Triage Cancer Estate Planning Toolkit: Arizona

Part II: Understanding Estate Planning Documents in Your State

State Laws About Wills

A will is a legal document that provides instructions for what you would like to have happen to your property upon death. A will is also a place where parents can name a guardian for any minor children or adult children with developmental disabilities.

Arizona probate courts accept written and holographic wills.

To make a valid written will in Arizona:

1. You need to be in the right state of mind to create a will. This means you need to be:
    - At least 18 years old
    - Of "sound mind" (meaning you know what you're doing)
    - Acting without the "undue" or coercive influences of other people
2. You need to sign the will, in front of two witnesses.
    - If your will was executed after October 1, 2019, the witness cannot be an individual designated to receive something in the will or an individual related by blood, marriage, or adoption to an individual benefitting from the will. If your will is "self-proving," meaning notarized, this witness rule does not apply.
3. Your will does not need to be notarized to be legal in Arizona. However, you can make your will "self-proving," or accepted in probate court without the court needing to contact your witnesses. To do this, sign an affidavit in front of a notary to prove your identity and that all parties had knowledge of the will.

Due to the COVID-19 pandemic, Arizona now allows you to execute your will remotely (e.g. sign an affidavit by teleconferencing with a notary). However, before you execute your will remotely, you should check your state's laws to make sure that this is still allowed at the time you are executing your will.

A holographic will is one that is handwritten by you. To make a valid holographic will in Arizona:

1. You need to be in the right state of mind to create a will. This means you need to be:
    - At least 18 years old
    - Of "sound mind" (meaning you know what you're doing)
2. Your will must be written in your handwriting and you must sign it.

If you use a holographic will in Arizona, you do not need witnesses to sign it. However, most estate planning experts do not recommend relying on holographic wills because it is more difficult to prove their validity in probate court.

State Laws About Financial Powers of Attorney

A power of attorney for financial affairs is a legal document where you (the principal) name a trusted adult (the agent) who is authorized to make financial decisions on your behalf.

Arizona's power of attorney statutory form allows you to appoint someone to manage your finances, including assets like your property, taxes, and government benefits. This person can make all financial decisions for you, or you can limit their powers to specific tasks, like filing taxes or banking. This document takes effect immediately after you sign it or you can indicate it should take effect later. You can also indicate whether this document should take or remain in effect if you become incapacitated. If you indicate that it will remain in effect if you become incapacitated, this is a durable power of attorney. Once in effect, this document will remain in effect until you die, unless you specify a specific date to terminate, or revoke your power of attorney.

Part III of this toolkit includes a sample form.

State Laws About Advance Directives for Health Care

An advance health care directive is a legal document you can use to provide written instructions, or state preferences, about your medical care in case you become unable to make decisions for yourself. To authorize this document in Arizona, you must be at least eighteen years old and of sound mind.

In Arizona, this document has five parts:

1. **Health Care Power of Attorney:** This document allows you to choose a trusted person (an agent) to make decisions about your medical care, including life-sustaining treatment, if you become unable to communicate. You can also appoint an alternate person to be your agent in case the first person you choose is not available. Included in the Health Care Power of Attorney form are the following decisions:
    - **Autopsy:** Arizona law requires an autopsy to be performed in certain circumstances after someone's death. In this document, you can indicate whether or not you consent to an autopsy, or authorize your agent to make this decision for you.
    - **Organ Donation:** This section lets you indicate if you would like to make an organ or tissue donation at the time of your death. This is optional.
    - **Funeral and Burial Disposition**: This document allows you to authorize your agent to make funeral and burial decisions, or you can express if you would like to be buried or cremated. This is optional.
2. **Living Will:** You can use a living will to express your wishes for your medical care in the event you become seriously ill or permanently unconscious. If you are pregnant or may become pregnant, you can indicate if you would like life-sustaining treatment to be given if it is possible the fetus/embryo would develop to birth via this treatment. This document will guide your agent as they make decisions about your care.
3. **Mental Health Care Power of Attorney:** You can use a Mental Health Care Power of Attorney to appoint a person to make future mental health care decisions if you become unable of making them yourself. The decision that you are unable can only be made by a specialist in neurology or Arizona licensed psychiatrist or psychologist.
4. **Pre-hospital Medical Care Directive:** In this section you can choose to inform emergency personnel not to resuscitate you, a DNR.
5. **Physician Affidavit:** If you spoke with your physician about the decisions you made in your AHCD, asking them to complete this affidavit creates a written record verifying your physician has agreed to follow your wishes. This is optional.

There are two ways to make your AHCD valid in Arizona.

You can sign the document, or ask someone to do so for you, in front of one witness. Or, you can sign in front of a notary. Your witness or notary cannot be:

- Your agent
- Related to you by blood, adoption, or marriage
- Included in your will or entitled to your estate in some other way
- Involved in providing your health care at the time the form is signed

If you cannot sign your AHCD yourself, your notary public or witness will also sign a statement that you indicated that your AHCD expresses your wishes.

If you change your mind about the decisions you made in your AHCD, you can revoke this document by:

- Revoking your AHCD in writing
- Telling your agent or health care provider you would like to revoke your AHCD
- Creating a new AHCD
- Any other act that demonstrates your desire to revoke your AHCD

Part III of this toolkit includes a sample Advance Health Care Directive for Arizona.

State Laws About POLST/MOLST

A physician order for life-sustaining treatment (POLST) is a medical order completed by a seriously ill person and signed by a physician. The POLST does not replace an advance health care directive. You can complete a POLST form with your doctor. Arizona offers POLST orders using the National POLST form, which can be found in Part III of this toolkit. This form lets you indicate your preferences for:

- Cardiopulmonary resuscitation orders (also known as a "Do not resuscitate," or DNR order)
- Medical Interventions, ranging from all medical and surgical treatments available to prolong your life, selective treatments to restore your health while avoiding burdensome procedures, or comfort-focused treatments to manage symptoms and allow natural death
- Medically assisted nutrition, or food offered through surgically-placed tubes
- Additional orders or instructions for your care

This form will not expire, so it is important for you and your physician to review it regularly to make sure it still reflects your wishes.

You can find this form in Part III of this toolkit.

State Laws About Funeral Designation Forms

Funeral designation forms allow you to tell your loved ones what you would like to happen to your remains after you pass away. These forms can be used to choose someone to control what happens to your remains after your death, specify what you would like to have happen, and other wishes depending on your state.

State law (Arizona Statute Title 32-1365.01) protects your right to indicate your preferences for burial or cremation. You can do this in the "Funeral Disposition" section of your Advance Health Care Directive.

State Laws About Death with Dignity

"Death with Dignity" laws, or physician-assisted dying/aid-in-dying laws, allow certain terminally ill people to voluntarily and legally request and receive a prescription medication from their physician to hasten their death in a peaceful, humane, and dignified way. By adding a voluntary option to the continuum of end-of-life care, these laws can give you dignity, control, and peace of mind during your final days with family and loved ones.

Arizona does not have a death with dignity law. But, you can indicate other preferences for end-of-life care through an advanced health care directive or POLST.

Federal Law About HIPAA

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) is a federal law that protects the privacy of your health information. HIPAA does allow your protected health information to a be shared with your personal representative who has authority to make health care decisions for you (i.e., your health care agent or proxy).

To guarantee your agent's access to information, a HIPAA authorization form should be signed and dated by you. Also, it must identify the information to be disclosed, the purpose of the disclosure, the recipients of the information, and an expiration date. This means that any advance health care directives should be clear about the scope of your agent's authority to receive protected health care information.

You can revoke a HIPAA authorization form at any time by notifying your health care provider in writing.

Part III of this toolkit includes a sample HIPAA authorization form. For more information: www.cdc.gov/phlp/publications/topic/hipaa.html.

Triage Cancer Estate Planning Toolkit: Arizona

Part III: Your State's Estate Planning Forms

- Power of Attorney for Financial Affairs
- Advance Health Care Directive
- Physician Order for Life-Sustaining Treatment (POLST)
- Funeral Designation Form
- HIPAA Authorization Form

Triage Cancer Estate Planning Toolkit

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Part III: Your State's Estate Planning Forms

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Power of Attorney for Financial Affairs

POWER OF ATTORNEY

(GENERAL)

FORMS AND INSTRUCTIONS

GNPOA1- **5330** - 050919

Law Library Resource Center

POWER OF ATTORNEY FORMS

CHECKLIST

A Power of Attorney is a legal document which you can use to give another adult the authority to act on your behalf.

- ✓ ***You may use the Law Library Resource Center Power of Attorney forms if:***
  - you are 18 years of age or older, and
  - you live in Arizona, and
  - you are of sound mind.

- ✓ These forms may not meet the legal requirements for states other than Arizona. If you need a Power of Attorney to be valid in another state, you should check with an attorney that practices in that state to ensure the Power of Attorney will be valid.

- ✓ Which Power of Attorney form you should use depends on what you want the other person to be able to do on your behalf. Please see below for more information on the different types of Powers of Attorney:

➢ If you want the other person to be able to act on your behalf in a wide variety of situations, you may want a **GENERAL POWER OF ATTORNEY:**

- **USE** the General Power of Attorney form to give another adult **complete** authority to act on your behalf in most situations, including personal finances, real and personal property, and a large range of business transactions.
- **DO NOT USE** the General Power of Attorney form to give another adult authority to make decisions regarding your health. Refer to the Health Care Directives available through that Arizona Attorney General's Office through their Webpage Life Care.

➢ If you want the other person to be able to act on your behalf in specific situations only, you may want a **SPECIAL POWER OF ATTORNEY:**

- **USE** the Special Power of Attorney form to give another adult authority to act on your behalf in **specific** situations only; such as a one-time business transaction or a specific sale of real or personal property.

➢ If you want to give the other person temporary authority over your child(ren), you may want a **PARENTAL POWER OF ATTORNEY**. The Parental Power of Attorney begins on a specific date and ends not more than **six months** later. The only exception to the six month period is for active military personnel, who are given one year delegation of parental authority.

- **USE** the Parental Power of Attorney form to give another adult **temporary** authority over your child or children in a specific situation ***and*** the person to whom you want to give the authority is willing to accept temporary authority over your child.
- **DO NOT USE** the Parental Power of Attorney form to give another adult guardianship or custody of your child. Please review the guardianship and/or custody paperwork in the Law Library Resource Center.

➢ If you want to give the other person authority over your health care decisions, you may want a **HEALTH CARE POWER OF ATTORNEY**. Please see the Arizona Secretary of State's website or the Maricopa County Superior Court Law Library for more information on Health Care Powers of Attorney. The Law Library Resource Center does not offer these forms.

➢ If you want to revoke or cancel a power or authority previously granted, you may want a **REVOCATION OF POWER OF ATTORNEY**

- **USE** the Revocation form to **cancel or revoke** any existing Power of Attorney.

Law Library Resource Center

General Power of Attorney

This packet contains court forms and instructions to file a general power of attorney. Items in BOLD are forms that you will need to file with the Court. Non-bold items are instructions or procedures. Do not copy or file those pages!

Order	File Number	Title	# pages
1	GNPOA1k	Checklist: *You may use these forms if . . .*	1
2	GNPOA1t	Table of Contents (this page)	1
3	GNPOA10i	Instructions to get a General Power of Attorney	1
4	GNPOA10f	**General Power of Attorney**	3
5	GNPOAFAQ	Frequently Asked Questions	3

INSTRUCTIONS FOR
GENERAL POWER OF ATTORNEY

A person (Principal) signs a Power of Attorney in front of a notary to give a trusted and willing person (Attorney-in-Fact or Agent) authority to act in place of the Principal. A *Regular* Power of Attorney has a beginning (effective) date, and ends either on the end date, when the Principal revokes it, or the Principal becomes mentally unable to handle their own affairs due to sickness or injury. A *Durable* Power of Attorney has no specified end date and ends on the death of the Principal, or upon revocation by the Principal. Also, with a Durable Power of Attorney, *if the Principal becomes disabled or incapacitated, the Attorney-in-Fact may continue acting as such despite the disability, incapacity or the expiration date*.

A Power of Attorney must be notarized.

This packet provides a General Power of Attorney form that asks you to choose either a regular or durable Power of Attorney.

STEP 1: **OBTAIN** the General Power of Attorney packet at the Maricopa County Superior Court "forms" website or at one of the Law Library Resource Centers located in the valley.

Downtown Phoenix
101 W. Jefferson St.
Phoenix, Arizona 85003

Northeast Court Facility
18380 North 40th Street
Phoenix, Arizona 85032

Northwest Court Facility
14264 West Tierra Buena Lane
Surprise, Arizona 85374

Southeast Court Facility
222 East Javelina Avenue
Mesa, Arizona 85210-6201

- Read General Power of Attorney FAQs and Instructions
- Choose one General Power of Attorney that best fits your situation (Regular or Durable)
- Complete the General Power of Attorney Form that best fits your situation

STEP 2: **TAKE** the following to a Notary Public. You may find a Notary at most banks or listed in the telephone book yellow pages. Notaries usually charge a fee. [The Clerk of Court will not notarize your documents and there is no need to file these documents with the Court.]

- The Witness
- The original, completed General Power of Attorney Form
- Photo ID for the witness, and you

STEP 3: **SIGN** the original General Power of Attorney in front of the Notary and

- Tell the Witness to sign the form in front of the Notary
- Wait for the Notary to notarize the Power of Attorney

STEP 4: **MAKE COPIES** of the notarized General Power of Attorney for each person or organization you deal with

- Keep the original notarized General Power of Attorney for your records
- Give one copy of the General Power of Attorney to the Attorney-in-Fact
- *Show* the people and organizations the *original* Power of Attorney and give them a copy

GENERAL POWER OF ATTORNEY

1. CHECK MARK ONE (1) TYPE OF POWER OF ATTORNEY:

☐ **General Regular Power of Attorney (has a beginning and end date), OR**

☐ **General Durable Power of Attorney (ends upon Principal's death or revocation)**

2. IDENTIFY the Principal and Attorney-in-Fact:

Name	Address of Residence	City	State	Zip Code	Date of Birth

Principal:

Agent / Attorney-In-Fact:

3. MARK the Sections that apply to you.

Principal, an individual, hereby appoints the above-named Agent/Attorney-in-Fact to act in name and place of Principal to perform the following general matters.

Scope and extent of powers granted by the General Power of Attorney: to exercise any or all of the following powers concerning:

☐ **a.** Personal Finances: to withdraw and deposit funds from bank accounts belonging to Principal and to enter and remove the contents of all safe deposit boxes rented by the principal; to ask, demand, sue for, recover, collect, and receive each and every sum of money, debt, account, legacy, bequest, interest, dividend, annuity and demand which now is or hereafter shall become due, owing or payable, belonging to or claimed by Principal and to use and take any lawful means for the recovery thereof by legal process or otherwise, and to execute and deliver a satisfaction or release therefor, together with the right and power to compromise or compound any claim or demand; to borrow money and to execute and deliver notes with or without security; and to loan money and receive notes with such security as Attorney-in-Fact shall deem proper;

☐ **b.** Real property, or any interest therein or any improvements thereon: to contract for, purchase, receive and take possession thereof and of evidence and title thereto; to lease the same for any term or purpose, including leases for business residence; to sell, exchange, subdivide, grant or convey the same with or without warranty, covenant or restrictions; to mortgage, transfer in trust, or otherwise encumber the same to secure payment of a note or performance of any obligation or agreement;

☐ **c.** Personal property: to contract for, buy, sell, exchange, transfer, endorse and in any legal manner deal in and with the same; and to mortgage, transfer in trust, or otherwise encumber the same to secure payment of a note of performance of any obligation or agreement;

☐ **d.** Business Transactions of any kind, and as the act and deed of Principal to sign, execute, acknowledge and deliver any deed, lease, assignment of lease, covenant, indemnity, agreement, mortgage, deed of trust, assignment of mortgage, or beneficial interest under deed of trust, subdivision or plat, extension or renewal of any obligation, subordination or waiver of priority, bill of lading, bill of sale, bond, note, receipt, check, evidence of debt, full or partial release of mortgage judgment or other debt, and such other instruments in writing of any kind or class as may be necessary or proper in the premises;

☐ **e.** To do and perform every and all acts required, necessary or appropriate to be done in and about the premises as fully to all intents and purposes as Principal might or could do if personally present, hereby ratifying all that Attorney-in-Fact shall lawfully do or cause to be done by virtue of this General Power of Attorney.

4. CHECK the ONE type of Power of Attorney that applies to you. Complete the information asked for in the Section.

☐ **General Regular Power of Attorney -** Has beginning and ending dates.

- Effective Date: the time from which this document is operational: _____, 20_____.

  This General Power of Attorney begins on the above effective date and continues until the expiration date of _____ 20 _____, unless the Principal revokes this Power of Attorney before expiration using a written document of Revocation.

- Manner of Revocation: The Principal may revoke this document in writing at any time before the expiration date for no reason or for cause. Also, if the Attorney-in-Fact exceeds or violates the scope and authority granted by this document, the Principal may revoke in writing the Power of Attorney at any time before the expiration date.

☐ **General Durable Power of Attorney** – Has a beginning effective date and lasts until the death of the Principal or until revocation.

- Effective Date: the time from which this document is operational: _____, 20_____.

- Manner of Revocation: The Principal may revoke this document in writing at any time before the expiration date for no reason or for cause, or if the Attorney-in-Fact exceeds or violates the scope and authority granted by this document. *If the Principal becomes disabled or incapacitated, the Attorney-in-Fact may continue acting as such despite the disability, incapacity or the expiration date*.

5. COMPENSATION of Attorney-in-Fact: None.

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6. SIGNATURES.

For Principal:

I, _____, the principal, sign my name to this power of attorney this ____ day of _____ and, being first duly sworn, do declare to the undersigned authority that I sign and execute this instrument as my power of attorney and that I sign it willingly, or willingly direct another to sign for me, that I execute it as my free and voluntary act for the purposes expressed in the power of attorney, and that as required by A.R.S. § 14-5501, I am eighteen years of age or older, of sound mind, and under no constraint or undue influence.

_____
Principal

For Witness:

I, _____, the witness, sign my name to the foregoing power of attorney being first duly sworn, and do declare to the undersigned authority the principal signs and executes this instrument as the principal's power of attorney and that the principal signs it willingly, or willingly directs another to sign for the principal, and that I, in the presence and hearing of the principal sign this power of attorney as witness to the principal's signing, and to the best of my knowledge the principal is eighteen years of age or older, of sound mind, and under no constraint or undue influence.

_____
Witness

7. NOTARIZATION.

STATE OF _____

COUNTY OF _____

Subscribed, sworn to or affirmed, and acknowledged before me by _____, the principal, and subscribed and sworn to or affirmed before me by _____, witness, this _____ day of _____.

(notary seal)

_____
Notary Public

Frequently Asked Questions
Power of Attorney and Related Forms

1. What is a Power of Attorney?

   A Power of Attorney is a legal document that gives an adult the authority to act in your place. The person you appoint to act in your place is known as the "Attorney in Fact" or agent. It is very important that your agent is someone you trust.

   With a valid Power of Attorney, the trusted person you name will be legally permitted to take care of important matters granted by the Principal – for example paying your bills or managing your investments.

2. Who can use a Power of Attorney?

   A person who is 18 years of age or older in Arizona and is of sound mind can use the Power of Attorney as either a Principal, witness or Attorney in Fact.

3. What types of Power of Attorney forms are available in the Law Library Resource Center?

   - *General Power of Attorney* – This power of attorney delegates unlimited authority to another person for them to act on your behalf.
   - *Special Power of Attorney* – This power of attorney delegates limited authority to another person for them to act on your behalf.
   - *Parental Power of Attorney* – This power of attorney temporarily delegates parental powers for six months unless you are active in the military.
   - *Durable Power of Attorney* -The general and special powers of attorney can all be made "durable" by adding certain text to the document. This means that the document will remain in effect or take effect if you become disabled or incapacitated.

   There are other types of Powers of Attorney. Further information is available at the Law Library Resource Center.

4. Who is "the Principal" on the Power of Attorney form?

   The Principal is the person who gives the permission and authority to carry out his or her business.

5. What is an "Attorney in Fact"?

   An Attorney in Fact is a person or agent chosen by the principal, who accepts the responsibility to act in place of the principal. He or she is an adult that the principal can trust, to do what the principal directs in writing. An Attorney in Fact has nothing to do with a lawyer or an "attorney at law."

6. What is the difference between a Power of Attorney and a Durable Power of Attorney?

   A power of attorney is a means by which by one person, called a principal, authorizes another person, called an attorney-in-fact or agent, to legally undertake some action or business of the principal on the principal's behalf. A durable power of attorney is a special form of authorization that allows the attorney-in-fact to continue acting on the principal's behalf even if the principal is ill or unable to communicate.

7. When does the Durable Power of Attorney become effective?

   The Durable Power of Attorney available from the Law Library Resource Center website becomes effective when the Principal and Witness sign the Power of Attorney in front of a notary.

8. How is the Durable Special Power of Attorney different from a Power of Attorney that delegates parental powers?

   A Durable Special Power of Attorney differs from a Parental Power of Attorney because it can be used for specific tasks other than delegation of parental powers. The Power of Attorney to delegate parental powers is specific only to the parent-child relationship.

9. Do I need to know the witness?

   No. However, you cannot expect that an informed adult will be available to act as a witness at the notary office. In order to be prepared, it is best to take a person willing to be a witness with you to the notary office. Also, it may be helpful to have a person (the witness) know that you executed a Power of Attorney.

   Also, it is not a requirement that the notary public provide customers with a translator. It may be in the best interest of the Principal to have a trusted witness to translate. A witness/translator may need to be present to verbally translate oaths before having their signature notarized.

10. May a non-Arizonan use these forms?

    These Power of Attorney forms are based on Arizona law. Arizona law has requirements for the Principal, witness, Attorney in Fact, Notary, as well as the Power of Attorney form. These requirements may differ from those in other states. The people who sign and use the Arizona Power of Attorney form must follow these instructions and abide by Arizona Power of Attorney laws.

11. May I edit or remove language from the Power of Attorney form?

    Yes, but in specific places only. The places for editing the form are indicated by a box to check or a line to mark, where you are given choices of the tasks you want the Attorney in Fact to perform. You may cross out any task you do not want your Attorney in Fact to do, or you may check mark the section you want the Attorney in Fact to perform. Both the principal and agent should initial any changes in these specified places.

12. May I use these Power of Attorney forms for health care or end-of-life planning?

    No. For a packet of forms for end-of-life and health planning go to the Arizona Attorney General's office or website.

13. Can a Power of Attorney be used to distribute assets upon death of the Principal?

    No. The Power of Attorney ends upon death the Principal (or on the end date, or date of revocation). Generally, the probate process is used to distribute assets if the Principal has died.

14. How can I cancel or revoke a Power of Attorney?

    Revocation means to recall or cancel a power or authority previously granted. You can revoke a Power of Attorney at any time and for whatever reason you wish. You must do it in writing and give a copy of the revocation form to any interested third party such as a bank or financial institution whom you or your Agent have business. If your power of attorney was recorded for real estate purposes, the revocation must be recorded as well.

    If you have a Durable Power of Attorney, you must be competent to make the decision to revoke or revise the Power of Attorney. If the Principal is not competent, a Durable Power of Attorney continues until the Principal dies.

15. When does a Power of Attorney end?

    Generally, a Power of Attorney ends upon revocation, at the designated end date, or upon the death of the Principal.

16. Do I need to record this Power of Attorney?

    It depends on what the Power of Attorney form directs the Attorney in Fact to do on your behalf. For example, you must record the Power of Attorney if the document directs the Attorney in Fact to transfer real property. (See A.R.S. §§ 33-411 through 33-423 – Conveyances and Deeds – Recording)

    Generally, other types of Power of Attorney forms do not need to be recorded. Recordation is the act of entering a document with the county's recorder's office. The act of recording a Power of Attorney makes it a public record and enables those who rely on its existence (banks, contractors, attorneys) to easily verify your document. Also, if your Power of Attorney is lost or destroyed, the recorded document enables the Attorney in Fact to prove that s/he was actually appointed and has the authority to act as your agent.

17. What do I do with the Power of Attorney after I complete it?

    The Power of Attorney does not need to be filed with the Court. Each person who is made your Agent should keep the original of his or her Power of Attorney form in a convenient place so that it can be located easily when needed. Many people will want to see the original Power of Attorney before permitting your Attorney-in-Fact to act on your behalf. At times, a copy of the Power of Attorney may be requested in connection with a particular transaction, but the Agent should never release the original. Please see #16 for information on recording the Power of Attorney.

Triage Cancer Estate Planning Toolkit

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Part III: Your State's Estate Planning Forms

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Advance Health Care Directive

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:

Health Current
AZ Healthcare Directives Registry
3877 N. 7th Street Suite 150
Phoenix AZ 85014
OR
Email: info@azhdr.org
OR
Fax: 602-264-8823

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

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

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

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
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

Signature of person completing this agreement	Date
Printed Name	

AD0002

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, Clergyperson 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/

- **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)*

You can mail, email or fax copies of the documents and the registration form to Health Current. The information to send the documents to is on the cover of this packet and below.

Health Current - AZ Healthcare Directives Registry
3877 N. 7th Street Suite 150
Phoenix AZ 85014
OR
Email: info@azhdr.org OR Fax: 602-264-8823

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.

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, adding, or revoking 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**

  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 and search Area Agency on Aging for locations.

- **Elder Law Hotline**
  - **1-800-231-5441**

  Free legal advice, information, and referrals provided o 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:

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. 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. 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. 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: _____

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Physician Orders for Life Sustaining Treatment (POLST)

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.

Pick 1

☐ **Full Treatments (required if choose CPR in Section A).** Goal: Attempt to sustain life by all medically effective means. Provide appropriate medical and surgical treatments as indicated to attempt to prolong life, including intensive care.

☐ **Selective Treatments.** Goal: Attempt to restore function while avoiding intensive care and resuscitation efforts (ventilator, defibrillation and cardioversion). May use non-invasive positive airway pressure, antibiotics and IV fluids as indicated. Avoid intensive care. Transfer to hospital if treatment needs cannot be met in current location.

☐ **Comfort-focused Treatments.** Goal: Maximize comfort through symptom management; allow natural death. Use oxygen, suction and manual treatment of airway obstruction as needed for comfort. Avoid treatments listed in full or select treatments unless consistent with comfort goal. Transfer to hospital **only** if comfort cannot be achieved in current setting.

C. Additional Orders or Instructions. These orders are in addition to those above (e.g., blood products, dialysis).
[EMS protocols may limit emergency responder ability to act on orders in this section.]

D. Medically Assisted Nutrition (Offer food by mouth if desired by patient, safe and tolerated)

Pick 1

☐ Provide feeding through new or existing surgically-placed tubes ☐ No artificial means of nutrition desired

☐ Trial period for artificial nutrition but no surgically-placed tubes ☐ Discussed but no decision made (standard of care provided)

E. SIGNATURE: Patient or Patient Representative (eSigned documents are valid)

I understand this form is voluntary. I have discussed my treatment options and goals of care with my provider. If signing as the patient's representative, the treatments are consistent with the patient's known wishes and in their best interest.

✖ (required)

If other than patient, print full name: | **Authority:**

The most recently completed valid POLST form supersedes all previously completed POLST forms.

F. SIGNATURE: Health Care Provider (eSigned documents are valid) Verbal orders are acceptable with follow up signature.

I have discussed this order with the patient or his/her representative. The orders reflect the patient's known wishes, to the best of my knowledge. [Note: Only licensed health care providers authorized by law to sign POLST form in state where completed may sign this order]

✖ (required) | **Date** (mm/dd/yyyy): Required / / | **Phone #:** ( )

Printed Full Name: | **License/Cert. #:**

Supervising physician signature: ☒ N/A | **License #:**

A copied, faxed or electronic version of this form is a legal and valid medical order. This form does not expire. 2019

Patient Full Name:

Contact Information (Optional but helpful)

Patient's Emergency Contact. (Note: Listing a person here does **not** grant them authority to be a legal representative. Only an advance directive or state law can grant that authority.)

Full Name:	☐ Legal Representative ☐ Other emergency contact	Phone #: Day: ( ) Night: ( )
Primary Care Provider Name:		Phone: ( )
☐ Patient is enrolled in hospice	Name of Agency: Agency Phone: ( )	

Form Completion Information (Optional but helpful)

Reviewed patient's advance directive to confirm no conflict with POLST orders: (A POLST form does not replace an advance directive or living will)	☐ Yes; date of the document reviewed:_____ ☐ Conflict exists, notified patient (if patient lacks capacity, noted in chart) ☐ Advance directive not available ☐ No advance directive exists

Check everyone who participated in discussion: ☐ Patient with decision-making capacity ☐ Court Appointed Guardian ☐ Parent of Minor ☐ Legal Surrogate / Health Care Agent ☐ Other: _____

Professional Assisting Health Care Provider w/ Form Completion (if applicable): Full Name:	Date (mm/dd/yyyy): / /	Phone #: ( )

This individual is the patient's: ☐ Social Worker ☐ Nurse ☐ Clergy ☐ Other:

Form Information & Instructions

- **Completing a POLST form**:
  - Provider should document basis for this form in the patient's medical record notes.
  - Patient representative is determined by applicable state law and, in accordance with state law, may be able to execute or to void this POLST form only if the patient lacks decision-making capacity.
  - Only licensed health care providers authorized to sign POLST forms in their state or D.C. can sign this form. See www.polst.org/state-signature-requirements-pdf for who is authorized in each state and D.C.
  - Original (if available) is given to patient; provider keeps a copy in medical record.
  - Last 4 digits of SSN are optional but can help identify / match a patient to their form.
  - If a translated POLST form is used during conversation, attach the translation to the signed English form.
- **Using a POLST form:**
  - Any incomplete section of POLST creates no presumption about patient's preferences for treatment. Provide standard of care.
  - No defibrillator (including automated external defibrillators) or chest compressions should be used if "No CPR" is chosen.
  - For all options, use medication by any appropriate route, positioning, wound care and other measures to relieve pain and suffering.
- **Reviewing a POLST form:** This form does not expire but should be reviewed whenever the patient:
  (1) is transferred from one care setting or level to another;
  (2) has a substantial change in health status;
  (3) changes primary provider; or
  (4) changes his/her treatment preferences or goals of care.
- **Modifying a POLST form:** This form cannot be modified. If changes are needed, void form and complete a new POLST form.
- **Voiding a POLST form:**
  - **If a patient or patient representative (for patients lacking capacity) wants to void the form**: destroy paper form and contact patient's health care provider to void orders in patient's medical record (and POLST registry, if applicable). State law may limit patient representative authority to void.
  - **For health care providers**: destroy patient copy (if possible), note in patient record form is voided and notify registries (if applicable).
- **Additional Forms.** Can be obtained by going to www.polst.org/form
- As permitted by law, this form may be added to a secure electronic registry so health care providers can find it.

Arizona Contact Information: Arizona Hospital & Healthcare Association – state lead AzPOLST.org 602-445-4300	For Barcodes / ID Sticker

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Funeral Designation Form

ARIZONA

POWER OF ATTORNEY FOR DISPOSITION OF MY BODY AFTER DEATH

Authorized by Arizona Statute 36-3221
form created 2013

I, _____, being 18 years of age or older and of sound mind, direct that _____ shall have the sole legal right to direct the disposition of my body after death. This power shall include all legal forms of disposition, including but not limited to burial, cremation, anatomical donation, and autopsy. This power of attorney supersedes any other claim by any other person, related to me or not, to direct the disposition of my body.

I ____have attached directions or guidelines for the disposition of my body which I direct my power of attorney to carry out

I____have **NOT** attached directions. I leave these decisions to my power of attorney.

_____ _____
(signature) (date)

WITNESSES

As Arizona law requires, the witnesses below are **not:**

- a person designated to make medical or body disposition decisions for me
- a person directly involved in providing me healthcare at the time this power of attorney is witnessed

If only one witness signs this power of attorney, that person is **not:**

- related to me by blood, marriage or adoption. This person is not entitled to any part of my estate by will or by operation of law at the time that the power of attorney is executed.

_____ _____
(signature of witness one) (date)

_____ _____
(signature of witness two) (date)

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HIPAA Authorization Form

Sample HIPAA Right of Access Form for Family Member/Friend

I, _____, direct my health care and medical services providers and payers to disclose and release my protected health information described below to:

Name: *Relationship:*

_____ _____

Contact information: _____

_____

Health Information to be disclosed upon the request of the person named above -- (Check either A or B):

- ☐ A. **Disclose** my complete health record (including but not limited to diagnoses, lab tests, prognosis, treatment, and billing, for all conditions) **OR**
- ☐ B. **Disclose** my health record, as above, **BUT do not disclose** the following (check as appropriate):
  - ☐ Mental health records
  - ☐ Communicable diseases (including HIV and AIDS)
  - ☐ Alcohol/drug abuse treatment
  - ☐ Other (please specify):

    _____
    _____

Form of Disclosure (unless another format is mutually agreed upon between my provider and designee):

- ☐ An electronic record or access through an online portal
- ☐ Hard copy

This authorization shall be effective until (Check one):

- ☐ All past, present, and future periods, OR
- ☐ Date or event:_____

unless I revoke it. (NOTE: You may revoke this authorization in writing at any time by notifying your health care providers, preferably in writing.)

_____ _____
Name of the Individual Giving this Authorization Date of birth

_____ _____
Signature of the Individual Giving this Authorization Date

Note: HIPAA Authority for Right of Access: 45 C.F.R. § 164.524