
- **Registration Agreement**
  - If you would like to register your documents with the Arizona Health Care Directives Registry, you MUST fill out this form and submit it with your documents.

## WHAT DOES THE LAW SAY?

If you are interested in the laws written about the forms in this packet you can look them up at [www.azleg.gov/arstitle/](http://www.azleg.gov/arstitle/)

- **Health Care Power of Attorney:** Arizona Revised Statutes §§ 36-3221 *et seq.*
- **Health Care Directives:** Arizona Revised Statutes §§ 36-3201 *et seq.*
- **Agents or Surrogate Decision-Makers:** Arizona Revised Statutes §§ 36-3231 *et seq.*
- **Living Will:** Arizona Revised Statutes §§ 36-3201 *et seq.* AND §§ 36-3261 *et seq.*
- **Mental Health Care Power of Attorney:** Arizona Revised Statutes §§ 36-3201 *et seq.* AND §§ 36-3281 *et seq.*
- **Prehospital Medical Care Directives (Do Not Resuscitate):** Arizona Revised Statutes § 36-3251.

## **WHAT TO DO WITH THESE DOCUMENTS IN 4 STEPS**

**Step 1:** Fill out all forms that apply to you and express your wishes for your end of life care.

Read through the documents carefully to select choices that are best suited to your wishes. Each document will need to be notarized OR witnessed. DO NOT have the documents signed by both, 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

**Step 2:** Keep the originals in a safe place that is easily accessible.

It is important to review your documents from time to time. Give copies to the person you choose as your agent, as well as your doctor and anyone else who may be contacted about your wishes, such as family members and close friends. Keep a few extra copies and be sure to take one with you if you go to a hospital or other health care provider.

**Step 3:** Register your documents on the Arizona Health Care Directives Registry. *(Optional)*

Send copies of the documents as well as the registration form to the Secretary of State's Office. The address is on the cover of this packet and below.

Arizona Secretary of State  
Advanced Directive Dept.  
1700 West Washington, 7<sup>th</sup> Floor  
Phoenix, AZ 85007

The purpose of registering Life Care Planning forms is to create a centralized location where your relatives, first responders, a hospital, or other health care facility can access the forms if they are not readily available.

**Step 4 – If Needed:** Replacing Existing Directives.

If you would like to make changes to your existing documents, you will need to complete any forms that are affected by that change, i.e. change of address, wishes, or agent. It is important that you have a list of people with copies of your documents so that you can send them all an updated version if needed or a letter revoking the forms. The state will accept the most recent version of your documents.

If you have registered your documents with the Registry, you will need to fill out another registration form and indicate that you are replacing or revoking your existing documents in the Registry.

## **LIFE CARE PLANNING IN OTHER STATES**

- If you have advance directives from another state, district, or territory of the US, 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 the other state to find out if they accept Arizona’s documents.

## **FREQUENTLY ASKED QUESTIONS:**

### **1. Where can I find these free forms?**

- You can get copies of this Life Care Planning packet and the individual forms on the Attorney General’s website at <https://www.azag.gov/seniors/life-care-planning>, or by calling the Community Outreach and Education Section at 602-542-2123.

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

- If you did not leave a Health Care Power of Attorney and there is no court appointed guardian, health care providers will contact the following people, in this order, who will have the authority to make health care decisions for you.
- These people are called "surrogates."
  1. Your spouse, unless you and your spouse are legally separated.
  2. 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.
  3. Your parent.
  4. Your domestic partner if no other person has assumed any financial responsibility for you.
  5. Your brother or sister.
  6. Your close friend.

### **3. Should I complete a Do Not Resuscitate "DNR" Form?**

- If you are healthy and strong, you may not wish to complete a DNR. You can express your wishes about how you want to be cared for should you become seriously ill without completing a DNR. DNRs are most appropriate for people who would probably not do well with CPR (cardiopulmonary resuscitation) because they are very sick, terminally ill or otherwise extremely weak. In any case, you will need to discuss the DNR with your doctor, who will also need to sign the form.

### **4. 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.

## 5. Will I need a lawyer to fill out these forms?

- No. You do not need a lawyer's help to fill out these documents, but you may wish to consult with a lawyer if you need advice. If 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](http://www.azbar.org)

For help finding an attorney in 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.

There are Area Agency on Aging regional offices designated to serve each Arizona county. See your local telephone book for the closest regional office or go to [www.des.az.gov](http://www.des.az.gov) and search Area Agency on Aging for 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. Attorneys do not provide services in criminal matters, and do not represent clients in court proceedings. They give advice, information, and referrals on a wide variety of legal matters important to seniors. Funded by the Arizona Supreme Court and operated by Southern Arizona Legal Aid, Inc.

### **WALLET-SIZED NOTICE:**

Complete and cut out the notice below. Keep it in your wallet with your driver's license and insurance cards so that law enforcement and medical personnel will know who to contact for copies of your advanced directives.

NOTICE IN CASE OF ACCIDENT OR  
EMERGENCY:

My Name:

Date:

I have signed the following forms: (check)

- Health Care Power of Attorney
- Living Will
- Mental Health Care Power of Attorney
- Prehospital Medical Directive (Do Not Resuscitate)

Please contact the following for copies:

Name:

Telephone:

# LIFE CARE PLANNING CHECKLIST

- Registration Agreement
  - This form HAS to be included if you want to register ANY forms.
- Health Care Power of Attorney
- Living Will
- Mental Health Care Power of Attorney
- Prehospital Medical Care Directive (Do Not Resuscitate)

**To register your completed documents,  
make photo copies and send the copies to:**

**Arizona Secretary of State  
Attn: Advance Directive Dept.  
1700 W. Washington Street, 7<sup>th</sup> Floor  
Phoenix, AZ 85007**



**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 - REV. 01/07/19

**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					
<b>Address to return documents and wallet card (IF DIFFERENT FROM ADDRESS ABOVE)</b>					
Name					
Address					
City		State		Zip	
I want to:					
<input type="checkbox"/> Store a health care directive(s) in the Registry					
<input type="checkbox"/> Replace a health care directive(s) now in the Registry with a new one					
<input type="checkbox"/> Add an additional document to my currently stored directive(s)					
<input type="checkbox"/> Remove my health care directive(s) from the Registry					
<input type="checkbox"/> Request a replacement wallet card (no change to health care directive(s) in Registry)					
<input type="checkbox"/> Change Registration Agreement information (such as new a address)					

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



AD0001





**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](http://www.azsos.gov)

FOR OFFICE USE ONLY - REV. 01/07/19

**REGISTRATION AGREEMENT**

I am providing this personal information, along with a copy of my advance directive, with the understanding that this information will be stored in the Arizona Health Care Directive Registry. I certify that the advance directive that accompanies this Agreement is my currently effective advance directive, and was duly executed, witnessed and acknowledged in accordance with the laws of the State of Arizona.

I understand this authorization is voluntary. This authorization to store my advance directive in the Arizona Health Care Directives Registry will remain in force until revoked by me. I understand that I may revoke this authorization at any time by giving written notice of my revocation to the Contact Office listed below. I understand that revocation of this authorization will NOT affect any action you took in reliance on this authorization before you received my written notice of revocation.

**Contact Office:** Office of the Arizona Secretary of State  
**Telephone:** 602-542-6187    **E-mail:** [AD@azsos.gov](mailto:AD@azsos.gov)  
**Address:** 1700 W. Washington Street, 7th Floor, Phoenix, AZ, 85007

Your registration form will be processed within three (3) weeks. You will receive further information in the mail. In order to complete the registration of your health care directive(s) you are required to reply to the letter that you will receive.

For further assistance please contact the Arizona Secretary of State at (602) 542-6187 or visit us online at: [www.azsos.gov](http://www.azsos.gov)

Signature of person completing this agreement	Date
Printed Name	



AD0002



## HEALTH CARE POWER OF ATTORNEY Instructions and Information

**GENERAL INSTRUCTIONS:** Use this form if you want to select a person, called an “agent”, to make future health care decisions for you so that if you become too ill or cannot make those decisions for yourself the person you choose and trust can make medical decisions for you. Be sure you understand the importance of this document. It is a good idea to talk to your doctor and loved ones if you have questions about the type of health care you do or do not want.

**AUTOPSY CHOICE:** If there is no legal reason to require an autopsy, you can decide if you want one done when you die, or whether you want your agent to choose for you. There is usually a charge for voluntary autopsies. You can help your family and loved ones by making your preferences on this topic clear. For additional information on autopsies please review Arizona Revised Statutes §§ 11-591 and 11-597.

**ORGAN DONATION CHOICE (OPTIONAL):** You can determine if you want to donate organs or tissues, and if you do, what organs or tissues you want to donate, for what purposes, and to what organizations. You also have the option of whole-body donation for research purposes. You can also choose to have your agent decide. For additional information on Organ Donation, please review Arizona Revised Statutes §§ Title 36, Chapter 7, Article 3 for the laws that pertain to it.

**FUNERAL AND BURIAL CHOICE (OPTIONAL):** You can determine, your funeral and burial choices in this form. You can select if, upon your death, you would like to be buried and where, or if you would like to be cremated and where your ashes will go, or you can select your agent to make that choice.

If you fill out this form, make sure you **DO NOT SIGN UNTIL** your witness or a notary public is present to watch you sign it.

**PLEASE NOTE:** At least one adult witness, not to include the proxy if there is one, OR a notary public must witness you signing this document.

**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

**OFFICE OF THE ARIZONA ATTORNEY GENERAL  
MARK BRNOVICH**

**Health Care Power of Attorney**

**My Information (I am the "Principal"):**

Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Address: \_\_\_\_\_

Phone: \_\_\_\_\_

\_\_\_\_\_

Email: \_\_\_\_\_

**Selection of my health care power of attorney and alternate:**

I choose the following person to act as my agent to make health care decisions for me:

Name: \_\_\_\_\_

Home Phone: \_\_\_\_\_

Address: \_\_\_\_\_

Work Phone: \_\_\_\_\_

\_\_\_\_\_

Cell Phone: \_\_\_\_\_

I choose the following person to act as an alternate to make health care decisions for me if my first agent is unavailable, unwilling, or unable to make decisions for me:

Name: \_\_\_\_\_

Home Phone: \_\_\_\_\_

Address: \_\_\_\_\_

Work Phone: \_\_\_\_\_

\_\_\_\_\_

Cell Phone: \_\_\_\_\_

I AUTHORIZE my agent to make health care decisions for me when I cannot make or communicate my own health care decisions. I want my agent to make all such decisions for me except any decisions that I have expressly stated in this form that I do not authorize him/her to make. My agent should explain to me any choices he or she made if I am able to understand. I further authorize my agent to have access to my "personal protected health care information and medical records". This appointment is effective unless it is revoked by me or by a court order.

**Health care decisions that I expressly DO NOT AUTHORIZE if I am unable to make decisions for myself:** (Explain or write in "None")

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**My specific wishes regarding autopsy (additional information on page 1):**

\*Please note that if not required by law a voluntary autopsy may cost money. Initial your choice.

\_\_\_\_\_: Upon my death I DO NOT consent to a voluntary autopsy.

\_\_\_\_\_: Upon my death I DO consent to a voluntary autopsy.

\_\_\_\_\_: My agent may give or refuse consent for an autopsy.

**My specific wishes regarding organ donation (additional information on page 1):**

If you do not initial this section your agent may make these decisions for you. Initial your choice.

\_\_\_\_\_: I DO NOT WANT to make an organ or tissue donation, and I DO NOT want this donation authorized on my behalf by my agent or my family.

\_\_\_\_\_: I have already signed a written agreement or donor card regarding donation with the following individual or institution: \_\_\_\_\_

\_\_\_\_\_: I DO WANT to make an organ or tissue donation when I die. Here are my directions:

**1. What organs/tissues I choose to donate (initial below):**

- a. \_\_\_\_\_: Whole body
- b. \_\_\_\_\_: Any needed parts or organs
- c. \_\_\_\_\_: These parts or organs only:
  - i. \_\_\_\_\_

**2. I am donating organs/tissue for (initial below):**

- a. \_\_\_\_\_: Any legally authorized purpose
- b. \_\_\_\_\_: Transplant or therapeutic purposes only
- c. \_\_\_\_\_: Research only
- d. \_\_\_\_\_: Other: \_\_\_\_\_

**3. The organization or person I want my organs/tissue to go to are (initial below):**

- a. \_\_\_\_\_: \_\_\_\_\_
- b. \_\_\_\_\_: Any that my agent chooses

**My specific wishes regarding funeral and burial disposition (additional information on page 1):**

\_\_\_\_\_: Upon my death, I direct my body to be buried. (Instead of cremated)

\_\_\_\_\_: Upon my death, I direct my body to be buried in: \_\_\_\_\_

\_\_\_\_\_: Upon my death, I direct my body to be cremated.

\_\_\_\_\_: Upon my death, I direct my body to be cremated with my ashes to be \_\_\_\_\_

\_\_\_\_\_: My agent will make all funeral and burial decisions.

**Do you have a living will?**

If you have a Living Will, **you must attach** the Living Will to this form. A blank Living Will is available on the Attorney General’s website [www.azag.gov](http://www.azag.gov). Initial below.

\_\_\_\_\_: I have SIGNED AND ATTACHED a completed Living Will to this Health Care Power of Attorney.

\_\_\_\_\_: I have NOT SIGNED a Living Will.

**Do you have a POLST (Portable Medical Order)?**

A **POLST** form is for when you become seriously ill or frail and toward the end of life. A blank POLST is available on the Attorney General’s website [www.azag.gov](http://www.azag.gov). Initial below.

\_\_\_\_\_: I have SIGNED AND ATTACHED a completed POLST to this Health Care Power of Attorney.

\_\_\_\_\_: I have NOT SIGNED a POLST.

**Do you have a Prehospital Medical Care Directive – a type of Do Not Resuscitate form (DNR)?**

A blank Prehospital Medical Care Directive or DNR is available on the Attorney General’s website [www.azag.gov](http://www.azag.gov). Initial below.

\_\_\_\_\_: I and my doctor or health care provider HAVE SIGNED a Prehospital Medical Care Directive or DNR on Paper with ORANGE background in the event that Emergency Medical Technicians or hospital emergency personnel are called and my heart or breathing has stopped.

\_\_\_\_\_: I have NOT SIGNED a Prehospital Medical Care Directive or DNR.

**PHYSICIAN AFFIDAVIT (OPTIONAL)**

You may wish to ask questions of your physician regarding a particular treatment or about the options in the form. If you do speak with your physician it is a good idea to ask your physician to complete this affidavit and keep a copy for his/her file.

I, Dr. \_\_\_\_\_ have reviewed this document and have discussed with \_\_\_\_\_ any questions regarding the probable medical consequences of the treatment choices provided above. This discussion with the principal occurred on this day \_\_\_\_\_.

I have agreed to comply with the provisions of this directive.

\_\_\_\_\_  
Signature of Physician

**HIPAA WAIVER OF CONFIDENTIALITY FOR MY AGENT**

\_\_\_\_\_ **(Initial)** I intend for my agent to be treated as I would be with respect to my rights regarding the use and disclosure of my individually identifiable health information or other medical records. This release authority applies to any information governed by the Health Insurance Portability and Accountability Act of 1996 (aka HIPAA), 42 USC 1320d and 45 CFR 160-164.

**Revocability of this Health Care Power of Attorney:** I retain the right to revoke all or any portion of this form or to disqualify any agent designated by me in this document.

**MY SIGNATURE VERIFICATION FOR THE HEALTH CARE POWER OF ATTORNEY**

My Signature (Principal): \_\_\_\_\_ Date: \_\_\_\_\_

**If you are unable to physically sign this document, your witness/notary may sign and initial for you. If applicable have your witness/notary sign below.**

Witness/Notary Verification: The principal of this document directly indicated to me that this Health Care Power of Attorney expresses their wishes and that they intend to adopt it at this time.

Witness/Notary Signature: \_\_\_\_\_

Name Printed: \_\_\_\_\_ Date: \_\_\_\_\_

**SIGNATURE OF WITNESS (See Page 1 for who CANNOT be a witness)**

I was present when this form was signed (or marked). The principal appeared to be of sound mind and was not forced to sign this form. I affirm that I meet the requirements to be a witness as indicated on page one of the health care power of attorney form.

Witness Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Name Printed: \_\_\_\_\_

Address: \_\_\_\_\_

**OR**

**SIGNATURE OF NOTARY (See Page 1 for who CANNOT be a Notary)**

Notary Public (NOTE: If a witness signs your form, you SHOULD NOT have a notary sign):

**NOTORIAL JURAT: Pertains to all five pages of this Health Care Power of Attorney**

**Dated** \_\_\_\_\_, **20**\_\_\_\_\_.

STATE OF ARIZONA) ss

COUNTY OF \_\_\_\_\_)

\_\_\_\_\_  
Principal's Name

Subscribed and sworn (or affirmed) before me this \_\_\_\_\_ day of \_\_\_\_\_, 20 \_\_\_\_\_

Notary Public Signature: \_\_\_\_\_

My Commission Expires: \_\_\_\_\_



## **LIVING WILL (End of Life Care) Instructions**

**GENERAL INSTRUCTIONS:** Use this form to make decisions now about your medical care if you are ever in a terminal condition, a persistent vegetative state or an irreversible coma. You should talk to your doctor about what these terms mean.

The Living Will is your written directions to your health care power of attorney, also referred to as your “agent”, your family, your physician, and any other person who might make medical care decisions for you if you are unable to communicate yourself.

It is a good idea to talk to your doctor and loved ones if you have questions about the type of care you do or do not want.

**IMPORTANT: If you have a Living Will and a Health Care Power of Attorney, you must attach the Living Will to the Health Care Power of Attorney.**

If you fill out this form, make sure you **DO NOT SIGN UNTIL** your witness or a notary public is present to watch you sign it.

**PLEASE NOTE:** At least one adult witness, not to include the proxy if there is one, OR a notary public must witness you signing this document.

**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

**OFFICE OF THE ARIZONA ATTORNEY GENERAL  
MARK BRNOVICH**

**Living Will**

**My Information (I am the "Principal"):**

Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Address: \_\_\_\_\_  
\_\_\_\_\_

Phone: \_\_\_\_\_

Email: \_\_\_\_\_

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).

**PLEASE NOTE:** You can attach additional instructions on your medical care wishes that have not been included in this Living Will form. Initial or put a check mark by box A or B below. Be sure to include the attachment if you check B.

\_\_\_\_\_ A. I HAVE NOT attached additional special instructions about End of Life Care I want.

\_\_\_\_\_ B. I HAVE attached additional special provisions or limitations about End of Life Care I want.



**MY SIGNATURE VERIFICATION FOR THE LIVING WILL**

My Signature (Principal): \_\_\_\_\_ Date: \_\_\_\_\_

**If you are unable to physically sign this document your witness/notary may sign and initial for you. If applicable, have your witness/notary sign below.**

Witness/Notary Verification: The principal of this document directly indicated to me that this Living Will expresses their wishes and that they intend to adopt it at this time.

Witness/Notary Signature: \_\_\_\_\_

Name Printed: \_\_\_\_\_ Date: \_\_\_\_\_

**SIGNATURE OF WITNESS**

I was present when this form was signed (or marked). The principal appeared to be of sound mind and was not forced to sign this form.

Witness Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Name Printed: \_\_\_\_\_

Address: \_\_\_\_\_

**OR**

**SIGNATURE OF NOTARY**

Notary Public (NOTE: If a witness signs your form, you SHOULD NOT have a notary sign):

**NOTORIAL JURAT: Pertains to all three pages of this Living Will**

**Dated \_\_\_\_\_, 20\_\_\_\_\_.**

STATE OF ARIZONA) ss

COUNTY OF \_\_\_\_\_)

\_\_\_\_\_  
Principals Name

Subscribed and sworn (or affirmed) before me this \_\_\_\_\_ day of \_\_\_\_\_, 20 \_\_\_\_\_

Notary Public Signature: \_\_\_\_\_

My Commission Expires: \_\_\_\_\_



**OFFICE OF THE ARIZONA ATTORNEY GENERAL  
MARK BRNOVICH**

**Mental Health Care Power of Attorney**

**GENERAL INSTRUCTIONS:** Use this form if you want to appoint a person, also referred to as your “agent”, to make future mental health care decisions for you if 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. It is a good idea to talk to your doctor and loved ones if you have questions about the type of mental health care you do or do not want.

If you fill out this form, make sure you **DO NOT SIGN UNTIL** your witness or a notary public is present to watch you sign it. **PLEASE NOTE:** At least one adult witness OR a notary public must witness you signing this document.

**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

**My Information (I am the “Principal”):**

Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Address: \_\_\_\_\_

Phone: \_\_\_\_\_

\_\_\_\_\_

Email: \_\_\_\_\_

**Selection of my mental health care power of attorney and alternate:**

I choose the following person to act as my agent to make mental health care decisions for me:

Name: \_\_\_\_\_

Home Phone: \_\_\_\_\_

Address: \_\_\_\_\_

Work Phone: \_\_\_\_\_

\_\_\_\_\_

Cell Phone: \_\_\_\_\_

I choose the following person to act as an alternate to make mental health care decisions for me if my first agent is unavailable, unwilling, or unable to make decisions for me:

Name: \_\_\_\_\_

Home Phone: \_\_\_\_\_

Address: \_\_\_\_\_

Work Phone: \_\_\_\_\_

\_\_\_\_\_

Cell Phone: \_\_\_\_\_

**Mental health treatments that I AUTHORIZE if I am unable to make decisions for myself:**

Here are the mental health treatments I authorize my agent to make for me if I become incapable of making my own mental health care decisions due to mental or physical illness, injury, disability, or incapacity. This appointment is effective unless and until it is revoked by me or by an order of a court. My agent is authorized to do the following which I have initialed or marked:

\_\_\_\_\_: To receive medical records and information regarding my mental health treatment and to receive, review, and consent to disclosure of any of my medical records related to that treatment.

\_\_\_\_\_: To consent to the administration of any medications recommended by my treating physician.

\_\_\_\_\_: To admit me to an inpatient or partial psychiatric hospitalization program.

\_\_\_\_\_: Other: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Mental health care treatments that I expressly DO NOT AUTHORIZE if I am unable to make decisions for myself:** (Explain or write in "None")

\_\_\_\_\_  
\_\_\_\_\_

**Revocability of this Mental Health Care Power of Attorney:** This mental health care power of attorney or any portion of it may not be revoked and any designated agent may not be disqualified by me during times that I am found to be unable to give informed consent. However, at all other times I retain the right to revoke all or any portion of this mental health care power of attorney or to disqualify any agent designated by me in this document.

**HIPAA WAIVER OF CONFIDENTIALITY FOR MY AGENT**

\_\_\_\_\_**(Initial)** I intend for my agent to be treated as I would be with respect to my rights regarding the use and disclosure of my individually identifiable health information or other medical records. This release of authority applies to any information governed by the Health Insurance Portability and Accountability Act of 1996 (aka HIPAA), 42 USC 1320d and 45 CFR 160-164.

**MY SIGNATURE VERIFICATION FOR THE MENTAL HEALTH CARE POWER OF ATTORNEY**

My Signature (Principal): \_\_\_\_\_ Date: \_\_\_\_\_

**If you are unable to physically sign this document your witness/notary may sign and initial for you. If applicable, have your witness/notary sign below.**

Witness/Notary Verification: The principal of this document directly indicated to me that this Health Care Power of Attorney expresses their wishes and that they intend to adopt it at this time.

Witness/Notary Signature: \_\_\_\_\_

Name Printed: \_\_\_\_\_ Date: \_\_\_\_\_

**SIGNATURE OF WITNESS (See Page 1 for who CANNOT be a witness)**

I was present when this form was signed (or marked). The principal appeared to be of sound mind and was not forced to sign this form. I affirm that I meet the requirements to be a witness as indicated on page one of the mental health care power of attorney form.

Witness Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Name Printed: \_\_\_\_\_

Address: \_\_\_\_\_

**OR**

**SIGNATURE OF NOTARY (See Page 1 for who CANNOT be a Notary)**

Notary Public (NOTE: If a witness signs your form, you SHOULD NOT have a notary sign):

**NOTORIAL JURAT: Pertains to all three pages of this State of Arizona Mental Health Care Power of Attorney dated \_\_\_\_\_, 20\_\_\_\_\_.**

STATE OF ARIZONA) ss

COUNTY OF \_\_\_\_\_)

\_\_\_\_\_  
Principal's Name

Subscribed and sworn (or affirmed) before me this \_\_\_\_\_ day of \_\_\_\_\_, 20 \_\_\_\_\_

Notary Public Signature: \_\_\_\_\_

My Commission Expires: \_\_\_\_\_



**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.

## 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:

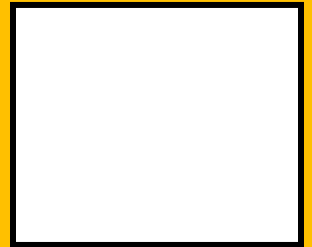
Date of Birth \_\_\_\_\_

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: \_\_\_\_\_