Making An Estate Plan—Applications

Sample Form: Health Care Power Of Attorney

Many people, especially as they age, become concerned that they may grow too ill to make decisions about their health care. They are worried that a family member might make a decision that would artificially extend their life or prematurely terminate it, or would otherwise choose care of which they would not approve. Their solution is to find one person they can trust, explain their health care desires, and give that person the power to make health care decisions in case they become incapacitated.

The purpose of this Power of Attorney is to give the person you designate (your "agent") broad powers to make health care decisions for you, including power to require, consent to, or withdraw any type of personal care or medical treatment for any physical or mental condition and to admit you or discharge you from any hospital, home, or other institution. This form does not impose a duty on your agent to exercise granted powers, but when powers are exercised, your agent will have to use due care to act for your benefit and in accordance with this form. He will also have to keep a record of receipts, disbursements, and significant actions taken as an agent. A court can take away your agent's powers if it finds that the agent is not acting properly. You may name successor agents under this form, but not co-agents. Unless you expressly limit the duration of this power in the manner provided below, your agent may exercise the powers given here throughout your lifetime, even after you become disabled, until you revoke this power or a court acting on your behalf terminates it. Note: This form is a sample. Every state has its own laws governing Powers of Attorney, and it is important to consult an attorney who knows the law of your state.

POWER OF ATTORNEY made this ____ day of _____ (month), 200___.

1. I, _____ (insert your name), of _____ (insert city), _____ (insert state), hereby appoint _____ (insert your agent's name), of _____ (insert agent's city), _____ (insert agent's state), as my attorney-in-fact (my "agent") to act for me in my name (in any way I could act in person) to make any and all decisions for me concerning my personal care, medical treatment, hospitalization, and health care and to require, withhold, or withdraw any type of medical procedure or treatment, even though my death may ensue. My agent shall have the same access to my medical records that I have, including the right to disclose the contents to others. My agent shall also have full power to make a disposition of any or all of my body for medical purposes, authorize an autopsy, and direct the disposition of my remains.

(THE ABOVE GRANT OF POWER IS INTENDED TO BE AS BROAD AS POSSIBLE SO THAT YOUR AGENT WILL HAVE AUTHORITY TO MAKE ANY DECISIONS YOU COULD MAKE TO OBTAIN OR TERMINATE ANY TYPE OF HEALTH CARE, INCLUDING WITHDRAWAL OF FOOD AND WATER AND OTHER LIFE-SUSTAINING MEASURES, IF YOUR AGENT BELIEVES SUCH ACTION WOULD BE CONSISTENT WITH YOUR INTENT AND DESIRES. IF YOU WISH TO LIMIT THE SCOPE OF YOUR AGENT'S POWERS OR PRESCRIBE SPECIAL RULES OR LIMIT THE POWER TO MAKE AN ANATOMICAL GIFT, AUTHORIZE AUTOPSY, OR DISPOSE OF REMAINS, YOU MAY DO SO IN THE FOLLOWING PARAGRAPHS.)

2. The powers granted above shall not include the following powers or shall be subject to the following rules or limitations:

(THE SUBJECT OF LIFE-SUSTAINING TREATMENT IS OF PARTICULAR IMPORTANCE. SOME GENERAL STATEMENTS CONCERNING THE WITHHOLDING OR REMOVAL OF LIFE-SUSTAINING TREATMENT ARE SET FORTH BELOW. IF YOU AGREE WITH ONE OF THESE STATEMENTS, YOU MAY INITIAL THAT STATEMENT; BUT DO NOT INITIAL MORE THAN ONE):

I do not want my life to be prolonged nor do I want life-sustaining treatment to be provided or continued if my agent believes the burdens of the treatment outweigh the expected benefits. I want my agent to consider the relief of suffering, the expense involved, and the quality as well as the possible extension of my life in making decisions concerning life-sustaining treatment.

Initialed _____

I want my life to be prolonged and I want life-sustaining treatment to be provided or continued unless I am in a coma that my attending physician believes to be irreversible, in accordance with reasonable medical standards at the time of reference. If and when I have suffered irreversible coma, I want life-sustaining treatment to be withheld or discontinued.

Initialed _____

I want my life to be prolonged to the greatest extent possible without regard to my condition, the chances I have for recovery, or the costs of the procedures.

Initialed _____

ABSENT AMENDMENT OR REVOCATION THIS POWER OF ATTORNEY WILL CONTINUE UNTIL YOUR DEATH, AND BEYOND IF AN ANATOMICAL GIFT, AUTOPSY, OR DISPOSITION OF REMAINS IS AUTHORIZED, UNLESS A LIMITATION ON THE BEGINNING DATE OR DURATION IS MADE BY INITIALING AND COMPLETING EITHER OR BOTH OF THE FOLLOWING:

3. This power of attorney shall become effective on _____ (enter date).

4. This power of attorney shall terminate on _____ (enter date).

(IF YOU WANT TO NAME SUCCESSOR AGENTS, INSERT THE NAMES AND ADDRESSES OF SUCH SUCCESSORS IN THE FOLLOWING PARAGRAPH).

5. If any agent named by me shall die, become incompetent, resign, refuse to accept the office of agent, or be unavailable, I name the following (each to act alone and successively, in the order named) as successors to such agent
(A) _____, of _____; and

(B) _____, of _____.

For the purposes of paragraph 5, a person shall be considered to be incompetent if and while the person is a minor or an adjudicated incompetent or disabled person or the person is unable to give prompt and intelligent consideration to health care matters, as certified by a licensed physician.

(IF YOU WISH TO NAME YOUR AGENT AS GUARDIAN OF YOUR PERSON, IN THE EVENT A COURT DECIDES THAT ONE SHOULD BE APPOINTED, YOU MAY, BUT ARE NOT REQUIRED TO, DO SO BY RETAINING THE FOLLOWING PARAGRAPH. THE COURT WILL APPOINT YOUR AGENT IF THE COURT FINDS THAT SUCH APPOINTMENT WILL SERVE YOUR BEST INTERESTS AND WELFARE. STRIKE OUT PARAGRAPH 6 IF YOU DO NOT WANT YOUR AGENT TO ACT AS GUARDIAN.)

6. If a guardian of my person is to be appointed, I nominate the agent acting under this power of attorney as such guardian, to serve without bond or security.

7. I am fully informed as to all the contents of this form and understand the full import of this grant of powers to my agent.

Signed_____

The principal has had an opportunity to read the above form and has signed the form or acknowledged his or her signature or mark on the form in my presence.

_____
Witness