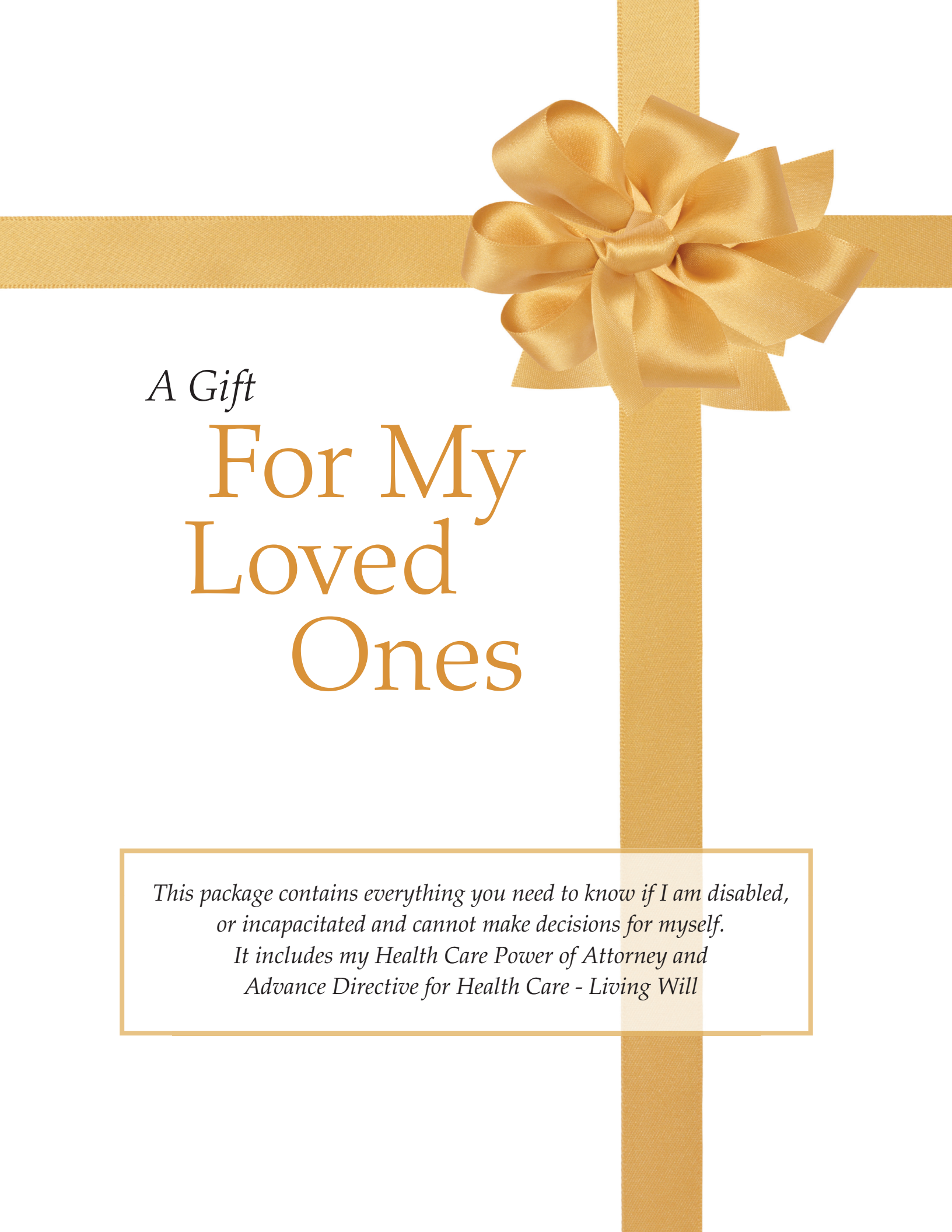

A Gift

For My Loved Ones

This package contains everything you need to know if I am disabled, or incapacitated and cannot make decisions for myself. It includes my Health Care Power of Attorney and Advance Directive for Health Care - Living Will

Dear Loved Ones,

It's hard to think about death. We cling so hard to the temporary pleasures of this life that sometimes we forget our true life; life in Christ. My life with you has been a gift from God. Through all the struggles, pain and great joy I have been loved by you and always by God. As an Orthodox Christian I've always known that our true home is with Christ. There will be no sorrow, no sadness and no loss, only love and joy when we are all together with our Lord.

Long ago I placed my life entirely in the hands of our gracious Lord. I know there are many things that I can't control, but there are several things that it's not only my option but also my duty to control. If I should be in an accident or otherwise incapacitated I know it would be very stressful for my loved ones to make the hard decisions that might need to be made. So I'm taking the hard step of thinking about these things myself so that you know how I would make these decisions and what I would want you to do.

In the following pages I will name a person to hold primary Health Care Power of Attorney and an alternate. I will give that person authority to make those hard decisions and direction by my own wishes. In another document I'll name someone to make funeral arrangements for me through my Advance Directive for Funeral Care and I will give them guidance as to my wishes with my funeral planning form.

In the event that I am gravely or terminally ill or in a state of diminished consciousness so that I can't make decisions for myself, I direct that decisions be made for me that are in conformity with the beliefs and tenets of the Eastern Orthodox Christian Church, some of which are outlined below. I request that an Orthodox priest be contacted to visit with me, hear confession and bring communion for some time prior to my death. When my death is near I request him to be present so that I might make a final confession of my sins and partake of the prayers and sacraments of the church. I also request that Orthodox Prayers for the Newly Departed be said immediately after my death.

My Orthodox Christian beliefs hold that it is unethical to take a life. While it is not the highest of all values to preserve life, affirmative steps to cause death, including but not limited to euthanasia or suicide, are not blessed by the Church. However, it can be permissible, and even appropriate, to allow nature to take its course without extraordinary medical intervention, until God determines to take my life. Using extraordinary medical measures to merely maintain my body's biological functioning may not be appropriate. My death, if with dignity and with proper respect for the rites and traditions of the church, can be a victory of faith.

The Orthodox Church does not condone Physician Assisted Suicide, removing artificial nutrition/hydration from a patient who is conscious but unable to communicate, nor removing artificial nutrition/hydration from a patient who has severe dementia but otherwise has no other acute health problems. However, I also recognize that , as one begins the dying process, forced nutrition/hydration do not help but can interfere with the process and can cause great discomfort. In this case, with the approval of my Agent and my doctors, nutrition/hydration may be withdrawn in favor of proper maintenance of my mucus membranes for my comfort.

Any type of Physicians order for Life Sustaining Treatment signed by a physician or my Agent must be consistent with the contents of my directives contained here.

The original of this form should be with the Agent named on this document. A copy should be with the alternate Agent named, and a copy on file with my church or burial society. Other copies should be distributed to my spouse, children, parents and/or any others who might need to know this information. A copy should be supplied to any hospital, nursing home, rehabilitation center, assisted living or other health care facility that I may enter. I do this to help avoid any

confusion over who I have authorized to make decisions regarding my healthcare and my remains after my death.

If I become incapacitated and unable to make my own healthcare decisions I name the following person(s) to make those decisions on my behalf based on my Orthodox Christian beliefs. The judgment of my incapacity to make health decisions must be made and agreed to by at least two medical physicians who have personally examined me.

I understand that this document gives the person(s) I name as my agent the power to make health care decisions for me if I can't make the decisions for myself. This power includes the power to make decisions about life-sustaining treatment. In the event of my incapacity my agent will have the same authority to make decisions about my healthcare as I would have. My agent will be obligated to follow my instructions when making decisions on my behalf. After I have signed this document, I have the right to make health care decisions for myself if I am mentally competent to do so. After I have signed this document, no treatment may be given to me or stopped over my objection if I am mentally competent to make that decision. I have the right to revoke this document, and terminate my agent's authority, by informing either my agent or my health care provider in writing.

This Healthcare power of attorney will not be valid unless two persons sign as witnesses and a Notary Public is present to witness all our signatures.

The following persons may NOT act as witnesses:

1. A person who is directly financially responsible for my medical care.
2. A person who is named in my will, or, if I have no will, who would inherit my property by intestate succession.
3. A beneficiary of a life insurance policy on my life.
4. The persons named in the Health Care Power of Attorney as my agent or successor agent.
5. My physician or an employee of my physician.
6. Any person who would have a claim against any portion of my estate (persons to whom I owe money).

If I am a patient in a health facility, no more than one witness may be an employee of that facility.

My agent to whom I grant Healthcare Power of Attorney must be a person who is 18 years old or older and of sound mind. It may not be my doctor or any other health care provider that is now providing me with treatment or an employee of my doctor or provider; or a spouse of the doctor, provider, or employee; unless the person is a relative of mine.

I understand that this letter to my loved ones is only explanatory. The terms and conditions of my Healthcare Power of Attorney and Living Will shall govern.

With love,

Contact List:

1. Local Church and priest:_____ phone:_____

2. Alternate Church and priest:_____ phone:_____

3. Power of Attorney: _____ phone:_____

HEALTH CARE POWER OF ATTORNEY

I - Designation of Health Care Agent

I, _____, being of sound mind and body, do hereby appoint the following as my health care attorney-in-fact (herein referred to as my "health care agent") to act for me and in my name (in any way I could act in person) to make health care decisions for me as authorized in this document:

Agent Name: _____
Address:_____

Cellular Telephone: _____ Home Telephone: _____

In the event that _____, ceases to act as my health care agent due to death, incapacity, resignation, divorce or separation, I hereby appoint the person named below as my alternate health care agent.
Alternate Agent Name: _____
Address:_____
Cellular Telephone: _____Home Telephone:_____

II - Effectiveness of Appointment

Absent revocation, the authority granted in this document shall become effective when and if my attending physician and one other physician who has personally examined me shall determine that I lack sufficient understanding or capacity to make or communicate decisions relating to my health care, including mental health treatment, and will continue in effect during my incapacity, until my death, except if I authorize my health care agent to exercise my rights with respect to anatomical gifts, autopsy, or disposition of my remains, this authority will continue after my death to the extent necessary to exercise the authority granted in this document for these purposes; provided, however, that paragraph I of Section III following shall be effective upon the signing of this document and is not dependent upon my incapacity. This determination shall be made by my then treating physician.

III - General Statement of Authority Granted

Except as indicated in section IV below, I hereby grant to my health care agent named above full power and authority to make health care decisions, including mental health treatment decisions on my behalf, including, but not limited to, the following:

A. To request, review, and receive any information, verbal or written, regarding my physical or mental health, including, but not limited to, medical and hospital records, and to consent to the disclosure of this information;

B. To employ or discharge my health care providers;

C. To consent to and authorize my admission to and discharge from a hospital, nursing or convalescent home, or other institution;

D. To consent to and authorize my admission to and retention in a facility for the care or treatment of mental illness;

E. To give consent to and authorize the administration of medications for mental health treatment but not electro-convulsive treatment (ECT) commonly referred to as “shock treatment;”

F. To give consent for, to withdraw consent for, or to withhold consent for, X ray, anesthesia, medication, surgery, and all other diagnostic and treatment procedures ordered by or under the authorization of a licensed physician, dentist, or podiatrist. This authorization specifically includes the power to consent to measures for relief of pain;

G. To authorize the withholding or withdrawal of life-sustaining procedures when and if my physicians determine I have a condition that is incurable or irreversible and, without the administration of life-sustaining procedures, expected to result in death within a relatively short period of time; or if I am in a state of permanent unconsciousness. Life-sustaining procedures are those forms of medical care that serve only to artificially prolong the dying process and may include mechanical ventilation, dialysis, antibiotics, and other forms of medical treatment which sustain, restore or supplant vital bodily functions. Life-sustaining treatments could also include artificial nutrition and hydration when the conditions above are met, and they are only prolonging the dying process.

H. To exercise any right that I may have to make a disposition of any part of my body for medical purposes: to authorize an autopsy only if required by law; to make an anatomical gift of my organs or part thereof, but not my whole body; and to direct the disposition of my remains according to the rites and teachings of the canonical Orthodox Christian faith; and

I. I intend for my agent named above 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 (a.k.a. HIPAA), 42 U.S.C .1320d and 45 C.F.R. 160-164. I authorize: any physician, health care professional, dentist, health plan, hospital, clinic, laboratory, pharmacy or other covered health care provider, any insurance company and the Medical Information Bureau, Inc. or other health care clearinghouse that has provided treatment or services to me, or that has paid for or is seeking payment from me for such services, to give, disclose and release to my agent, without restriction, all of my individually identifiable health information and medical records regarding any past, present or future medical or mental health condition, including all information relating to the diagnosis and treatment of HIV/AIDS, sexually transmitted diseases, mental illness, and drug or alcohol abuse. The authority given my agent shall supersede any prior agreement that I may have made with my health care providers to restrict access to or disclosure of my individually identifiable health information. The authority granted under this HIPAA Release is effective immediately. The authority given my agent has no expiration date and shall expire only in the event that I revoke the authority in writing and deliver it to my health care provider. and

J. To take any lawful actions that may be necessary to carry out these decisions, including the granting of releases of liability to medical providers.

IV - Special Provisions and Limitations

A. In exercising the authority to make health care decisions on my behalf, the authority of my health care agent is subject to the following special provisions and limitations: he shall not allow

Physician Assisted Suicide, removing artificial nutrition/hydration from me if I am conscious but unable to communicate, nor removing artificial nutrition/hydration from me if I have severe dementia but otherwise have no other acute health problems.

B. In exercising the authority to make mental health decisions on my behalf, the authority of my health care agent is subject to the following special provisions and limitations: My health care agent may not consent to nor authorize the administration of electroconvulsive treatment (ECT), commonly referred to as "shock treatment;"

C. I have executed a Living Will and it is my direction that my health care agent act consistently with my instructions in the Living Will. In the event of a conflict between the instructions contained in my Living Will and the instructions of my health care agent, it is my desire and intention that the provisions of my Living Will should control; and

D. In exercising the authority to make decisions regarding autopsy, anatomical gifts and disposition of remains on my behalf, the authority of my health care agent is subject to the following special provisions and limitations: no autopsy shall be performed unless it is required by law, no whole body donation. *(Initial one below)*

_____ Organ donations are allowable.

_____ No organ donation.

Other _____

V - Guardianship Provision

If it becomes necessary for a court to appoint a guardian of my person, I nominate my health care agent acting under this document to be the guardian of my person, to serve without bond or security. The guardian shall act consistently with provisions of this State's laws.

VI - Reliance of Third Parties on Health Care Agent

A. No person who relies in good faith upon the authority of or any representations by my health care agent shall be liable to me, my estate, my heirs, successors, assigns, or personal representatives, for actions or omissions by my health care agent; and

B. The powers conferred on my health care agent by this document may be exercised by my health care agent alone, and my health care agent's signature or act under the authority granted in this document may be accepted by persons as fully authorized by me and with the same force and effect as if I were personally present, competent, and acting on my own behalf. All acts performed in good faith by my health care agent pursuant to this power of attorney are done with my consent and shall have the same validity and effect as if I were present and exercised the powers myself, and shall inure to the benefit of and bind me, my estate, my heirs, successors, assigns, and personal representatives. The authority of my health care agent pursuant to this power of attorney shall be superior to and binding upon my family, relatives, friends and others.

C. Any party dealing with my alternate health care agent may rely upon his representation as to my original health care agent's death, incapacity or resignation as conclusively correct. A copy of this form shall be as good as the original.

VII - Miscellaneous Provisions

A. I revoke any prior health care power of attorney;

B. My health care agent shall be entitled to sign, execute, deliver, and acknowledge any contract or other document that may be necessary, desirable, convenient or proper in order to exercise and carry out any of the powers described in this document and to incur reasonable costs on my behalf incident to the exercise of these powers; provided, however, that except as shall be necessary in order to exercise the powers described in this document relating to my health care, my health care agent shall not have any authority over my property or financial affairs;

C. My health care agent and my health care agent's estate, heirs, successors, and assigns are hereby released and forever discharged by me, my estate, my heirs, successors, and assigns and personal representatives from all liability and from all claims or demands of all kinds arising out of the acts or omissions of my health care agent pursuant to this document, except for willful misconduct or gross negligence; and

D. No act or omission of my health care agent, or of any other person, institution, or facility acting in good faith in reliance on the authority of my health care agent pursuant to this health care power of attorney shall be considered suicide, nor the cause of my death for any civil or criminal purposes, nor shall it be considered unprofessional conduct or as a lack of professional competence. Any person, institution, or facility against whom criminal or civil liability is asserted because of conduct authorized by this health care power of attorney may interpose this document as a defense.

VIII - Signature of Principal

By signing here, I indicate that I am mentally alert and competent, fully informed as to the contents of this document, and understand the full import of this grant of powers to my health care agent.

_____ _____ (SEAL)

Date Signature of Principal

A notary public or other officer completing this certificate verifies only the identity of the individual who signed the document to which this certificate is attached, and not the truthfulness, accuracy, or validity of that document.

STATE OF _____

COUNTY OF _____

I, _____, a Notary Public for _____County, _____ hereby certify that _____appeared before me and swore to me and to the Witnesses in my presence that this instrument is a Health Care Power of Attorney, and that he/she willingly and voluntarily made and executed it as his/her free act and deed for the purposes expressed in it.

This the _____ day of _____, 20_____.

Notary Public:_____My Commission Expires: _____

IX - Signature of Witnesses

I hereby state that the Principal, _____, being of sound mind, signed the foregoing health care power of attorney in my presence, and that I am not related to the principal by blood or marriage, and I would not be entitled to any portion of the estate of the principal under any existing Will or Codicil of the principal or as an heir under any law regulating intestate succession in this state, if the principal died on this date without a Will. I also state that I am not the principal's attending physician, nor an employee of the principal's attending physician, nor an employee of a nursing home or any group care home where the principal resides. I further state that I do not have any claim against the principal.

_____ _____

Date Witness 1

_____ _____

Date Witness 2

A notary public or other officer completing this certificate verifies only the identity of the individual who signed the document to which this certificate is attached, and not the truthfulness, accuracy, or validity of that document.

STATE OF _____

COUNTY OF _____

I hereby certify that _____ and _____, Witnesses, are personally known to me or have provided proper identification and appeared before me and swore that they witnessed _____sign the attached Health Care Power of Attorney, believing him/her to be of sound mind; and also swore that at the time they witnessed the signing (i) they were not related within the third degree to him/her or his/her spouse, and (ii) they did not know nor have a reasonable expectation that they would be entitled to any portion of his/her estate upon his/her death under any Will or Codicil thereto then existing or under any law regulating intestate succession in this state, as it provided at that time, and (iii) they were not a physician attending to him/her, nor an employee of an attending physician, nor an employee of a health facility in which he/she was a patient, nor an employee of a nursing home or any group-care home in which he/she resided, and (iv) they did not have a claim against him/her. I further certify that I am satisfied as to the genuineness and due execution of the instrument.

This the ___ day of _____, 201___.

Notary Public:_____My Commission Expires: _____

DECLARATION OF A DESIRE FOR A NATURAL DEATH

I, _____, of (Town) _____, [State)_____, believe it is important to make known my decision regarding the administration and continuation of any medical procedure or intervention that would serve only to postpone the moment of my death. To this end I am making the following declaration.

I am of sound mind and at least eighteen years of age. I direct that my life shall not be artificially prolonged under the circumstances set forth below and hereby declare that:

If at any time my attending physician and one other physician who has personally examined me certify in writing that I am: (initial all those that apply)

_____ Permanently unconscious with a ventilator breathing for me;

_____ Permanently unconscious with a feeding tube and/or intravenous (IV) hydration;

_____ Maintained on a ventilator when there is little or no chance for recovery;

_____ or In any other permanent and terminal medical condition due to which the application of life sustaining treatment would serve only to artificially prolong the process of dying or maintain me in the permanent medical condition, then;

I direct that life-sustaining procedures shall be withdrawn and withheld pursuant to the terms of this declaration, it being understood that life-sustaining procedures shall not include any medical procedure or intervention for nourishment and hydration considered necessary by the attending physician to provide comfort or alleviate pain. The life-sustaining procedures which may be withheld or withdrawn include, but are not limited to: surgery, antibiotics, cardiac resuscitation, respiratory support, chemotherapy, radiation, dialysis and transfusions, and other forms of medical treatment which sustain, restore or supplant vital bodily functions.

I seek treatment only to keep me comfortable, even if such treatment may shorten my life.

Note: Physician Assisted Suicide is prohibited. Removing artificial nutrition/hydration if I am conscious but unable to communicate but otherwise have no other acute health problems is prohibited. Removing artificial nutrition/hydration if I have severe dementia but otherwise have no other acute health problems is prohibited.

However, I may specifically direct that artificial nourishment be withdrawn or withheld pursuant to the terms of this declaration above. “Artificial nourishment” means nourishment supplied by means of a naso-gastric tube or tube inserted into the stomach or intestines, or nutrients injected intravenously into the bloodstream.

With respect to Nutrition and Hydration, I direct that in situations where life-sustaining treatments are being withheld or withdrawn pursuant to conditions above (INITIAL **ONLY ONE** OF THE FOLLOWING THREE PARAGRAPHS):

_____Artificial nourishment shall not be continued; or

_____Artificial nourishment shall be continued; or

_____Artificial nourishment shall be continued until such time as my Agent and two (2) physicians who have personally examined me determine that the dying process has begun and continuation of nutrition/hydration would only cause me discomfort.

In the event my physicians certify my condition as terminal, my physician may discharge his or her obligation of notice by notifying my Health Care Agent or any successor Health Care Agent serving under my Health Care Power of Attorney.

This instrument is made and given in the full knowledge that I can rely on the love and affection of my relatives and friends and with thankfulness that they will understand my reasons.

This the ____ day of _____, 20_____. _____

[Principal Signature], Declarant

I hereby state that the declarant, _____, being of sound mind, signed the above declaration in my presence and that I am not related to the declarant by blood or marriage and that I do not know or have a reasonable expectation that I would be entitled to any portion of the estate of the declarant under any existing Will or Codicil of the declarant or as an heir under any law regulating intestate succession in this state, if the declarant died on this date without a Will. I also state that I am not the declarant's attending physician or an employee of the declarant's attending physician, or an employee of a health facility in which the declarant is a patient or an employee of a nursing home or any group-care home where the declarant resides. I further state that I do not now have any claim against the declarant.

_____ residing at _____

Witness 1

_____ residing at _____

Witness 2

A notary public or other officer completing this certificate verifies only the identity of the individual who signed the document to which this certificate is attached, and not the truthfulness, accuracy, or validity of that document.

STATE OF _____

COUNTY OF _____

I,_____,aNotaryPublicfortheCountyof_____, State of _____, hereby certify that _____, the declarant, appeared before me and swore to me and to the Witnesses in my presence that this instrument is Declaration of a Desire for a Natural Death, and that he/she had willingly and voluntarily made and executed it as a free act and deed for the purposes expressed in it.

I further certify that _____and _____, Witnesses, personally known to me or providing proper identification appeared before me and swore that they witnessed _____, declarant, sign the attached declaration, believing him/her to be of sound mind; and also swore that at the time they witnessed the declaration (i) they were not related within the third degree to the declarant or to the declarant's spouse, and (ii) they did not know or have a reasonable expectation that they would be entitled to any portion of the estate of the declarant upon the declarant's death under any Will of the declarant or Codicil thereto then existing or under any law regulating intestate succession in this state, as it provides at that time, and (iii) they were not a physician attending the declarant or an employee of an attending physician or an employee of a health facility in which the declarant was a patient or an employee of a nursing home or any group-care home in which the declarant resided, and (iv) they did not have a claim against the declarant. I further certify that I am satisfied as to the genuineness and due execution of the declaration.

This the ____ day of _____, 20____.

Notary Public: _____ My Commission Expires:_____

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