Triage Cancer Estate Planning Toolkit: Ohio

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.

Ohio probate courts accept written, holographic and oral wills. To make a valid written will in Ohio:

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)
    - Free from coercion or outside pressure
2. You need to sign the will, in front of two witnesses who are not benefitting from your will and watched you sign the will.

Ohio does not recognize "self-proving" wills, so witnesses must be available to verify your will in probate court.

Due to the COVID-19 pandemic, Ohio now allows you to execute your will remotely (e.g. witness the signing of a will by teleconferencing). 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 Ohio:

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)
    - Free from coercion or outside pressure
2. Your will must be written entirely in your handwriting and you must sign it and have it witnessed by two witnesses.

To make a valid oral will in Ohio, you must be in "last sickness," or approaching death due to illness. To create an oral will:

1. Declare that this statement is your will in front of two witnesses not included in your will
2. One witness should write down your will within 10 days of your declaration
3. Submit the will for probate within three months after your death

While oral and holographic wills are better than no will at all, experts recommend you make a written will if you can, to reduce potential problems 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.

In Ohio, the statutory form for power of attorney allows you to appoint someone to manage your finances, including assets like your property, taxes, and government benefits. You can also appoint a successor agent, and a second successor agent, in case the first person you choose cannot be your agent. This person can make all financial decisions for you, or you can limit their powers to specific areas, like filing taxes or banking. Unless you indicate otherwise in the "special instructions" section, your agent is entitled to reasonable compensation for their help. This document goes into effect when you sign it, unless you specify otherwise in the "special instructions" section. After that point, this document will remain in effect until you die, unless you revoke your power of attorney.

Part III of this toolkit includes a sample form.

State Laws About Advance Health Care Directives

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 communicate. In Ohio, this document includes three parts.

1. **Durable Power of Attorney for Health Care:** You can choose someone (your "agent") to make health care decisions for you (including decisions about life-sustaining care) any time your doctor determines that you cannot make them yourself. You can appoint an alternate person to make these decisions if the first person you chose isn't available. This section also allows you to express your preferences for advance planning decisions to help guide your agent, and limit their powers in certain situation (e.g., authority for mental health decisions).
2. **Ohio Living Will Declaration:** You can express your preferences for life-sustaining procedures (including medically assisted nutrition and pain management) if you develop a terminal condition and can no longer make your own health care decisions.
3. **Organ Donation Form:** You can register your organ donation instructions.

You need to sign your advance health care directive to make it legal, and have your signature witnessed by a notary public and two witnesses. Your witnesses must be at least 18 years old, and cannot be:

- Related to you
- Your agent
- Your doctor
- The administrator of your residential nursing home

Your advance health care directive takes effect when your doctor determines you can no longer make or communicate your health care decisions.

You can revoke your advance health care directive in any way you are able to communicate this decision (e.g., destroying the document or telling your doctor).

Part III of this toolkit includes a sample advance health care directive.

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.

Ohio does not yet offer a POLST form. However, the state does offer a do not resuscitate order (DNR). A DNR order is a document written by a physician that tells medical professionals not to resuscitate an individual who goes into

cardiac or respiratory distress. A DNR order may allow natural death for someone whose heart is not beating or who is not breathing. For this reason, the order is sometimes called an "allow natural death" order.

Part III of this toolkit includes a sample Ohio DNR form.

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.

In Ohio, has a form called **Ohio Appointment of Representative for Disposition of Bodily Remains, Funeral Arrangements, and Burial or Cremation Goods and Services**. You can appoint a representative (and a successor representative) to organize your funeral arrangements and the disposal of your remains, and you can provide instructions to guide them in making these decisions.

Part III of this toolkit includes a sample form.

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.

Ohio does not have a death with dignity law.

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.

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Part III: Your State's Estate Planning Forms

- Power of Attorney for Financial Affairs
- Advanced Health Care Directive
- Do Not Resuscitate Order (DNR)
- Ohio Appointment of Representative for Disposition of Bodily Remains, Funeral Arrangements, and Burial or Cremation Goods and Services
- HIPAA Authorization Form

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Power of Attorney for Financial Affairs

OHIO
STATUTORY FORM POWER OF ATTORNEY

IMPORTANT INFORMATION

This power of attorney authorizes another person (your agent) to make decisions concerning your property for you (the principal). Your agent will be able to make decisions and act with respect to your property (including your money) whether or not you are able to act for yourself. The meaning of authority over subjects listed on this form is explained in the Uniform Power of Attorney Act (sections 1337.21 to 1337.64 of the Revised Code).

This power of attorney does not authorize the agent to make health-care decisions for you.

You should select someone you trust to serve as your agent. Unless you specify otherwise, generally the agent's authority will continue until you die or revoke the power of attorney or the agent resigns or is unable to act for you.

Your agent is entitled to reasonable compensation unless you state otherwise in the Special Instructions.

This form provides for designation of one agent. If you wish to name more than one agent you may name a coagent in the Special Instructions. Coagents are not required to act together unless you include that requirement in the Special Instructions.

If your agent is unable or unwilling to act for you, your power of attorney will end unless you have named a successor agent. You may also name a second successor agent.

This power of attorney becomes effective immediately unless you state otherwise in the Special Instructions.

ACTIONS REQUIRING EXPRESS AUTHORITY

Unless expressly authorized and initialed by me in the Special Instructions, this power of attorney does not grant authority to my agent to do any of the following:

(1) Create a trust;
(2) Amend, revoke, or terminate an inter vivos trust, even if specific authority to do so is granted to the agent in the trust agreement;
(3) Make a gift;
(4) Create or change rights of survivorship;
(5) Create or change a beneficiary designation;
(6) Delegate authority granted under the power of attorney;
(7) Waive the principal's right to be a beneficiary of a joint and survivor annuity including a survivor benefit under a retirement plan;
(8) Exercise fiduciary powers that the principal has authority to delegate.

CAUTION: Granting any of the above eight powers will give your agent the authority to take actions that could significantly reduce your property or change how your property is distributed at your death.

If you have questions about the power of attorney or the authority you are granting to your agent, you should seek legal advice before signing this form.

DESIGNATION OF AGENT

I _____ (Name of Principal) name the following person as my agent:

_____

Name of Agent

_____

Agent's Address

_____

Agent's Telephone Number

DESIGNATION OF SUCCESSOR AGENT(S) (OPTIONAL)

If my agent is unable or unwilling to act for me, I name as my successor agent:

_____

Name of Successor Agent

_____

Successor Agent's Address

_____

Successor Agent's Telephone Number

If my successor agent is unable or unwilling to act for me, I name as my second successor agent:

_____

Name of Second Successor Agent

_____

Second Successor Agent's Address

_____

Second Successor Agent's Telephone Number

GRANT OF GENERAL AUTHORITY

I grant my agent and any successor agent general authority to act for me with respect to the following subjects as defined in the Uniform Power of Attorney Act (sections 1337.21 to 1337.64 of the Revised Code):

(INITIAL each subject you want to include in the agent's general authority. If you wish to grant general authority over all of the subjects you may initial "All Preceding Subjects" instead of initialing each subject.)

(_____) Real Property
(_____) Tangible Personal Property
(_____) Stocks and Bonds
(_____) Commodities and Options
(_____) Banks and Other Financial Institutions
(_____) Operation of Entity or Business
(_____) Insurance and Annuities
(_____) Estates, Trusts, and Other Beneficial Interests
(_____) Claims and Litigation
(_____) Personal and Family Maintenance

(_____) Benefits from Governmental Programs or Civil or Military Service

(_____) Retirement Plans

(_____) Taxes

(_____) Digital Assets

(_____) All Preceding Subjects

(_____) My agent shall have access to the content of electronic communications sent or received by me.

LIMITATION ON AGENT'S AUTHORITY

An agent that is not my ancestor, spouse, or descendant MAY NOT use my property to benefit the agent or a person to whom the agent owes an obligation of support unless I have included that authority in the Special Instructions.

SPECIAL INSTRUCTIONS (OPTIONAL)

You may give special instructions on the following lines:

_____

_____

_____

_____

_____

_____

EFFECTIVE DATE

This power of attorney is effective immediately unless I have stated otherwise in the Special Instructions.

NOMINATION OF GUARDIAN (OPTIONAL)

If it becomes necessary for a court to appoint a guardian of my estate or my person, I nominate the following person(s) for appointment:

_____

Name of Nominee for Guardian of my Estate

_____

Nominee's Address

_____

Nominee's Telephone Number

_____

Name of Nominee for Guardian of my Person

_____

Nominee's Address

_____

Nominee's Telephone Number

RELIANCE ON THIS POWER OF ATTORNEY

Any person, including my agent, may rely upon the validity of this power of attorney or a copy of it unless that person knows it has terminated or is invalid.

SIGNATURE AND ACKNOWLEDGMENT

_____ _____

Your Signature Date

_____

Your Name Printed

_____

Your Address

_____

Your Telephone Number

State of Ohio
County of_____

This document was acknowledged before me on _____ _____, _____ (Date), by _____ (Name of Principal).

_____

Notary

My commission expires: _____

This document prepared by: _____

IMPORTANT INFORMATION FOR AGENT

Agent's Duties

When you accept the authority granted under this power of attorney, a special legal relationship is created between you and the principal. This relationship imposes upon you legal duties that continue until you resign or the power of attorney is terminated or revoked. You must:

(1) Do what you know the principal reasonably expects you to do with the principal's property or, if you do not know the principal's expectations, act in the principal's best interest;
(2) Act in good faith;
(3) Do nothing beyond the authority granted in this power of attorney;
(4) Attempt to preserve the principal's estate plan if you know the plan and preserving the plan is consistent with the principal's best interest;
(5) Disclose your identity as an agent whenever you act for the principal by writing or printing the name of the principal and signing your own name as "agent" in the following manner:

(Principal Name) by (Agent's Name) as Agent

Unless the Special Instructions in this power of attorney state otherwise, you must also:

(1) Act loyally for the principal's benefit;
(2) Avoid conflicts that would impair your ability to act in the principal's best interest;
(3) Act with care, competence, and diligence;
(4) Keep a record of all receipts, disbursements, and transactions made on behalf of the principal;
(5) Cooperate with any person that has authority to make health-care decisions for the principal to do what you know the principal reasonably expects or, if you do not know the principal's expectations, to act in the principal's best interest.

Termination of Agent's Authority

You must stop acting on behalf of the principal if you learn of any event that terminates this power of attorney or your authority under this power of attorney. Events that terminate a power of attorney or your authority to act under a power of attorney include:

(1) The death of the principal;
(2) The principal's revocation of the power of attorney or your authority;
(3) The occurrence of a termination event stated in the power of attorney;
(4) The purpose of the power of attorney is fully accomplished;
(5) If you are married to the principal, a legal action is filed with a court to end your marriage, or for your legal separation, unless the Special Instructions in this power of attorney state that such an action will not terminate your authority.

Liability of Agent

The meaning of the authority granted to you is defined in the Uniform Power of Attorney Act (sections 1337.21 to 1337.64 of the Revised Code). If you violate the Uniform Power of Attorney Act or act outside the authority granted, you may be liable for any damages caused by your violation.

If there is anything about this document or your duties that you do not understand, you should seek legal advice.

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Advance Health Care Directive

Choices

Living Well at the End of Life

Advance Directives Packet

Eighth Edition

LeadingAge Ohio expresses deep appreciation and gratitude for the cooperation of the Ohio State Medical Association, the Ohio Hospital Association and the Ohio Osteopathic Association for their efforts in the development and distribution of this Advance Directives Packet: Choices, Living Well at the End of Life. We also thank the Ohio State Bar Association for providing the legal language for the Living Will and Health Care Power of Attorney forms. The packet includes information regarding Hospice and Do-Not-Resuscitate Orders, a Donor Registry Enrollment Form and one copy each of Ohio's Living Will and Health Care Power of Attorney forms. The Living Will and Health Care Power of Attorney forms conform with the requirements of Ohio's Advance Directive laws, as amended effective March 2014.

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www.LeadingAgeOhio.org

Ohio State Medical Association

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Ohio Hospital Association
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Ohio Osteopathic Association
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Columbus, Ohio 43201-0130

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LeadingAge Ohio

Ohio State Medical Association
The power of many. The voice of one.®

Ohio Hospital Association

Ohio Osteopathic Association

Introduction

Today, advances in medicine and medical technology save many lives that only 60 years ago might have been lost. Unfortunately, sometimes this same technology also artificially prolongs life for people who have no reasonable hope of recovery.

Death and dying are inescapable realities of life. Armed with the information and forms in this packet, the goal is to provide you with the information you need to document your future health care decisions and take control of many choices regarding your medical future.

It is important to understand what Ohio's laws allow or do not allow in regards to expressing your desires, goals and wishes by using tools such as Ohio's Advance Directives. This packet is meant to educate you about Ohio's Living Will; Health Care Power of Attorney; Anatomical Gifts; and Do Not Resuscitate laws.

In 1991, Ohio recognized your right to have a Living Will. Ohio's other recognized advance directive at that time was the Health Care Power of Attorney. In 1998, Ohio recognized yet another tool to help you and your physician with effective health care planning called a DNR (Do-Not-Resuscitate) Order.

The Living Will allows you to decide and document, in advance, the type of care you would like to receive if you were to become permanently unconscious or terminally ill and unable to communicate. The Health Care Power of Attorney enables you to select someone to make decisions for you.

A person who does not wish to have Cardiopulmonary Resuscitation (CPR) performed may make this wish known through a doctor's order called a DNR Order. A DNR Order addresses the various methods used to revive people whose hearts have stopped (cardiac arrest) or people who have stopped breathing (respiratory arrest). This physician order allows emergency medical workers and health care providers to honor individual wishes about resuscitation inside or outside a hospital, nursing home, home or various other settings.

In contrast, if you choose, you can fill out the Living Will or Health Care Power of Attorney forms without the assistance of a lawyer. However, since these are important legal documents, you may wish to consult a lawyer for advice.

In addition to the Living Will and Health Care Power of Attorney forms, you will find a copy of the Donor Registry Enrollment Form in this packet. Also included in this packet is information on hospice care and end of life issues and options. The last page offers a convenient wallet card that will provide important information to your health care provider.

The elements involved in drafting or determining one's wishes regarding Advance Directives are very important. After reviewing the contents of this packet, you may have additional questions or concerns specific to your personal situation. In such case, it may be important that you discuss your decisions with your family, your clergy, your physician and/or your lawyer.

Your Questions **Answered**

"Living Will and Health Care Power of Attorney"

Q: Who should complete a Living Will or Health Care Power of Attorney?

A: Serious illness or injury can strike at any stage of life, so it is important for anyone over age eighteen to think about filling out these documents. A Living Will or Health Care Power of Attorney will help to ensure that your wishes regarding life-sustaining treatment are followed regardless of your age.

Q: Can I indicate that I wish to donate my organs after death through a Living Will or Health Care Power of Attorney?

A: Ohio's Living Will no longer includes a section to indicate preferences for organ donation. Within this brochure are instructions and a standardized form to register your wishes regarding organ and tissue donation with theBureau of Motor Vehicles. This is the most appropriate way to document your wishes if you want to be a donor. This form should be filed with the Bureau of Motor Vehicles.

Q: If I state in my Living Will that I don't want to be hooked up to life support equipment, will I still be given medication for pain?

A: Yes. A Living Will affects only care that artificially or technologically postpones death. It does not affect care that eases pain. You would continue to be given pain medication and other treatments necessary to keep you comfortable. The same is true with a Health Care Power of Attorney. The person you name to make your health care decisions may not refuse treatments that alleviate pain.

Q: Which is better to have, a Living Will or a Health Care Power of Attorney?

A: It is a good idea to fill out both documents because they address different aspects of your medical care. A Living Will applies only when you are terminally ill and unable to communicate your healthcare wishes or are permanently unconscious. In both cases, if you have indicated that you do not want your dying to be artificially prolonged and two physicians determine that there is no reasonable hope of recovery, your wishes will be honored.

A Health Care Power of Attorney becomes effective even if you are only temporarily unconscious and medical decisions need to be made. For example, if you were to become temporarily unconscious due to an accident or surgery, the person you name in your Health Care Power of Attorney could make medical decisions on your behalf.

If you have both documents and become terminally ill and unable to communicate or become permanently unconscious, the Living Will would be followed since it identifies your wishes in these situations.

Q: Can I draft a Living Will or Health Care Power of Attorney that says if I become critically ill, I want everything possible done to keep me alive?

A: Yes, but you would need to speak with an attorney about drafting a document expressing those wishes rather than using the standard forms in this packet. You should also discuss your wishes with your personal physician.

Q. If I name someone in my Health Care Power of Attorney to make decisions for me, how much authority does that person have?

A. The person you name as your attorney-in-fact has the authority to make decisions regarding aspects of your medical care if you become unable to express your wishes. For this reason, you should tell the person you name how you feel about life-sustaining treatment, being fed through feeding or fluid tubes, and other important issues.

Also it is important to remember that a Health Care Power of Attorney document is not the same as a Financial Power of Attorney document, which you might use to give someone authority over your financial or business affairs.

Q. If my condition becomes hopeless, can I specify that I want my feeding and fluid tubes removed?

A. Special instructions are needed to allow for the removal of feeding or fluid tubes if you become permanently unconscious and if the feeding and fluid tubes aren't needed to provide you with comfort. If you want to make certain that the tubes are removed should you become permanently unconscious, you need to place your initials on the space provided on the Living Will or Health Care Power of Attorney form. If you don't want the tubes removed when you are permanently unconscious, don't initial the forms.

Q. If I want to complete a Health Care Power of Attorney, do I also have to nominate a Guardian of my Person and Estate?

A. In 2014, the Ohio Health Care Power of Attorney was expanded to allow you to nominate a guardian to your person and a guardian to your estate. In Ohio, guardianship is typically pursued when a person becomes incompetent, such as with advanced dementia, and there is no family member or significant other willing to undertake the responsibility to advocate for that person. In some cases, guardianship may also be pursued if there is conflict between responsible family members. By nominating a guardian in the Health Care Power of Attorney, you would communicate your preferences to the probate court to consider your preferences, should a guardianship process ever begin. However, you are not required to complete this section if you do not wish to. If you prefer not to nominate a guardian, simply draw a large "X" over this section of the form.

Q. Do I have to use the standard forms for a Living Will or Health Care Power of Attorney or can I draw up my own documents?

A. The enclosed forms were produced jointly by the Ohio State Bar Association, the Ohio State Medical Association, the Ohio Hospital Association, Ohio Osteopathic Association and the Midwest Care Alliance. They comply with the requirements of Ohio law, but you do not have to use these forms. You may wish to consult an attorney for assistance in drafting a document or you may draft your own. In either case, the documents must comply with the specific language spelled out in the Ohio Revised Code.

Q. Can I use Advance Directive or DNR orders from states for healthcare decisions in Ohio?

A. Advance directives and health care decision forms vary from state to state. For example, some states may recognize Five Wishes (www.Fivewishes.org) or a POLST form (Physician's Orders for Life-Sustaining Treatment/www.polst.org). Under Ohio law, health care providers should attempt to honor any advance directive presented to them. However, it is strongly recommended that if you spend any regular amount of time in Ohio, that you complete Ohio's advance directives in accordance with Ohio law.

Ohio's Health Care Power of Attorney

What you should know about a Health Care Power of Attorney:

A **Health Care Power of Attorney** is a document that allows you to name a person to act on your behalf to make health care decisions for you if you become unable to make them for yourself. **This person becomes an attorney-in-fact for you.**

The Health Care Power of Attorney also allows you to nominate a guardian to your person and a guardian of your estate. Nomination does not guarantee that this individual will be appointed to be your guardian. Instead, it provides an opportunity for individuals to express their preferences for guardianship which can be taken into account should the issue ever be brought to probate court.

If you have a **Health Care Power of Attorney** and a **Living Will**, health care workers must follow the wishes you state in your **Living Will**, once the **Living Will** becomes effective. In other words, your **Living Will** takes precedence over your **Health Care Power of Attorney**.

You can change your mind and revoke your **Health Care Power of Attorney** at any time. You can do this simply by telling your attorney-in-fact, your physician and your family that you have changed your mind and wish to revoke your **Health Care Power of Attorney**. In this case, it is a good idea to ask for a copy of the document back from anyone to whom you may have given it.

A Healthcare Power of Attorney is different from a Financial Power of Attorney that you use to give someone authority over your financial matters.

The person you appoint as your **attorney-in-fact**, by completing the **Health Care Power of Attorney** form, has the power to authorize and refuse medical treatment for you. **This authority is recognized in all medical situations when you are unable to express your own wishes**. Unlike a **Living Will**, it is not limited to situations in which you are terminally ill or permanently unconscious. For example, your physician or the hospital may consult with your attorney-in-fact should you be injured in a car accident and become temporarily unconscious. You may also choose to allow protected health care information to be shared with your attorney-in-fact immediately, by initialing the appropriate box in the document.

There are **five limitations** on the authority of your attorney-in-fact:

1. **An attorney-in-fact has limited authority to order that life-sustaining treatment be withdrawn from you.** Your attorney-in-fact may order that life-sustaining treatment be refused or withdrawn only if you have a terminal condition or if you are in a permanently unconscious state. And even then, the attending physician and, if applicable, the consulting physician, must confirm that diagnosis, and your attending physician(s) must determine that you have no reasonable possibility of regaining decision-making ability.

2. **Your attorney-in-fact does not have the authority to order the withdrawal of "comfort care."** Comfort care is any type of medical or nursing care that would provide you with comfort or relief from pain.

3. **If you are pregnant, your attorney-in-fact cannot order the withdrawal of life-sustaining treatment unless certain conditions are met.** Life-sustaining treatment cannot be withdrawn if doing so would terminate the pregnancy unless there is substantial risk to your life or two physicians determine that the fetus would not be born alive.

4. **Your attorney-in-fact may order that nutrition and hydration be withdrawn only if you are in a terminal condition or permanently unconscious state and two physicians agree that nutrition and hydration will no longer provide comfort or alleviate pain.** If you want to give your attorney-in-fact the authority to withhold nutrition and hydration if you were to become permanently unconscious, you must indicate this in the appropriate section of the **Health Care Power of Attorney** form. If you also have a **Living Will**, it should be consistent with your **Health Care Power of Attorney** regarding the withholding of nutrition and hydration. In other words, if you indicate in your **Health Care Power of Attorney** that it is permissible for your attorney-in-fact to order that nutrition and hydration be withheld, then you also should indicate in your **Living Will** that it is permissible for your physician to withhold nutrition and hydration.

5. **If you previously have given consent for treatment (before becoming unable to communicate), your attorney-in-fact cannot withdraw your consent unless certain conditions are met.** Either your physical condition must have changed and/or the treatment you approved is no longer of benefit or the treatment has not been proven effective.

How to fill out the Health Care Power of Attorney form:

You should use this form to appoint someone to make health care decisions for you if you should become unable to make them for yourself.

NOTE: The section titled NOTICE TO ADULT EXECUTING THIS DOCUMENT is required by law to be part of the document and must accompany it and any copies distributed.

1.Read over all information carefully. You may reference the definitions found on pages one and two of the twelve-page State of Ohio Health Care Power of Attorney form located in this booklet for further clarification.

2. On the first two lines of the form, print your full name and birth date.

3. Under, "Naming of My Agent," fill in the name of the person you are appointing as your attorney-in-fact, the agent's current address and telephone number. Immediately following, you may initial the box if you wish for your agent to immediately have access to your protected health care information (PHI). If you choose not to initial this box, your agent will only have access to your protected health care information in the event that you are incapacitated and the Health Care Power of Attorney is activated.

4. In the middle of the third page, you may name alternate agents on the indicated spaces; if you choose not to name alternate agents, you should cross out the unused lines. You may not name your attending physician or the administrator of any nursing home where you are receiving care as your attorney-in-fact.

5. On page five of the Health Care Power of Attorney form, written in bold face type under ***Special Instructions***, is the statement that will give your physician permission to withhold food and water in the event you are permanently unconscious. If you want to give your physician permission to withhold food and water in this situation, then you must place your initials in the box indicated.

6. On page five at the bottom, the form provides a section where you may write additional instructions and impose additional limitations that you may consider appropriate to document. You may attach additional pages if needed. You should include all attached pages with any copy(ies) you make and you should note the attached pages on the form itself in the related area.

7. On page six, there is an explanation of the nomination of guardianship. If you wish to nominate the same individual whom you named as agent to also serve as your guardian of person, place your initials in the indicated box and cross out the unused lines. If you wish to nominate a different individual to serve as guardian of your person, write the name, address and relationship to you on the line indicated.

8. On page seven, you may nominate an individual to serve as guardian of your estate. If you wish to nominate the same individual whom you named as agent to also serve as your guardian of estate, place your initials in the indicated box and cross out the unused lines. If you wish to nominate a different individual to serve as guardian of your estate, write the name, address and relationship to you on the line indicated. Below, please indicate whether you would prefer the individual nominated to serve as guardian off your estate be bonded, or if you would prefer any bond be waived by placing your initials in the appropriate box.

9. Following the nomination of guardians is a section where you indicate whether or not you have a **Living Will**.

10. On page eight, there are spaces to date and sign the form. Remember, the **Health Care Power of Attorney** is not considered valid or effective unless you do one of the following:

    First Option (Page 9) – Date and sign the **Health Care Power of Attorney** in the presence of two witnesses, who also must sign and include their addresses and indicate the date of their signatures.

    OR

    Second Option (Page 9) – Date and sign the **Health Care Power of Attorney** in the presence of a notary public and have the **Health Care Power of Attorney** notarized on the appropriate space provided on the form.

The following people may **not** serve as a witness to your **Health Care Power of Attorney**:

- *Primary agent;*
- *Guardian of your Person or Estate;*
- *Alternate or successor agent or guardian;*
- *Anyone related to you by blood, marriage, or adoption (your spouse and children);*
- *Your attending physician;*
- *The administrator of nursing home where you are receiving care.*

Ohio's Guardianship

DEFINITIONS

***Principal*:** (also known as Declarant) is the Competent Adult who completes any advance directive like a Power of Attorney, a Health Care Power of Attorney, Living Will or other document.

***Agent*:** (also known as an Attorney in fact) is the person that the Principal names in the advance directive.

***Guardian*:** is the person that the Probate Court names to act for the Superior Guardian which is the court. The person serves at the direction of the Probate Court and is answerable to that Court.

NAMING VS NOMINATING

There are many differences between a Principal **naming** an Agent to act for him/her if necessary and a Principal **nominating** an individual to be his/her guardian.

Naming an Agent through an advance directive, such as a Power of Attorney, Health Care Power of Attorney or a Living Will, is completed by a Principal who is a COMPETENT ADULT. Completing this naming occurs before the need arises for the Agent to act and is done solely at the discretion and desire of the Principal. The Agent usually takes over decision making when the Principal becomes incapable of making decisions.

Nominating a person to become the guardian of the person, the estate or both is also completed by a Principal who is a competent adult. This occurs through an advance directive before the need arises for a guardian. However, nominating a person to become guardian if one is needed does not *automatically* mean the nominated person will become the guardian.

The actual **naming** of a guardian of the person, the estate or both is done solely by a Probate Court in Ohio after the Principal becomes incompetent. **Nominating** a person to become the guardian in any advance Directive is the means by which the Principal communicates to the Probate Court whom the Principal wishes to be appointment by the Court as guardian. Nominating a person to become the guardian does not insure that the Court will name that person. There are numerous factors which the court must examine in making its decision and it is totally up to the court who it names as guardian.

To begin the process of seeking a guardianship, the nominated person must first make a written application to the Court to become the guardian. The Court will make three (3) decisions:

1. Is the Principal legally incompetent;
2. Is it necessary that a guardianship be established in place of any other written document such as a Health Care Power of Attorney; and
3. Is the applicant a suitable and competent person whom the court desired to name as guardian?

FREQUENTLY ASKED QUESTIONS

Q: What is the difference between an Agent and a guardian?

A: An agent is named by the competent Principal and has no oversight by any other person or agency once the Principal becomes incapable of making decisions. A guardian is named by the Probate Court after it determines that the principal is incompetent and the Court provides oversight as the Court is the superior guardian.

Q: I have always heard that if I name someone to be my Agent, there will not ever be a need for a guardianship to be established through the court.

A: One of the reasons to name an Agent in an Advance Directive is the desire to avoid guardianship. However, any number of reasons could arise which force the need for a guardianship. One example: the Principal becomes incompetent, thus precluding naming someone other than the person acting as Agent. A friend of the Principal finds out that the Agent is taking advantage of the Principal. The only way to obtain a different person to act for the incompetent Principal is to apply for guardianship through the Court so that the court can provide oversight.

Q: Are there different kinds of guardianships?

A: Depending on the needs of the Principal, there may be the necessity to name a guardian of the person, the estate, or both. A guardian of the person makes decisions concerning such items as where to live, health care, end of life, and so forth. A guardian of the estate makes decisions on how to spend the principal's money within the directions from the Court. If you are unsure what type of guardianship is necessary, you are advised to obtain legal advice.

Q: What if different people are nominated to be the guardian in different documents?

A: The principal may choose to nominate different people to be guardian of the estate and guardian of the person. The preference of the Court is to name one person to act as guardian of both but there can be solid reasons for different people to act in different capacities. On the other hand, if the nominating of a guardian is inadvertent and two people are nominated in the same capacity, both will have to make an application to the Court, and the Court will decide which of the two to choose. The Court may also choose a third applicant, not even named by the principal. It is solely within the discretion of the Court. This is why it is critical to make sure that all of your advance directives, such as a General Durable Power of Attorney, a Healthcare Power of Attorney, a Living Will, and any other written document which names someone to serve in the future, are coordinated and done with full planning. Because of the critical need to coordinate nominations of agents and guardians, it is advisable to work with an attorney for this consistency.

Q: What if the Court names a different guardian that the Principal selected as an Agent through one of the written advance directives?

A: During the process of the court's naming a guardian, all written advance directive documents must be given to the court to examine. At the time of the hearing, the Court will determine what the powers of the guardian are and what if any decisions will belong to the Agent. If there is ever a disagreement between the guardian and the Agent, the Court, as the superior guardian, will determine the decision to be made. If there is a conflict at any time during the application process, it is advisable to seek legal counsel.

Q: What happens if I name an agent or nominate a person I desire to be my guardian and then change my mind?

A: A Principal can change his/her mind whom to name as the agent or guardian at any time as long as the adult is competent. The Principal may revoke any document and rename/re-nominate different people as long as the Principal is competent. Once the Principal becomes incapable of making decisions about his/her person or estate, that person cannot change any advance directive.

Q: Are there minimum or maximums required for a guardianship of the Estate?

A: This is a complex issue that should be discussed with legal counsel.

State of Ohio
Health Care Power of Attorney

[R.C. §1337]

_____

(Print Full Name)

_____

(Birth Date)

This is my Health Care Power of Attorney. I revoke all prior Health Care Powers of Attorney signed by me. I understand the nature and purpose of this document. If any provision is found to be invalid or unenforceable, it will not affect the rest of this document.

I understand that my agent can make health care decisions for me only whenever my attending physician has determined that I have lost the capacity to make informed health care decisions. However, this does not require or imply that a court must declare me incompetent.

Definitions

Adult means a person who is 18 years of age or older.

Agent or attorney-in-fact means a competent adult who a person (the "principal") can name in a Health Care Power of Attorney to make health care decisions for the principal.

Artificially or technologically supplied nutrition or hydration means food and fluids provided through intravenous or tube feedings. *[You can refuse or discontinue a feeding tube or authorize your Health Care Power of Attorney agent to refuse or discontinue artificial nutrition or hydration.]*

Bond means an insurance policy issued to protect the ward's assets from theft or loss caused bythe Guardian of the Estate's failure to properly perform his or her duties.

Comfort care means any measure, medical or nursing procedure, treatment or intervention,including nutrition and/or hydration, that is taken to diminish a patient's pain or discomfort,but not to postpone death.

CPR means cardiopulmonary resuscitation, one of several ways to start a person's breathing or heartbeat once either has stopped. It does not include clearing a person's airway for a reason other than resuscitation.

Do Not Resuscitate or DNR Order means a physician's medical order that is written into a patient's record to indicate that the patient should not receive cardiopulmonary resuscitation.

Guardian means the person appointed by a court through a legal procedure to make decisions for a ward. A **Guardianship** is established by such court appointment.

Health care means any care, treatment, service or procedure to maintain, diagnose or treat an individual's physical or mental health.

Health care decision means giving informed consent, refusing to give informed consent, or withdrawing informed consent to health care.

Health Care Power of Attorney means a legal document that lets the principal authorize an agent to make health care decisions for the principal in most health care situations when the principal can no longer make such decisions. Also, the principal can authorize the agent to gather protected health information for and on behalf of the principal immediately or at any other time. A Health Care Power of Attorney is NOT a financial power of attorney.

The Health Care Power of Attorney document also can be used to nominate person(s) to act as guardian of the principal's person or estate. Even if a court appoints a guardian for the principal, the Health Care Power of Attorney remains in effect unless the court rules otherwise.

Life-sustaining treatment means any medical procedure, treatment, intervention or other measure that, when administered to a patient, mainly prolongs the process of dying.

Living Will Declaration means a legal document that lets a competent adult ("declarant") specify what health care the declarant wants or does not want when he or she becomes terminally ill or permanently unconscious and can no longer make his or her wishes known. It is NOT and does not replace a will, which is used to appoint an executor to manage a person's estate after death.

Permanently unconscious state means an irreversible condition in which the patient is permanently unaware of himself or herself and surroundings. At least two physicians must examine the patient and agree that the patient has totally lost higher brain function and is unable to suffer or feel pain.

Principal means a competent adult who signs a Health Care Power of Attorney.

Terminal condition means an irreversible, incurable, and untreatable condition caused by disease, illness, or injury from which, to a reasonable degree of medical certainty as determined in accordance with reasonable medical standards by a principal's attending physician and one other physician who has examined the principal, both of the following apply: (1) there can be no recovery and (2) death is likely to occur within a relatively short time if life-sustaining treatment is not administered.

Ward means the person the court has determined to be incompetent. The ward's person, financial estate, or both, is protected by a guardian the court appoints and oversees.

Naming of My Agent. The person named below is my agent who will make health care decisions for me as authorized in this document.

Agent's name and relationship:_____

Address:_____

Telephone number(s): _____

☐ **By placing my initials, signature, check or other mark in this box, I specifically authorize my agent to obtain my protected health care information immediately and at any future time.**

Guidance to Agent. My agent will make health care decisions for me based on my instructions in this document and my wishes otherwise known to my agent. If my agent believes that my wishes conflict with what is in this document, this document will take precedence. If there are no instructions and if my wishes are unclear or unknown for any particular situation, my agent will determine my best interests after considering the benefits, the burdens and the risks that might result from a given decision. If no agent is available, this document will guide decisions about my health care.

Naming of alternate agent(s). If my agent named above is not immediately available or is unwilling or unable to make decisions for me, then I name, in the following order of priority, the persons listed below as my alternate agents *[cross out any unused lines]*:

X out area if not used

First alternate agent's name and relationship: _____

Address:_____

Telephone number(s):_____

Second alternate agent's name and relationship: _____

Address:_____

Telephone number(s):_____

Any person can rely on a statement by any alternate agent named above that he or she is properly acting under this document and such person does not have to make any further investigation or inquiry.

Authority of Agent. Except for those items I have crossed out and subject to any choices I have made in this Health Care Power of Attorney, my agent has full and complete authority to make all health care decisions for me. This authority includes, but is not limited to, the following:

1. To consent to the administration of pain-relieving drugs or treatment or procedures (including surgery) that my agent, upon medical advice, believes may provide comfort to me, even though such drugs, treatment or procedures may hasten my death.

2. If I am in a terminal condition and I do not have a Living Will Declaration that addresses treatment for such condition, to make decisions regarding life-sustaining treatment, including artificially or technologically supplied nutrition or hydration.

3. To give, withdraw or refuse to give informed consent to any health care procedure, treatment, interventions or other measure.

4. To request, review and receive any information, verbal or written, regarding my physical or mental condition, including, but not limited to, all my medical and health care records.

5. To consent to further disclosure of information and to disclose medical and related information concerning my condition and treatment to other persons.

6. To execute for me any releases or other documents that may be required in order to obtain medical and related information.

7. To execute consents, waivers and releases of liability for me and for my estate to all persons who comply with my agent's instructions and decisions. To indemnify and hold harmless, at my expense, any person who acts while relying on this Health Care Power of Attorney. I will be bound by such indemnity entered into by my agent.

8. To select, employ and discharge health care personnel and services providing home health care and the like.

9. To select, contract for my admission to, transfer me to or authorize my discharge from any medical or health care facility, including, but not limited to, hospitals, nursing homes, assisted living facilities, hospices, adult homes and the like.

10. To transport me or arrange for my transportation to a place where this Health Care Power of Attorney is honored, if I am in a place where the terms of this document are not enforced.

11. To complete and sign for me the following:

- Consents to health care treatment, or to the issuing of Do Not Resuscitate (DNR) Orders or other similar orders; and
- Requests to be transferred to another facility, to be discharged against health care advice, or other similar requests; and
- Any other document desirable or necessary to implement health care decisions that my agent is authorized to make pursuant to this document.

Special Instructions. [These instructions apply only if I DO NOT have an active Living Will Declaration.]

☐ **By placing my initials, signature, check or other mark in this box, I specifically authorize my agent to refuse or, if treatment has started, to withdraw consent to, the provision of artificially or technologically supplied nutrition or hydration if I am in a permanently unconscious state AND my physician and at least one other physician who has examined me have determined, to a reasonable degree of medical certainty, that artificially or technologically supplied nutrition and hydration will not provide comfort to me or relieve my pain.** [R.C. §1337.13(E)(2)(a) and (b)]

Limitations of Agent's Authority. I understand there are limitations to the authority of my agent under Ohio law:

1. My agent does not have authority to refuse or withdraw informed consent to health care necessary to provide comfort care.

2. My agent does not have the authority to refuse or withdraw informed consent to health care if I am pregnant, if the refusal or withdrawal of the health care would terminate the pregnancy, unless the pregnancy or the health care would pose a substantial risk to my life, or unless my attending physician and at least one other physician to a reasonable degree of medical certainty determines that the fetus would not be born alive.

3. My agent cannot order the withdrawal of life-sustaining treatment, including artificially or technologically supplied nutrition or hydration, unless I am in a terminal condition or in a permanently unconscious state and two physicians have determined that life-sustaining treatment would not or would no longer provide comfort to me or alleviate my pain.

4. If I previously consented to any health care, my agent cannot withdraw that treatment unless my condition has significantly changed so that the health care is significantly less beneficial to me, or unless the health care is not achieving the purpose for which I chose the health care.

Additional Instructions or Limitations. I may give additional instructions or impose additional limitations on the authority of my agent. Below are my specific instructions or limitations:

[If the space below is not sufficient, you may attach additional pages. If you do not have any additional instructions or limitations, write "None" below.]

NOMINATION OF GUARDIAN

[R.C. §1337.28 (A) and R.C. §2111.121]

[You may, but are not required to, use this document to nominate a guardian, should guardianship proceedings be started, for your person or your estate.]

I understand that any person I nominate is not required to accept the duties of guardianship, and that the probate court maintains jurisdiction over any guardianship. [R.C. §2111.121(C)]

I understand that the court will honor my nominations except for good cause shown or disqualification. [R.C. §2111.121(B)]

I understand that, if a **guardian of the person** is appointed for me, such guardian's duties would include making day-to-day decisions of a personal nature on my behalf, such as food, clothing, and living arrangements, but this or any subsequent Health Care Power of Attorney would remain in effect and control health care decisions for me, unless determined otherwise by the court. The court will determine limits, suspend or terminate this or any subsequent Health Care Power of Attorney, if they find that the limitation, suspension or termination is in my best interests. [R.C. §1337.28 (C)]

I intend that the authority given to my agent in my Health Care Power of Attorney will eliminate the need for any court to appoint a guardian of my person. However, should such proceedings start, I nominate the person(s) below in the order listed as **guardian of my person.**

☐ By writing my initials, signature, a check mark or other mark in this box, I nominate my agent and alternate agent(s), if any, to be **guardian of my person**, in the order named above.

If I do not choose my agent or an alternate agent to be the **guardian of my person**, I choose the following person(s), in this order *[cross out any unused lines]:*

X out area if not used

Guardian of my person's name and relationship: _____

Address: _____

Telephone number(s): _____

Alternate guardian of my person's name and relationship: _____

Address: _____

Telephone number(s): _____

Guardian of the estate means the person appointed by a court to make financial decisions on behalf of the ward, with the court's involvement. The guardian of the estate is required to be bonded, unless bond is waived in writing or the court finds it unnecessary.

☐ By placing my initials, signature, check or other mark in this box, I nominate my agent or alternate agent(s), if any, as **guardian of my estate**, in the order named above.

If I do not choose my agent or an alternate agent to be the **guardian of my estate**, I choose the following person(s), in this order *[cross out any unused lines]:*

X out area if not used

Guardian of my estate and relationship: _____

Address: _____

Telephone number(s): _____

Alternate guardian of my estate and relationship: _____

Address: _____

Telephone number(s): _____

☐ By placing my initials, signature, check or other mark in this box, I direct that bond be waived for guardian or successor **guardian of my estate**. [R.C. §1337.28 (B)]

If I do **not** make any mark in this box, it means that I expect the guardian or successor guardian of my estate to be bonded. [R.C. §1337.28 (B)]

No Expiration Date. This Health Care Power of Attorney will have no expiration date and will not be affected by my disability or by the passage of time.

Enforcement by Agent. My agent may take for me, at my expense, any action my agent considers advisable to enforce my wishes under this document.

Release of Agent's Personal Liability. My agent will not be liable to me or any other person for any breach of duty unless such breach of duty was committed dishonestly, with an improper motive, or with reckless indifference to the purposes of this document or my best interests. [R.C. §1337.35]

Copies are the Same as Original. Any person may rely on a copy of this document. [R.C. §1337.26(D)]

Out of State Application. I intend that this document be honored in any jurisdiction to the extent allowed by law. [R.C. §1337.26(C)]

I have completed a **Living Will**: Yes_____No _____

SIGNATURE of PRINCIPAL

I understand that I am responsible for telling members of my family and my physician, my lawyer, my religious advisor and others about this Health Care Power of Attorney. I understand I may give copies of this Health Care Power of Attorney to any person.

I understand that I may file a copy of this Health Care Power of Attorney with the probate court for safekeeping. [R.C. §1337.12(E)(3)]

I understand that I must sign this Health Care Power of Attorney and state the date of my signing, and that my signing either must be witnessed by two adults who are eligible to witness my signing OR the signing must be acknowledged before a notary public. [R.C. §1337.12]

I sign my name to this Health Care Power of Attorney

on_____,at _____, Ohio.

_____

Principal

[Choose Witnesses OR a Notary Acknowledgment.]

WITNESSES [R.C. §1337.12(B)]

[The following persons CANNOT serve as a witness to this Health Care Power of Attorney:

- *Your agent, if any;*
- *The guardian of your person or estate, if any;*
- *Any alternate or successor agent or guardian, if any;*
- *Anyone related to you by blood, marriage, or adoption (for example, your spouse and children);*
- *Your attending physician; and*
- *The administrator of any nursing home where you are receiving care.]*

I attest that the principal signed or acknowledged this Health Care Power of Attorney in my presence, and that the principal appears to be of sound mind and not under or subject to duress, fraud or undue influence.

_____/_____/_____

Witness One's Signature Witness One's Printed Name Date

_____

Witness One's Address

_____/_____/_____

Witness Two's Signature Witness Two's Printed Name Date

_____

Witness Two's Address

OR, if there are no witnesses:

NOTARY ACKNOWLEDGMENT [R.C. §1337.12]

State of Ohio
County of_____ss.

On_____, before me, the undersigned notary public, personally appeared

_____, principal of the above Health Care Power of Attorney, and who has acknowledged that (s)he executed the same for the purposes expressed therein. I attest that the principal appears to be of sound mind and not under or subject to duress, fraud or undue influence.

_____

Notary Public

My Commission Expires: _____

My Commission is Permanent: _____

NOTICE TO ADULT EXECUTING THIS DOCUMENT

This is an important legal document. Before executing this document, you should know these facts:

This document gives the person you designate (the attorney in fact) the power to make MOST health care decisions for you if you lose the capacity to make informed health care decisions for yourself. This power is effective only when your attending physician determines that you have lost the capacity to make informed health care decisions for yourself and, notwithstanding this document, as long as you have the capacity to make informed health care decisions for yourself, you retain the right to make all medical and other health care decisions for yourself.

You may include specific limitations in this document on the authority of the attorney in fact to make health care decisions for you.

Subject to any specific limitations you include in this document, if your attending physician determines that you have lost the capacity to make an informed decision on a health care matter, the attorney in fact GENERALLY will be authorized by this document to make health care decisions for you to the same extent as you could make those decisions yourself, if you had the capacity to do so. The authority of the attorney in fact to make health care decisions for you GENERALLY will include the authority to give informed consent, to refuse to give informed consent, or to withdraw informed consent to any care, treatment, service, or procedure to maintain, diagnose, or treat a physical or mental condition.

HOWEVER, even if the attorney in fact has general authority to make health care decisions for you under this document, the attorney in fact NEVER will be authorized to do any of the following:

(1) Refuse or withdraw informed consent to life-sustaining treatment, unless your attending physician and one other physician who examines you determine, to a reasonable degree of medical certainty and in accordance with reasonable medical standards, that either of the following applies:

(a) You are suffering from an irreversible, incurable and untreatable condition caused by disease, illness, or injury from which

(i) there can be no recovery and

(ii) your death is likely to occur within a relatively short time if life-sustaining treatment is not administered, and your attending physician additionally determines, to a reasonable degree of medical certainty and in accordance with reasonable medical standards, that there is no reasonable possibility that you will regain the capacity to make informed health care decisions for yourself.

(b) You are in a state of permanent unconsciousness that is characterized by you being irreversibly unaware of yourself and your environment and by a total loss of cerebral cortical functioning, resulting in you having no capacity to experience pain or suffering, and your attending physician additionally determines, to a reasonable degree of medical certainty and in accordance with reasonable medical standards, that there is no reasonable possibility that you will regain the capacity to make informed health care decisions for yourself;

(2) Refuse or withdraw informed consent to health care necessary to provide you with comfort care (except that, if the attorney in fact is not prohibited from doing so under (4) below, the attorney in fact could refuse or withdraw informed consent to the provision of nutrition or hydration to you as described under (4) below). **(You should understand that comfort care is defined in Ohio law to mean artificially or technologically administered sustenance (nutrition) or fluids (hydration) when administered to diminish your pain or discomfort, not to postpone your death, and any other**

Notice as required by Ohio Revised Code §1337.17

medical or nursing procedure, treatment, intervention, or other measure that would be taken to diminish your pain or discomfort, not to postpone your death. Consequently, if your attending physician were to determine that a previously described medical or nursing procedure, treatment, intervention, or other measure will not or no longer will serve to provide comfort to you or alleviate your pain, then, subject to (4) below, your attorney in fact would be authorized to refuse or withdraw informed consent to the procedure, treatment, intervention, or other measure.);

(3) Refuse or withdraw informed consent to health care for you if you are pregnant and if the refusal or withdrawal would terminate the pregnancy (unless the pregnancy or health care would pose a substantial risk to your life, or unless your attending physician and at least one other physician who examines you determine, to a reasonable degree of medical certainty and in accordance with reasonable medical standards, that the fetus would not be born alive);

(4) Refuse or withdraw informed consent to the provision of artificially or technologically administered sustenance (nutrition) or fluids (hydration) to you, unless:

(a) You are in a terminal condition or in a permanently unconscious state.

(b) Your attending physician and at least one other physician who has examined you determine, to a reasonable degree of medical certainty and in accordance with reasonable medical standards, that nutrition or hydration will not or no longer will serve to provide comfort to you or alleviate your pain.

(c) If, but only if, you are in a permanently unconscious state, you authorize the attorney in fact to refuse or withdraw informed consent to the provision of nutrition or hydration to you by doing both of the following in this document:

(i) Including a statement in capital letters or other conspicuous type, including, but not limited to, a different font, bigger type, or boldface type, that the attorney in fact may refuse or withdraw informed consent to the provision of nutrition or hydration to you if you are in a permanently unconscious state and if the determination that nutrition or hydration will not or no longer will serve to provide comfort to you or alleviate your pain is made, or checking or otherwise marking a box or line (if any) that is adjacent to a similar statement on this document;

(ii) Placing your initials or signature underneath or adjacent to the statement, check, or other mark previously described.

(d) Your attending physician determines, in good faith, that you authorized the attorney in fact to refuse or withdraw informed consent to the provision of nutrition or hydration to you if you are in a permanently unconscious state by complying with the above requirements of (4)(c)(i) and (ii) above.

(5) Withdraw informed consent to any health care to which you previously consented, unless a change in your physical condition has significantly decreased the benefit of that health care to you, or unless the health care is not, or is no longer, significantly effective in achieving the purposes for which you consented to its use.

Additionally, when exercising authority to make health care decisions for you, the attorney in fact will have to act consistently with your desires or, if your desires are unknown, to act in your best interest. You may express your desires to the attorney in fact by including them in this document or by making them known to the attorney in fact in another manner.

When acting pursuant to this document, the attorney in fact GENERALLY will have the same rights that you have to receive information about proposed health care, to review health care records, and to consent to the disclosure of health care records. You can limit that right in this document if you so choose.

Notice as required by Ohio Revised Code §1337.17

Generally, you may designate any competent adult as the attorney in fact under this document. However, you CANNOT designate your attending physician or the administrator of any nursing home in which you are receiving care as the attorney in fact under this document. Additionally, you CANNOT designate an employee or agent of your attending physician, or an employee or agent of a health care facility at which you are being treated, as the attorney in fact under this document, unless either type of employee or agent is a competent adult and related to you by blood, marriage, or adoption, or unless either type of employee or agent is a competent adult and you and the employee or agent are members of the same religious order.

This document has no expiration date under Ohio law, but you may choose to specify a date upon which your durable power of attorney for health care will expire. However, if you specify an expiration date and then lack the capacity to make informed health care decisions for yourself on that date, the document and the power it grants to your attorney in fact will continue in effect until you regain the capacity to make informed health care decisions for yourself.

You have the right to revoke the designation of the attorney in fact and the right to revoke this entire document at any time and in any manner. Any such revocation generally will be effective when you express your intention to make the revocation. However, if you made your attending physician aware of this document, any such revocation will be effective only when you communicate it to your attending physician, or when a witness to the revocation or other health care personnel to whom the revocation is communicated by such a witness communicates it to your attending physician.

If you execute this document and create a valid durable power of attorney for health care with it, it will revoke any prior, valid durable power of attorney for health care that you created, unless you indicate otherwise in this document.

This document is not valid as a durable power of attorney for health care unless it is acknowledged before a notary public or is signed by at least two adult witnesses who are present when you sign or when you acknowledge your signature. No person who is related to you by blood, marriage, or adoption may be a witness. The attorney in fact, your attending physician, and the administrator of any nursing home in which you are receiving care also are ineligible to be witnesses. If there is anything in this document that you do not understand, you should ask your lawyer to explain it to you.

Notice as required by Ohio Revised Code §1337.17

ADDENDUM

This notice was not updated when certain provisions of the law regarding the Health Care Power of Attorney were changed in March 2014. Please be advised of the following changes:

You may, but are not required to, authorize your agent to get your health information, including information that is protected by law and otherwise not available to your agent. You can authorize your agent to have access to your health information immediately upon your signing of this document or at any later time, even though you are still able to make your own health care decisions.

You may also, but are not required to, use this document to name guardians for you or your estate should guardianship proceedings be started.

Ohio's Living Will

What You Should Know About Living Wills

A **Living Will** is a document that allows you to establish, in advance, the type of medical care you would want to receive if you were to become permanently unconscious, or if you were to become terminally ill and unable to tell your physician or family what kind of life-sustaining treatments you want to receive.

- A **Living Will** is used only in situations where you are unable to tell your physician what kind of health care services you want to receive. Before your Living Will goes into effect, you either must be:

  (1) Terminally ill (see definition as described in the **Living Will** Declaration Form) and unable to tell your physician your wishes regarding health-care services;

  OR

  (2) Permanently unconscious. To be considered permanently unconscious, two physicians (one of whom must be a medical specialist in an appropriate field) must decide that you have no reasonable possibility of regaining consciousness.

Regardless of your condition, if you were able to speak and tell your physician your wishes about life-prolonging treatments, then the Living Will wouldn't be used – your physician would just talk directly with you about your wishes. A Living Will is used by the physician only if you are unable to tell him or her what you want to be done.

- A Living Will may give your physician the authority to withhold all life-sustaining treatment and permit you to die naturally and take no action to postpone your death, providing you with only that care necessary to make you comfortable and relieve your pain. This may include writing a DNR Order or withdrawing life-sustaining treatment such as cardiopulmonary resuscitation (CPR). Such "comfort care" also may include removing nutrition and hydration (food and water) that is administered through feeding tubes or intravenously. If you wish to give your physician this authority if you become permanently unconscious, there is a space on the Living Will form that you must initial. If you want nutrition and hydration to be continued, regardless of the circumstances, don't initial this space.

- A Living Will can be honored only if your attending physician and others know about it. It is important to let your physician and your family and friends know that you have a Living Will before you become ill. It is a good idea for you to give your attending physician a copy of your Living Will. It also is important to give copies to family and friends so that, if necessary, they can advise your physician that you have a Living Will. In addition, it is important that you notify a health care facility that you have a Living Will when you are admitted as a patient. Please note: You do not have to go to court to put your Living Will into effect.

- If a decision is made to withhold or withdraw life-sustaining treatment, your physician must make a reasonable effort to notify the person or persons you designate in your Living Will or your closest family member.

- The law allows your family members to challenge a physician's determination that you have a terminal illness or that you are in a permanently unconscious state. This challenge is limited in nature and may be made only by your closest relatives. The law does not, however, allow your family members to challenge your own legally-documented decision not to be resuscitated.

- If you have both a Living Will and a Health Care Power of Attorney, the physician must comply with the wishes you state in your Living Will. In other words, your Living Will takes precedence over your Health Care Power of Attorney. On page four of the Living Will form, there is a space that you may check to let your physician and family and friends know that you have a Health Care Power of Attorney.

- You can revoke your Living Will at any time. You can do this by simply telling your physician and family that you have changed your mind and wish to revoke your Living Will. It is a good idea to ask anyone who has a copy of the document to return it to you.

How to Fill Out the Living Will Form

You should use this form to let your physician and your family know what kind of life-sustaining treatments you want to receive if you become terminally ill or permanently unconscious and are unable to express your wishes.

1. Read over all information carefully. Important definitions are included in the document.

2. On the first two lines on page 2 of the form, print your full name and birth date.

3. On page 4, you may indicate whether you have completed a Health Care Power of Attorney. The next section of the form provides space for you to list the names, addresses and phone numbers of the contacts (usually family members and close friends) that you want your physician to notify when the decision is made to withhold or withdraw life-sustaining treatment.

4. On page 5 of the form is a box next to the **boldface** section which will give your physician permission to withhold food and fluids in the event you are permanently unconscious. If you want to give your physician permission to withhold food and water in this situation, then you must place your initials in this box.

5. On page 6 of the form is a place for you to date and sign the form. **Remember, the Living Will is not considered valid or effective unless you do one of the following:**

> **First Option –** Date and sign the **Living Will** in the presence of two witnesses, who also must sign and include their addresses and indicate the date of their signatures.

The following people may **not** serve as a witness to your **Living Will**:

- *Primary agent in the declarant's Health Care Power of Attorney;*
- *The nominated guardian of the declarant's person or estate;*
- *Alternate or successor agent in the declarant's Health Care Power of Attorney;*
- *Anyone related to the declarant by blood, marriage or adoption (the declarant's spouse and children);*
- *The declarant's attending physician;*
- *The administrator of the nursing home where the declarant is receiving care.*

> OR
>
> **Second Option** – Date and sign the **Living Will** in the presence of a notary public and have the **Living Will** notarized on the appropriate spac**e** provided on the form.

6. Once you have filled out the **Living Will** and either signed it in the presence of witnesses or in the presence of a notary public, then it is a good idea to give a copy to your personal physician and any contacts you have listed in the **Living Will**. In some Ohio counties, people may be able to register their **Living Wills** with the county recorder. However, it is important to keep in mind that a registered **Living Will** form becomes a public record.

State of Ohio
Living Will Declaration
Notice to Declarant

The purpose of this Living Will Declaration is to document your wish that life-sustaining treatment, including artificially or technologically supplied nutrition and hydration, be withheld or withdrawn if you are unable to make informed medical decisions and are in a terminal condition or in a permanently unconscious state. This Living Will Declaration does not affect the responsibility of health care personnel to provide comfort care to you. Comfort care means any measure taken to diminish pain or discomfort, but not to postpone death.

If you would not choose to limit any or all forms of life-sustaining treatment, including CPR, you have the legal right to so choose and may wish to state your medical treatment preferences in writing in a different document.

Under Ohio law, a Living Will Declaration is applicable **only to individuals in a terminal condition or a permanently unconscious state**. If you wish to direct medical treatment in other circumstances, you should prepare a Health Care Power of Attorney. If you are in a terminal condition or a permanently unconscious state, this Living Will Declaration takes precedence over a Health Care Power of Attorney.

[You should consider completing a new Living Will Declaration if your medical condition changes or if you later decide to complete a Health Care Power of Attorney. If you have both a Living Will Declaration and a Health Care Power of Attorney, you should keep copies of these documents together. Bring your document(s) with you whenever you are a patient in a health care facility or when you update your medical records with your physician.]

Ohio
Living Will Declaration

[R.C. §2133]

_____

(Print Full Name)

_____

(Birth Date)

This is my Living Will Declaration. I revoke all prior Living Will Declarations signed by me. I understand the nature and purpose of this document. If any provision is found to be invalid or unenforceable, it will not affect the rest of this document.

I am of sound mind and not under or subject to duress, fraud or undue influence. I am a competent adult who understands and accepts the consequences of this action. I voluntarily declare my direction that my dying not be artificially prolonged. [R.C. §2133.02 (A)(1)]

I intend that this Living Will Declaration will be honored by my family and physicians as the final expression of my legal right to refuse certain health care. [R.C.§2133.03(B)(2)]

Definitions

Adult means a person who is 18 years of age or older.

Agent or attorney-in-fact means a competent adult who a person (the "principal") can name in a Health Care Power of Attorney to make health care decisions for the principal.

Artificially or technologically supplied nutrition or hydration means food and fluids provided through intravenous or tube feedings. *[You can refuse or discontinue a feeding tube, or authorize your Health Care Power of Attorney agent to refuse or discontinue artificial nutrition or hydration.]*

Comfort care means any measure, medical or nursing procedure, treatment or intervention, including nutrition and or hydration, that is taken to diminish a patient's pain or discomfort, but not to postpone death.

CPR means cardiopulmonary resuscitation, one of several ways to start a person's breathing or heartbeat once either has stopped. It does not include clearing a person's airway for a reason other than resuscitation.

Declarant means the person signing the Living Will Declaration.

Do Not Resuscitate or DNR Order means a physician's medical order that is written into a patient's record to indicate that the patient should not receive cardiopulmonary resuscitation.

Health care means any care, treatment, service or procedure to maintain, diagnose or treat an individual's physical or mental health.

Health care decision means giving informed consent, refusing to give informed consent, or withdrawing informed consent to health care.

Health Care Power of Attorney means a legal document that lets the principal authorize an agent to make health care decisions for the principal in most health care situations when the principal can no longer make such decisions. Also, the principal can authorize the agent to gather protected health information for and on behalf of the principal immediately or at any other time. A Health Care Power of Attorney is NOT a financial power of attorney.

The Health Care Power of Attorney document also can be used to nominate person(s) to act as guardian of the principal's person or estate. Even if a court appoints a guardian for the principal, the Health Care Power of Attorney remains in effect unless the court rules otherwise.

Life-sustaining treatment means any medical procedure, treatment, intervention or other measure that, when administered to a patient, mainly prolongs the process of dying.

Living Will Declaration means a legal document that lets a competent adult ("declarant") specify what health care the declarant wants or does not want when he or she becomes terminally ill or permanently unconscious and can no longer make his or her wishes known. It is NOT and does not replace a will, which is used to appoint an executor to manage a person's estate after death.

Permanently unconscious state means an irreversible condition in which the patient is permanently unaware of himself or herself and surroundings. At least two physicians must examine the patient and agree that the patient has totally lost higher brain function and is unable to suffer or feel pain.

Principal means a competent adult who signs a Health Care Power of Attorney.

Terminal condition means an irreversible, incurable, and untreatable condition caused by disease, illness, or injury from which, to a reasonable degree of medical certainty as determined in accordance with reasonable medical standards by a declarant's attending physician and one other physician who has examined the declarant, both of the following apply: (1) there can be no recovery and (2) death is likely to occur within a relatively short time if life-sustaining treatment is not administered.

No Expiration Date. This Living Will Declaration will have no expiration date. However, I may revoke it at any time. [R.C. §2133.04(A)]

Copies the Same as Original. Any person may rely on a copy of this document. [R.C. §2133.02(C)]

Out of State Application. I intend that this document be honored in any jurisdiction to the extent allowed by law. [R.C. §2133.14]

I have completed a **Health Care Power of Attorney**: Yes_____No _____

Notifications. *[Note: You do not need to name anyone. If no one is named, the law requires your attending physician to make a reasonable effort to notify one of the following persons in the order named: your guardian, your spouse, your adult children who are available, your parents, or a majority of your adult siblings who are available.]*

In the event my attending physician determines that life-sustaining treatment should be withheld or withdrawn, my physician shall make a reasonable effort to notify one of the persons named below, in the following order of priority *[cross out any unused lines]*: [R.C. §2133.05(2)(a)]

X out area if not used

First contact's name and relationship:_____

Address: _____

Telephone number(s): _____

Second contact's name and relationship:_____

Address: _____

Telephone number(s): _____

Third contact's name and relationship:_____

Address: _____

Telephone number(s): _____

If I am in a **TERMINAL CONDITION** and unable to make my own health care decisions, OR if I am in a **PERMANENTLY UNCONSCIOUS STATE** and there is no reasonable possibility that I will regain the capacity to make informed decisions, then I direct my physician to let me die naturally, providing me only with **comfort care**.

For the purpose of providing comfort care, I authorize my physician to:

1. Administer no life-sustaining treatment, including CPR;
2. Withhold or withdraw artificially or technologically supplied nutrition or hydration, provided that, if I am in a permanently unconscious state, I have authorized such withholding or withdrawal under **Special Instructions** below and the other conditions have been met;
3. Issue a DNR Order; and
4. Take no action to postpone my death, providing me with only the care necessary to make me comfortable and to relieve pain.

***Special Instructions*.**

☐ **By placing my initials, signature, check or other mark in this box, I specifically authorize my physician to withhold, or if treatment has commenced, to withdraw, consent to the provision of artificially or technologically supplied nutrition or hydration if I am in a permanently unconscious state AND my physician and at least one other physician who has examined me have determined, to a reasonable degree of medical certainty, that artificially or technologically supplied nutrition and hydration will not provide comfort to me or relieve my pain.** [R.C. §2133.02(A)(3) and R.C. §2133.08]

Additional instructions or limitations.

[If the space below is not sufficient, you may attach additional pages.
If you do not have any additional instructions or limitations, write "None" below.]

SIGNATURE of DECLARANT

I understand that I am responsible for telling members of my family, the agent named in my Health Care Power of Attorney (if I have one), my physician, my lawyer, my religious advisor and others about this Living Will Declaration. I understand I may give copies of this Living Will Declaration to any person.

I understand that I must sign (or direct an individual to sign for me) this Living Will Declaration and state the date of the signing, and that the signing either must be witnessed by two adults who are eligible to witness the signing OR the signing must be acknowledged before a notary public. [R.C. §2133.02]

I sign my name to this Living Will Declaration

on_____, at _____, Ohio.

_____

Declarant

[Choose Witnesses OR a Notary Acknowledgment.]

WITNESSES [R.C. §2133.02(B)(1)]

[The following persons CANNOT serve as a witness to this Living Will Declaration:

- *Your agent in your Health Care Power of Attorney, if any;*
- *The guardian of your person or estate, if any;*
- *Any alternate agent or guardian, if any;*
- *Anyone related to you by blood, marriage or adoption (for example, your spouse and children);*
- *Your attending physician; and*
- *The administrator of the nursing home where you are receiving care.]*

I attest that the Declarant signed or acknowledged this Living Will Declaration in my presence, and that the Declarant appears to be of sound mind and not under or subject to duress, fraud or undue influence.

_____/_____/_____
Witness One's Signature Witness One's Printed Name Date

_____
Witness One's Address

_____/_____/_____
Witness Two's Signature Witness Two's Printed Name Date

_____
Witness Two's Address

OR, if there are no witnesses,

NOTARY ACKNOWLEDGMENT [R.C. §2133.02(B)(2)]

State of Ohio
County of_____ss.

On_____, before me, the undersigned notary public, personally appeared _____, declarant of the above Living Will Declaration, and who has acknowledged that (s)he executed the same for the purposes expressed therein. I attest that the declarant appears to be of sound mind and not under or subject to duress, fraud or undue influence.

_____
Notary Public

My Commission Expires: _____

My Commission is Permanent: _____

State of Ohio
Donor Registry Enrollment Form
Notice to Declarant

The purpose of the Donor Registry Enrollment Form is to document your wish to donate organs, tissues and/or corneas at the time of your death.

This form should be completed only if you have **NOT** already registered as a donor with the Ohio Bureau of Motor Vehicles (BMV) when renewing a driver license or state identification card; online through the BMV website; or previously through a paper form. If you wish to make an anatomical gift or modify an existing registration this form must be sent to the BMV to ensure your wishes for organ, tissue and/or cornea donation will be honored. This document will serve as your authorization to recover the organs, tissue and/or corneas indicated at the time of your death, if medically possible.

In submitting this form your wishes will be recorded in the Ohio Donor Registry maintained by the BMV and will be accessible only to the appropriate organ, tissue and cornea recovery agencies at the time of death. You are encouraged to share your wishes with your next of kin so they are aware of your intentions to be a donor.

This form can also be used to amend or revoke your wishes for donation. The completed form should be mailed to:

Ohio Bureau of Motor Vehicles
Attn: Records Request
P. O. Box 16583
Columbus, OH 43216-6583

Frequently asked questions about organ, tissue and cornea donation are addressed on page three of this section. If you have more specific questions, contact information for the state's organ and tissue recovery agencies is also listed, and you are encouraged to contact them or visit their websites.

Ohio Donor Registry Enrollment Form

If you have NOT already registered as a donor with the Ohio Bureau of Motor Vehicles (BMV) when renewing a driver license or state ID, the Ohio Donor Registry Form must be filed with the BMV to ensure your wishes concerning organ and tissue donation will be honored. This document will serve as your authorization to recover the organs and/or tissues indicated at the time of your death, if medically possible. In submitting this form, your wishes will be recorded in the Ohio Donor Registry maintained by the BMV and will be accessible only to the appropriate organ and tissue recovery agencies at the time of death. Be sure to share your wishes with loved ones so they are aware of your intentions. This form can also be used to amend or revoke your wishes for donation.

To register, please complete and mail this enrollment form to:
Ohio Bureau of Motor Vehicles
Attn: Records Request
P.O. Box 16583
Columbus, OH 43216-6583

PLEASE PRINT

LAST NAME	FIRST	MIDDLE
MAILING ADDRESS		
CITY	STATE	ZIP
PHONE ( ) -	DATE OF BIRTH / / /	STATE OF OHIO DL/ID CARD # **OR** SOCIAL SECURITY #

DONOR REGISTRY ENROLLMENT OPTIONS

OPTION 1

☐ Upon my death, I make an anatomical gift of my organs, tissues, and eyes for any purpose authorized by law.

OPTION 2

☐ Upon my death, I make an anatomical gift of the following organs, tissues, and/or eyes selected below:

☐ All organs, tissues and eyes

ORGANS

☐ Heart
☐ Lungs
☐ Liver (and associated vessels)
☐ Kidneys (and associated vessels)
☐ Pancreas/Islet Cells
☐ Intestines
☐ Small Bowel

TISSUES

☐ Eyes/Corneas
☐ Heart Valves
☐ Bone
☐ Tendons
☐ Ligaments
☐ Veins
☐ Fascia
☐ Skin
☐ Nerves

For the following purposes authorized by law:

☐ All purposes ☐ Transplantation ☐ Therapy ☐ Research ☐ Education

OPTION 3

☐ Please take me out of the Ohio Donor Registry.

SIGNATURE OF DONOR REGISTRANT	DATE
X	

Organ and Tissue Donation in Ohio

One individual can save or improve the quality of life for people who suffer from organ failure, congenital defects, bone cancer, orthopedic injuries, burns, blindness and more. One organ donor can save up to 8 lives by donating heart, lungs, kidneys, pancreas, small intestine and liver. More than 123,000 Americans are on the national waiting list for a life-saving organ transplant; 3,400 in Ohio. Statistically, 18 people in the U.S. die every day while waiting for transplants. If you register as a donor, be sure to share the decision with your family members.

Who can become a donor? All individuals over the age of 15½ can register and give advance authorization for donation. Medical suitability for donation is determined at the time of death. If a minor dies before the age of 18, a parent can amend or revoke the donation decision.

Are there age limits for donors? People of all ages and medical histories should consider themselves potential donors. Newborns as well as senior citizens have been organ donors. Medical condition at the time of death will determine what organs and tissues can be donated.

If I join the Donor Registry, will it affect the quality of medical care I receive at the hospital? No, doctors at hospitals are concerned with caring for the patient in front of them and are not involved with donation and transplantation. Every effort is made to save your life before donation is considered.

Will donation disfigure my body? Can there be an open casket funeral? Donation does not disfigure the body and does not interfere with or delay a funeral, including open casket services.

Are there any costs to my family for donation? The donor's family does NOT pay for the cost of the donation. All costs related to donation of organs, eyes and tissues are paid by the designated recovery agency.

Does my religion approve of donation? All major religions support organ, eye and tissue donation as an unselfish act of charity.

Can I sell my organs? No. The National Organ Transplant Act makes it illegal to sell human organs and tissue. Violators are subject to fines and imprisonment. Among the reasons for this rule is the concern of Congress that buying and selling of organs might lead to inequitable access to donor organs, with the wealthy having an unfair advantage.

How are organs distributed? Donor organs are matched to recipients through a federally-regulated system based on a number of factors including blood type, body size, medical urgency, time on waiting list and geographical location.

Can I be an organ and tissue donor and also donate my body to science? Total body donation takes precedence over organ and tissue donation. If you wish to donate your entire body, you must make arrangements with a medical school or research facility prior to your death. Medical schools, research facilities and other agencies study bodies to gain greater understanding of anatomy and disease mechanisms in humans. This research is also vital to saving and improving lives.

Does the registry authorize living donation? No, living donation is not authorized by the registry. It is possible to donate a kidney, or part of a liver or lung while alive, but that is arranged on an individual basis through specific transplant centers.

For more information on donation, contact one of the state's four federally designated organ procurement organizations:

Northeastern Ohio	North-West/West-Central Ohio	Central and Southeastern Ohio	Southwestern Ohio
LifeBanc	Life Connection of Ohio	Lifeline of Ohio	LifeCenter Organ Donor Network
www.lifebanc.org	www.lifeconnection.org	www.lifelineofohio.org	www.lifepassiton.org
216.752.5433	937.223.8223	800.525.5667	513.558.5555

Ohio's **Do-Not-Resuscitate** Law

What You Should Know About Do-Not-Resuscitate (DNR) Laws in Ohio

Ohio's Do-Not-Resuscitate (DNR) Law gives individuals the opportunity to exercise their right to limit care received in emergency situations in special circumstances. "Special circumstances" include care received from emergency personnel when 911 is dialed. The law authorizes a physician, advanced practice registered nurse or physician assistant (authorized health care provider) to write an order letting health care personnel know that a patient does not wish to be resuscitated in the event of a cardiac arrest (no palpable pulse) or respiratory arrest (no spontaneous respirations or the presence of labored breathing).

The following information is included as a brief overview of some of the more common questions, issues and concerns regarding Ohio's Do-Not-Resuscitate law. It is not meant to provide all information needed to make the decision to have a Do-Not-Resuscitate order written. An individual may have a DNR order written after **consultation** with his or her authorized health care provider regarding end-of-life issues.

The DNR order may be honored in multiple settings, including but not limited to: nursing facilities, residential care facilities, hospitals, outpatient areas, home, and public places. For a DNR order to be useful in multiple settings, it must be recognizable by health care workers. The Ohio Department of Health has developed a standard DNR order form that is the only state authorized form that is fully transportable and recognized throughout Ohio. You may choose to display the form in your residence to be easily visible to healthcare personnel and transport it with you when you are away from home. Other DNR identifications, including a necklace, bracelet or wallet identification card, may be used but must include the Ohio DNR logo and identifying information of the individual to be valid.

Unlike a Living Will and Health Care Power of Attorney, which can be executed without the input of a healthcare professional, a DNR Order must be written and signed by a physician, an advanced-practice registered nurse, or physician assistant after consultation with the patient.

A DNR order on the state approved document is legally-sanctioned and implemented according to Ohio Law. The DNR order is implemented at different points, depending upon the patient's wishes and must be consistent with reasonable medical standards.

Care that eases pain and suffering will always be implemented regardless of a DNR order. Other related care will be provided depending on the specific order that your physician prescribes. You should check with your prescriber regarding the right type of DNR order needed when considering your specific medical needs.

DNR/CPR Care: The Facts

Ohio first adopted a law concerning DNR orders in 1998. DNR stands for "do not resuscitate." A person who does not wish to have cardiopulmonary resuscitation (CPR) performed may make this wish known through a DNR order from their authorized healthcare provider. A DNR order assists emergency responders in knowing if an individual does not want CPR if or when their heart stops or if they stop breathing.

If an emergency responder comes upon someone with a DNR Comfort Care order, the emergency responder will provide these comfort measures:

- Conduct an initial assessment
- Perform Basic Medical Care
- Clear airway of obstruction or suction airway
- If necessary for comfort, may administer oxygen, CPAP or BiPAP
- May obtain IV access for hydration or pain medication to relieve discomfort, but not to prolong death
- If possible, may contact other appropriate healthcare providers (hospice, home health, physician, APRN or PA)

The emergency responder will not:

- Perform CPR
- Administer resuscitation medications with the intent of restarting the heart or breathing
- Insert an airway adjunct
- De-fibrillate, cardiovert or initiate pacing
- Initiate continuous cardiac monitoring

CPR can be life-saving but some people may not want it administered in certain cases.
In some cases, CPR saves lives. In many cases, it is not effective. Many people overestimate the success of CPR. A person who is revived may be left with permanent or painful injury. Resuscitation also may include other treatment, such as drugs, tubes and electric shock. People with terminal illnesses or other serious medical conditions may prefer to focus on comfort care at the end of life rather than receiving CPR when the time comes. For more information about the pros and cons of CPR and whether it is right for you, ask your physician.

It is easy to make your wishes about CPR known.
If you want to receive CPR when appropriate, you do not need to do anything. Health care providers are required to perform CPR when necessary. If you do not want CPR, you need to discuss your wishes with your physician and ask your physician to write a DNR Order. If your physician agrees that you should not get CPR, he or she can fill out the required form to make your wishes known in case of an emergency.

There are different DNR orders that you can choose and discuss with your authorized health care provider.
Under Ohio's DNR Law, the Ohio Department of Health has established a standardized DNR order form. When completed by an authorized health care provider (physician, advance practice registered nurse, or physician assistant), these standardized DNR orders allow patients to choose the extent of the treatment they wish to receive or not receive at the end of life. Your authorized health care provider can further explain the differences in DNR orders.

Even if you are healthy now, you may want to state that you do not want to receive CPR if you ever become terminally ill.
Ohio has a standard Living Will Declaration form. This form specifically allows you to direct health care providers not to administer life-sustaining treatments, including CPR, and to issue a DNR Order if two physicians have agreed that you are either terminally ill or permanently unconscious.

DNR Comfort Care does NOT mean "Do Not Treat."
The DNR Comfort Care Protocol is very specific in terms of what treatment is to be given and what treatment is to be withheld. Only those items listed on the "will not" list are to be withheld. The items listed on the "will" list, along with any other treatment that may be needed for the patient's condition, may be provided as appropriate.

DNR Orders may be revoked.
You always have the right to change your mind and request CPR. If you do change your mind, you should speak with your authorized health care provider right away about revoking your DNR Order. You also should tell your family and caregivers about your decision and throw away any DNR identification items you might have.

If you have a DNR Order or identification, your family cannot demand that CPR be provided.
You have the right to make your own decisions about your health care. You should make sure your family knows your desires about CPR. In certain medical situations, your physician and agent may make decisions regarding your care based upon new medical information. This could include decisions related to CPR. You should make sure these individuals know your desires about CPR.

Since a DNR is a medical order, you need an authorized health care provider to write and sign it for you.
Unlike Living Wills and Health Care Powers of Attorney, DNR Orders must be written and signed by a physician, advanced practice registered nurse or physician assistant after consultation with the patient.

Copies of these forms should be kept in easily accessible places where others can find them.
You also should give copies of your Living Will, Health Care Power of Attorney and/or DNR Order to your authorized health care provider, family members and any close friends who might serve as caretakers. **At home, a DNR order should be displayed prominently either on the refrigerator or elsewhere so that an emergency responder will see it.**

The Hospice Choice

When choices seem few and unpleasant…

… there is hospice. Life is full of choices. We all want to be in control, capable of making our own decisions, and determine how we live our lives. When cure is no longer possible, we experience fear, frustration and confusion. We can feel as if we have lost control of our lives. Hospice helps to restore our ability to make decisions, to put life back on track by offering positive choices as we confront life's end.

What does hospice offer?

Hospice provides care for a patient by an interdisciplinary team comprised of physicians, nurses, social workers, counselors, home health aides, chaplains, therapists and volunteers as needed. In addition, hospices help provide medications, durable medical equipment, supplies and inpatient care. The hospice provides care on a 24-hour, 7-day a week basis, always there to assist with crises or concerns that may arise.

Moreover, hospice is a philosophy of care which wraps around patient wishes: your wishes will be respected and that you will be allowed to die, as pain free as possible, surrounded by those who love you, and with the utmost respect and dignity. Hospice focuses on improving the quality of life that remains, rather than just increasing the quantity.

When can I choose hospice?

People who choose hospice have medical conditions that no longer can be cured, and who are approaching the last phase of life. Hospice, with more than four decades of experience in caring for the terminally ill, offers tremendous advances in pain management that dramatically improve quality of life.

Where is hospice care provided?

Hospice services generally are provided in the soothing, familiar surroundings of your home where you are most comfortable and where loved ones can be involved more easily. If you live in a nursing home or assisted living facility, hospice care is provided in those locations as well. On occasion, an individual may choose to go to an inpatient facility to receive intensive hospice care focused on treating pain or other symptoms that cannot be treated in their home environment. Once these symptoms are under control, an individual will usually return home.

If I choose hospice care, how will I pay for the services?

Medicare, Medicaid and most private insurance companies cover the costs of hospice care. Local hospices will work closely with you to identify possible sources of payment. Hospice, the ultimate expression of caring, support and love, has served millions of people of all income levels, races, creeds, ages and medical circumstances. Hospice is here to help you when needed.

Can a hospice patient who shows signs of recovery be returned to regular medical treatment?
Yes. If the individual's condition seems to improve, the patient can be discharged from hospice and return to aggressive therapy of go on about his or her daily life. If a discharged patient should later need to return to hospice care, Medicare and most private insurance policies allow additional coverage for this purpose.

What does the hospice admission process involve?
One of the first things hospice will do is to contact the patient's physician to make sure he or she agrees that hospice care is appropriate for this patient at this time. If an individual does not have a physician, hospices may have medical staff available to help determine eligibility. Once a patient is identified as appropriate for hospice care, he or she will be asked to sign consent and insurance forms. These are similar to the forms patients sign when they enter a hospital.

Isn't hospice care just for people who have cancer?
No. Hospice care is available for patients with many terminal illnesses such as amyotrophic lateral sclerosis (ALS), dementia, heart disease, HIV/AIDS, liver disease, pulmonary disease, stroke, coma and other conditions. Inquire at your local hospice to learn more.

How do I make the hospice choice?
Speak to your physician, clergy, hospital discharge planner, social worker, nurse or local/state hospice organization. When you and your family realize that care, instead of cure, is most important to you, that is when to ask for hospice.

If I want to make the hospice choice and need more information about Ohio's hospices, who can help me?
LeadingAge Ohio, whose mission is to advance solutions for exceptional care and successful living, can provide this information. Call 800-776-9513 or visit www.LeadingAgeOhio.org.

Notes Page

For more information about organ, eye and tissue donation, please contact www.donatelifeohio.org or your local organ procurement organization:

Lifeline of Ohio
Central and Southeastern Ohio
770 Kinnear Road, Suite 200
Columbus, OH 43212
(800) 525-5667
www.lifelineofohio.org

LifeBanc
Northeastern Ohio
4775 Richmond Road
Cleveland, OH 44128-5919
(216) 752-5433
(888) 558-5433
www.lifebanc.org

Life Center Organ Donor Network
Southwestern Ohio
615 Elsinore Place, Suite 400
Cincinnati, OH 45202
(513) 558-5555
(800) 981-5433
www.lifepassiton.org

Life Connection of Dayton
40 Wyoming Street
Dayton, OH 45409
(937) 223-8223
(800) 535-9206
www.lifeconnection.org

Life Connection of Toledo
3661 Briarfield Boulevard, Suite 105
Maumee, OH 43537
(419) 893-1618
(800) 262-5443
www.lifeconnection.org

It is important to let your loved ones know that you have Advance Directives. This card is provided for your use. Please complete the card and place it in your wallet or purse so your wishes will be known to medical professionals.

Emergency Health Care Information
Advance Directives Wallet Card

Forms Located: _____
My Healthcare Power of Attorney(s)/Agent(s)
Primary
Name: _____
Phone: _____
Secondary
Name: _____
Phone: _____

I have a Living Will.
I have a Healthcare Power of Attorney Form.
I am an Anatomical Gifts Donor and have registered with the Bureau of Motor Vehicles.

Name: _____
Address: _____
City: _____ Zip: _____
State: _____
Phone: _____

Emergency Health Care Information

Advance Directives Wallet Card

LeadingAge™ Ohio

Ohio State Medical Association
The power of many. The voice of one.®

OHIO HOSPITAL ASSOCIATION

OHIO OSTEOPATHIC ASSOCIATION

Triage Cancer Estate Planning Toolkit

⌘

Part III: Your State's Estate Planning Forms

⌘

Funeral Designation Form

OHIO APPOINTMENT OF REPRESENTATIVE FOR DISPOSITION OF BODILY REMAINS, FUNERAL ARRANGEMENTS, AND BURIAL OR CREMATION GOODS AND SERVICES

Authorized by House Bill 426, Effective October 12, 2006

I, (legal name and address) _____, an adult being of sound mind, willfully and voluntarily appoint my representative, named below, to have the right of disposition, as defined in section 2108.70 of the Revised Code, for my body upon my death. All decisions made by my representative with respect to the right of disposition shall be binding.

REPRESENTATIVE(S):
(If the representative is a group of persons, indicate the name, last known address and phone number of each person in the group. Attach additional sheet if necessary.)

Name: _____

Address:_____

Telephone Number: _____

SUCCESSOR REPRESENTATIVE(S):
If my representative is disqualified from serving as my representative as described in section 2108.75 of the Revised Code, then I hereby appoint the following person or group of persons to serve as my successor representative.

(If the representative is a group of persons, indicate the name, last known address and phone number of each person in the group. Attach additional sheet if necessary.)

Name: _____

Address:_____

Telephone Number: _____

PREFERENCES REGARDING HOW THE RIGHT OF DISPOSITION SHOULD BE EXERCISED, INCLUDING ANY RELIGIOUS OBSERVANCES THE DECLARANT WISHES A REPRESENTATIVE OR A SUCCESSOR REPRESENTATIVE TO CONSIDER (attach additional sheets if necessary):

_____

_____

_____

_____

ONE OR MORE SOURCES OF FUNDS THAT COULD BE USED TO PAY FOR GOODS AND SERVICES ASSOCIATED WITH AN EXERCISE OF THE RIGHT OF DISPOSITION:

_____

_____

_____

_____

_____

DURATION:
The appointment of my representative and, if applicable, successor representative, becomes effective upon my death.

PRIOR APPOINTMENTS REVOKED:
I hereby revoke any written declaration that I executed in accordance with section 2108.70 of the Ohio Revised Code prior to the date of execution of this written declaration indicated below.

AUTHORIZATION TO ACT:
I hereby agree that any of the following that receives a copy of this written declaration may act under it:
- Cemetery organization;
- Crematory operator;
- Business operating a columbarium;
- Funeral director;
- Embalmer;
- Funeral home;
- Any other person (such as the representative named herein) asked to assist with my funeral, burial, cremation, or other manner of final disposition.

MODIFICATION AND REVOCATION - WHEN EFFECTIVE:
Any modification or revocation of this written declaration is not effective as to any party until that party receives actual notice of the modification or revocation.

LIABILITY:
No person who acts in accordance with a properly executed copy of this written declaration shall be liable for damages of any kind associated with the person's reliance on this declaration.

Signed this _____ day of _____, 2 _____

_____
(Signature of declarant)

WITNESSES:
I attest that the declarant signed or acknowledged this assignment of the right of disposition under section 2108.70 of the Revised Code in my presence and that the declarant is at least eighteen years of age and appears to be of sound mind and not under or subject to duress, fraud, or undue influence. I further attest that I am not the declarant's representative or successor representative, I am at least eighteen years of age, and I am not related to the declarant by blood, marriage, or adoption.

(CONTINUED NEXT PAGE)

First witness:
Name (printed) _____

Residing at:_____

Signature:_____ Date:_____

Second witness:
Name (printed) _____

Residing at:_____

Signature:_____Date:_____

~OR~

NOTARY ACKNOWLEDGMENT:
State of Ohio, County of_____ SS.

On _____ before me, the undersigned notary public, personally appeared _____ known to me or satisfactorily proven to be the person whose name is subscribed as the declarant, and who has acknowledged that he or she executed this written declaration under section 2108.70 of the Revised Code for the purposes expressed in that section. I attest that the declarant is at least eighteen years of age and appears to be of sound mind and not under or subject to duress, fraud, or undue influence.

Signature of notary public:
_____

My commission expires on: _____

For further reference, see ORC 2108.70 et seq. Consult your attorney for specific questions.

_____

Triage Cancer Estate Planning Toolkit

⌘

Part III: Your State's Estate Planning Forms

⌘

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