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ADVANCE DIRECTIVES

FOR MENTAL HEALTH TREATMENT IN OHIO

DURABLE POWER OF ATTORNEY - HEALTH CARE

DECLARATION FOR MENTAL HEALTH TREATMENT

OHIO
LEGAL
RIGHTS
SERVICE

About This Booklet

This booklet tells you about **advance directives**: what they are, what they look like, how to make them, how to use them, how to change them and cancel them.

Advance directives are documents which state your instructions today about your health care for the future, in case you become unable to speak for yourself at the time you need treatment. You can state your instructions about the kinds of treatment you want and do not want, who may provide you treatment and who may not, and where you will and will not receive treatment.

Ohio law allows you to use different kinds of documents to state your instructions about your health care. There are important differences between these documents. The **durable power of attorney for health care** can state your instructions about medical treatment or mental health treatment or both. The **declaration for mental health treatment** can state your instructions for mental health treatment. You may have both of these documents stating your instructions about mental health treatment, but the **declaration for mental health treatment** controls.

The most important difference between these two documents is that the **durable power of attorney for health care** is always “revocable:” you may change or cancel your instructions at any time. The **declaration for mental health treatment** is not always “revocable:” if you become unable to make your own decisions because of a mental illness, you will be bound by the instructions for treatment that you gave when you created the document.

This booklet is not a substitute for professional, legal advice. You should consult with a lawyer about your rights and options in your own specific circumstances.

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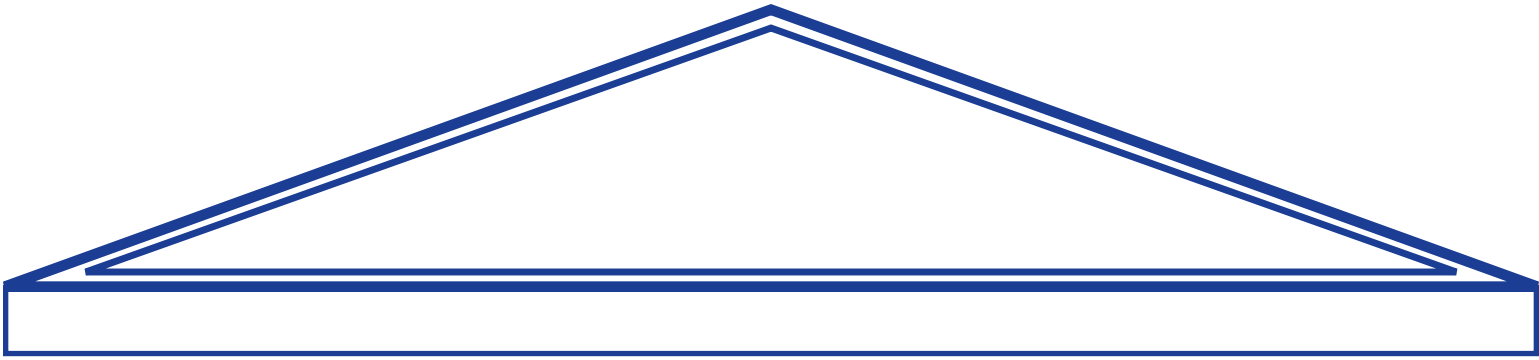
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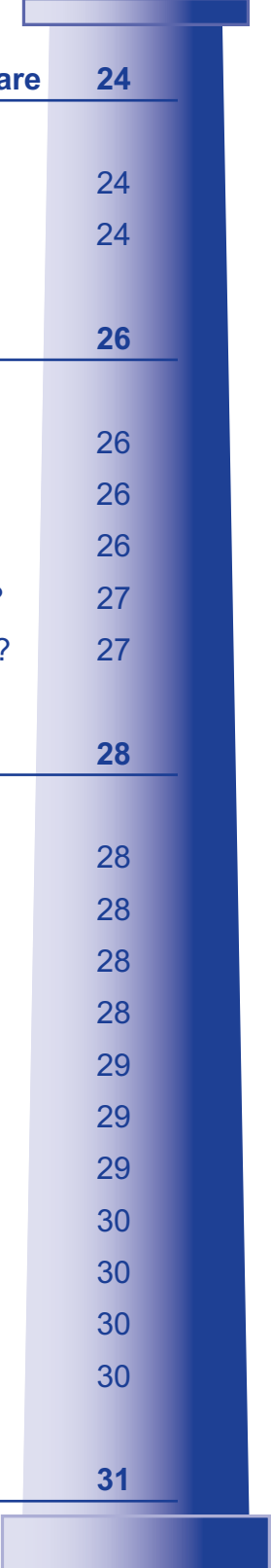
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PART I - INTRODUCTION

Note: For definitions of legal terms used in this booklet, see Part VI, page 28.

WHAT ARE ADVANCE DIRECTIVES?

Advance directives are your instructions for your health care in the future, in case you become ill and unable to speak for yourself. Advance directives are stated in legal documents. This booklet describes two kinds of legal documents you can use to state your advance directives: the **DURABLE POWER OF ATTORNEY FOR HEALTH CARE** and the **DECLARATION FOR MENTAL HEALTH TREATMENT**. This booklet then focuses on the **DURABLE POWER OF ATTORNEY FOR HEALTH CARE**. Advance directives documents may state your instructions for both medical treatment and for mental health treatment. This booklet focuses on advance directives for mental health treatment.

Like any publication about the law and your legal rights, this booklet is not a substitute for professional legal advice. In order to protect your legal rights, you should consult a lawyer about the details of your own situation. For referrals to lawyers, contact:

- ▶ Ohio State Bar Association (OSBA)
TEL> 614-487-2050
WEB> <http://www.ohiobar.org/memsrc/memdir/>

- ▶ Ohio State Legal Services Association (OSLSA)
TEL> 866-529-6446
WEB> <http://www.oslsa.org./OSLSA/PublicWeb/LegalSvcs>

- ▶ Ohio Legal Rights Service (OLRS)
TEL> 800-282-9181 or 614-466-7264
TTY> 800-858-3542 or 614-728-2553
WEB> <http://olrs.ohio.gov>

HOW CAN I NAME SOMEONE TO SPEAK FOR ME IN CASE I CAN NOT SPEAK FOR MYSELF?

Ohio laws define five kinds of legal documents by which you may name other people to speak for you, in case you are not able to speak for yourself. In these documents you are called the principal. As the principal, you execute a document when you create and sign the document and your signature is witnessed or notarized. The person you name to speak for you may be called your agent, your proxy or your attorney-in-fact, depending upon the kind of document you execute. Whatever the term, you name that person to speak for you according to your instructions. The five kinds of legal documents defined by Ohio laws are:

General Power of Attorney

In the general power of attorney, you direct your agent, proxy or attorney-in-fact to speak for you, usually in financial or property-related matters such as signing your checks or signing closing papers to sell your house. The general power of attorney is temporary and loses effect if you are incapacitated or judged to be incompetent. The general power of attorney is defined in Ohio Revised Code (ORC) sections 1337.01 through 1337.08. New ORC section 1337.18, effective March 18, 2006, creates a statutory form for power of attorney.

Durable Power of Attorney

In the durable power of attorney, you also direct your attorney-in-fact to speak for you, as you would in the general power of attorney, except that the durable power of attorney endures, or remains in effect for as long as you specify and remains in effect if you become incapacitated or are judged to be incompetent. The durable power of attorney is defined in ORC section 1337.09.

Durable Power of Attorney for Health Care

In the **DURABLE POWER OF ATTORNEY FOR HEALTH CARE**, you name an attorney-in-fact to make health care treatment decisions (medical treatment, mental health treatment or both) for you, if your attending physician determines that you have lost the capacity to make health care decisions for yourself. If you wish, you may state specific instructions to your attorney-in-fact, such as when to consent to treatment, when to refuse treatment, and when to withdraw consent to treatment. The **DURABLE POWER OF ATTORNEY FOR HEALTH CARE** is defined in ORC sections 1337.11 through 1337.17.

Declaration for Mental Health Treatment

In the **DECLARATION FOR MENTAL HEALTH TREATMENT**, you declare your instructions for the use or continuation of mental health treatment, or for the withholding or withdrawal of mental health treatment. If you wish, you may designate a proxy to make mental health treatment decisions according to your declaration. The **DECLARATION FOR MENTAL HEALTH TREATMENT** is defined in ORC sections 2135.01 through 2135.14.

Living Will

In a living will, you declare your instructions for the use or continuation of life-sustaining treatment, or for the withholding or withdrawal of life-sustaining treatment. Unless you specify otherwise, the living will is triggered or becomes active if your attending physician and one other physician determine that you are in a terminal condition or in a permanently unconscious state. The living will is defined in ORC sections 2133.01 through 2133.15. If you have both a living will and a “Do-not-resuscitate” (DNR) order, the living will controls treatment decisions over the DNR, if the DNR is not consistent with your living will.

WHAT ARE TWO KINDS OF LEGAL DOCUMENTS FOR MENTAL HEALTH TREATMENT?

Among the five kinds of legal documents, two documents may be used to declare advance directives for mental health treatment. You may execute the **DURABLE POWER OF ATTORNEY FOR HEALTH CARE** or the **DECLARATION FOR MENTAL HEALTH TREATMENT** as your advance directives for mental health treatment.

You may have both of these documents in effect at the same time to declare your advance directives for health care. You may have the **DURABLE POWER OF ATTORNEY FOR HEALTH CARE** to state your medical treatment instructions, and you may have the **DECLARATION FOR MENTAL HEALTH TREATMENT** to state your mental health treatment instructions. However, if both documents state your instructions for your mental health treatment, then your **DECLARATION FOR MENTAL HEALTH TREATMENT** would be the controlling document for your mental health treatment.

An important difference between the two documents is that a **DURABLE POWER OF ATTORNEY FOR HEALTH CARE** is revocable (able to be revoked or cancelled) at any time. You may cancel or change your instructions whenever you wish. A **DECLARATION FOR MENTAL HEALTH TREATMENT** is not necessarily revocable at any time. If your doctor determines that you lack capacity to make decisions about your health care, you may not revoke your **DECLARATION FOR MENTAL HEALTH TREATMENT**. You may revoke the declaration only after you have regained decision-making capacity.

The **DECLARATION FOR MENTAL HEALTH TREATMENT** is a relatively new document, defined by an Ohio law enacted October 29, 2003. Because the law is fairly new, it is not clear how Ohio courts will

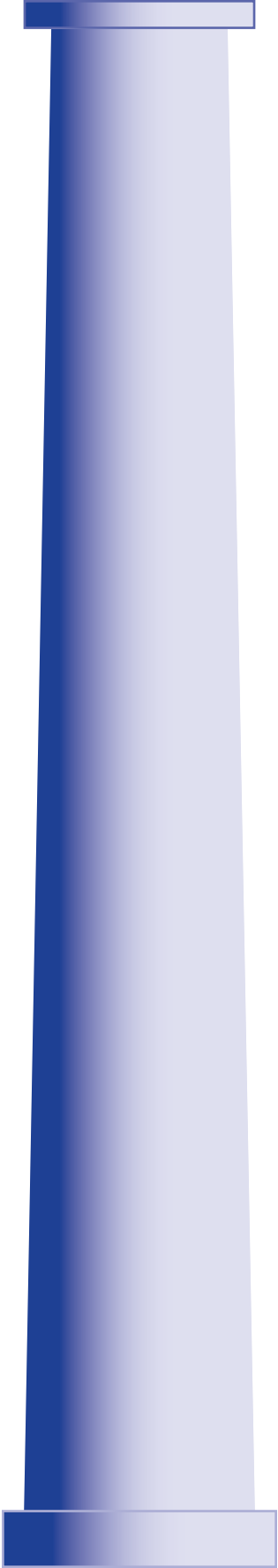
interpret or enforce a **DECLARATION FOR MENTAL HEALTH TREATMENT** and your wishes stated in that document.

WHAT ARE THE BENEFITS AND LIMITATIONS OF ADVANCE DIRECTIVES?

Advance directives can be an important tool for you as a consumer of mental health services to guide your care if your physician determines that you lack capacity to make your own health care choices. In Ohio, you may state your advance directives for mental health treatment by executing the two kinds of legal documents described above, the **DURABLE POWER OF ATTORNEY FOR HEALTH CARE** and the **DECLARATION FOR MENTAL HEALTH TREATMENT**.

Under Ohio laws, advance directives are only one aspect of informed consent to treatment. The right to informed consent means that you have the right to be given enough information to make your own decisions about your medical and mental health treatment. However, if a probate court finds that you are not competent to make these decisions, the court may appoint a guardian to make these decisions for you. If a probate court orders you to be admitted to a hospital for mental health treatment, the hospital can ask the court to issue an order to give you medication without your consent.

By executing advance directives documents – the **DURABLE POWER OF ATTORNEY FOR HEALTH CARE** or the **DECLARATION FOR MENTAL HEALTH TREATMENT** – and by giving your agent, proxy or attorney-in-fact instructions about your preferences for mental health treatment, you may be able to exercise more control over your care. You may be able to avoid involvement of the probate court, because during times you can not speak for yourself, health care decisions will be made by your agent, proxy or attorney-in-fact according to your instructions.



You may also state your directions for non-health care matters such as child care, notifying your employer of your hospitalization, paying your bills while you are in the hospital, and other non-health care matters. While these matters are beyond the scope of the advance directives documents (**DURABLE POWER OF ATTORNEY FOR HEALTH CARE** and **DECLARATION FOR MENTAL HEALTH TREATMENT**), you can plan for other non-health care matters in advance by creating and executing a general power of attorney to state your directions. You should consult an attorney to create and execute a general or a durable power of attorney.

Advance directives do not require your health care providers to provide kinds of health care that are not otherwise available to you through your insurance or public benefits. Advance directives documents also do not direct the kinds of treatment that your health care providers would prescribe for you according to their professional judgment. However, advance directives can give you a voice, through your agent, proxy or attorney-in-fact, to make your instructions known to your health care provider and to others involved.

As stated earlier, the **DECLARATION FOR MENTAL HEALTH TREATMENT** is a relatively new document, and it is not clear how Ohio courts will interpret or enforce a **DECLARATION FOR MENTAL HEALTH TREATMENT** and the principal's wishes stated in that document. Also, using the declaration limits your freedom to change your mind about (revoke) the directive. Therefore, the remainder of this booklet will focus on the well-established form of advance directives, the **DURABLE POWER OF ATTORNEY FOR HEALTH CARE**.

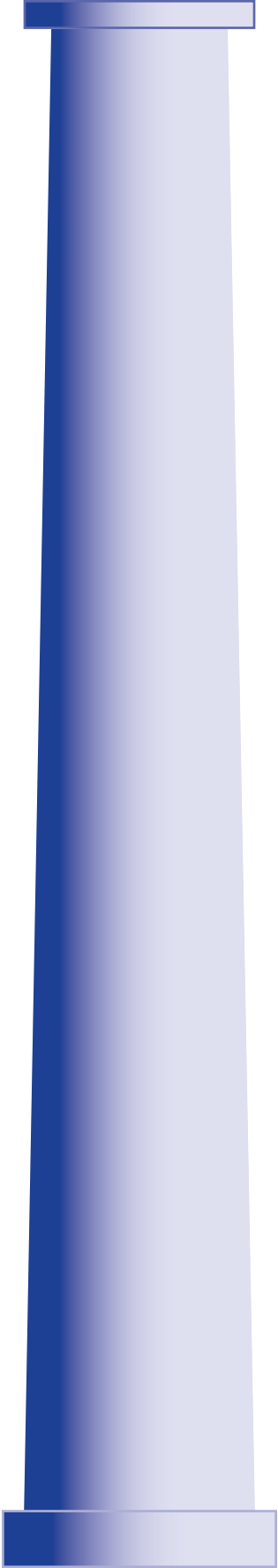
WHAT ELSE SHOULD I KNOW ABOUT THE DURABLE POWER OF ATTORNEY FOR HEALTH CARE?

In order to have a **DURABLE POWER OF ATTORNEY FOR HEALTH CARE**, you must complete a **DURABLE POWER OF ATTORNEY FOR HEALTH CARE** form, sign it, and have your signature either notarized or witnessed by people who meet the legal requirements to be a notary or witness. These legal requirements are stated in ORC section 1337.17. That section must be stated at the end of the **DURABLE POWER OF ATTORNEY FOR HEALTH CARE** form.

In the **DURABLE POWER OF ATTORNEY FOR HEALTH CARE** form, you name the agent you want to make health care decisions for you if you lose the capacity to make informed health care decisions for yourself. You may name alternate agents and list them in order of priority, in case your first-choice agent is unable or unwilling to serve when needed. You should name a primary agent and one or two alternate agents.

In addition to naming your agent, you may give oral and written instructions to your agent about your health care. You may tell your agent the kinds of treatment you want and the kinds of treatment you do not want and the circumstances. Your agent is required by law to act according to your wishes if your wishes are known. If your agent does not know what your wishes are, your agent is required to act in your best interests, as determined by your agent.

If you have a **DURABLE POWER OF ATTORNEY FOR HEALTH CARE**, you will continue to make your own health care decisions unless your attending physician determines that you have lost the capacity to make informed health care decisions. If your attending physician determines that you have lost the capacity to make informed health



care decisions, your **DURABLE POWER OF ATTORNEY FOR HEALTH CARE** then “springs” into effect, and your agent begins making health care decisions for you.

Unless your **DURABLE POWER OF ATTORNEY FOR HEALTH CARE** document states otherwise, your agent has the same power as you would have to make health care decisions. In addition to making decisions about your health care, your agent will be informed about your proposed health care, will review your health care records, and will give or refuse consent to the disclosure of your health care records.

You should give a copy of your **DURABLE POWER OF ATTORNEY FOR HEALTH CARE** document to your agent, to your doctors, and to other health care providers. Your agent and health care providers can rely on your **DURABLE POWER OF ATTORNEY FOR HEALTH CARE** only if they are given a copy. Your health care providers must follow your agent’s instructions if all of the following conditions are met:

- ▶ if your **DURABLE POWER OF ATTORNEY FOR HEALTH CARE** document has been given to them, and the document is properly executed;
- ▶ if your **DURABLE POWER OF ATTORNEY FOR HEALTH CARE** document substantially complies with all legal requirements; and
- ▶ if your health care providers have not been notified by either you or by a witness that you have revoked your **DURABLE POWER OF ATTORNEY FOR HEALTH CARE**.

You may revoke your **DURABLE POWER OF ATTORNEY FOR HEALTH CARE** at any time, even after your attending physician has determined that you lack capacity to make health care decisions.

PART II - CREATING A DURABLE POWER OF ATTORNEY FOR HEALTH CARE

WHO DECIDES WHETHER I SHOULD HAVE THIS DOCUMENT?

Only you may decide whether you should have a **DURABLE POWER OF ATTORNEY FOR HEALTH CARE**. Your decision must be voluntary. The witnesses and the notary public who sign your document attest that you created and signed the document freely, and not under or subject to duress, fraud or undue influence. You should never sign a **DURABLE POWER OF ATTORNEY FOR HEALTH CARE** document under pressure or coercion to sign.

Health care providers may not interfere with your **DURABLE POWER OF ATTORNEY FOR HEALTH CARE** rights under Ohio law. Under ORC section 1337.16(A), health care providers may not require you to create, to not create, to revoke, or to not revoke a **DURABLE POWER OF ATTORNEY FOR HEALTH CARE** as a condition to be admitted to a facility, to be provided health care, to be covered by insurance, or to receive benefits.

WHO MAY HAVE A DURABLE POWER OF ATTORNEY FOR HEALTH CARE?

If you are an Ohio resident who meets all of the following criteria, you may execute a **DURABLE POWER OF ATTORNEY FOR HEALTH CARE**:

- ▶ you must be at least eighteen years old;
- ▶ you must be of sound mind; and
- ▶ you must not be under or subject to duress, fraud, or undue influence in executing the document.

WHAT DOES IT MEAN TO BE “OF SOUND MIND?”

Ohio courts have not decided the exact meaning of “of sound mind” in this context. The phrase is not defined in the **DURABLE POWER OF ATTORNEY FOR HEALTH CARE** statute (ORC section 1337.12). However, Ohio courts generally apply a functional test. A person of sound mind must have the ability to understand and to communicate the decision to execute a **DURABLE POWER OF ATTORNEY FOR HEALTH CARE** and the effect of the document. Mental illness alone, even having a legal guardian, does not necessarily mean that you are not “of sound mind” for the purposes of executing a **DURABLE POWER OF ATTORNEY FOR HEALTH CARE**. However, these are factors that could later be used to challenge your document.

Given Ohio courts’ functional test, a working definition of “of sound mind” would be:

- ▶ at the time you execute the **DURABLE POWER OF ATTORNEY FOR HEALTH CARE**, you have the capacity to make informed health care decisions for yourself; and
- ▶ you understand the basic purpose of the document you are signing, and the consequences of signing the document.

WHAT DOES IT MEAN TO “EXECUTE” A DURABLE POWER OF ATTORNEY FOR HEALTH CARE?

To execute a **DURABLE POWER OF ATTORNEY FOR HEALTH CARE** document means doing all of the following:

- ▶ properly completing the document;
- ▶ either signing the document or acknowledging your signature in the presence of a notary public or two witnesses who qualify as notary or witness under Ohio law;

- ▶ having the document signed by either a notary public or two witnesses who qualify as notary or witness under Ohio law; and
- ▶ dating the document.

WHO IS QUALIFIED UNDER OHIO LAW TO WITNESS MY DOCUMENT?

Any person may sign your **DURABLE POWER OF ATTORNEY FOR HEALTH CARE** as a witness if that person:

- ▶ is at least eighteen years old
- ▶ is not related to you by blood, marriage or adoption;
- ▶ is not named in your **DURABLE POWER OF ATTORNEY FOR HEALTH CARE** document as your agent, or as an alternate agent;
- ▶ is not your attending physician;
- ▶ is not the administrator of a nursing home in which you receive care; and
- ▶ does not have a court-appointed guardian.

By signing a **DURABLE POWER OF ATTORNEY FOR HEALTH CARE** either as a witness or a notary, the witness or notary attests that you appear to be of sound mind and are not under or subject to duress, fraud or undue influence. The witness or notary must believe that you understand the document and the consequences of signing and are signing freely without coercion or pressure to sign.

WHOM SHOULD I CHOOSE AS MY AGENT?

It is important to give careful thought to choosing your agent. You should only choose someone you know well and someone you trust,

such as a trusted relative or friend. You should feel comfortable discussing all aspects of your health care with your agent. Your agent must be willing to serve as your agent and should be willing to listen to your health care wishes and to act accordingly, even if the agent might disagree with your wishes. For some people, it is important to choose an agent who has health care values and treatment preferences that are similar to their own. For others, this is less important.

When your **DURABLE POWER OF ATTORNEY FOR HEALTH CARE** springs into effect, your agent will have access to all information about your medical condition and treatment options. Your agent will discuss your medical condition with your doctors and other health care providers and will make all medical and mental health treatment decisions for you.

ARE THERE PEOPLE I MAY NOT NAME AS MY AGENT?

Yes. You may not name as your agent any of the following people:

- ▶ a person who is under age eighteen;
- ▶ a person who has a court-appointed guardian;
- ▶ your attending physician;
- ▶ the administrator of a nursing home in which you are receiving care;
- ▶ an employee or agent of your attending physician, unless you are related to that employee or agent by blood, marriage or adoption, or you are members of the same religious order; or
- ▶ an employee or agent of any health care facility in which you are being treated, unless you are related to that person by blood, marriage or adoption, or you are members of the same religious order. For example, you may not name your case

manager as your agent unless you are related to your case manager by blood, marriage or adoption, or you are members of the same religious order.

To avoid conflict of interest, you also should not name as your agent the owner or operator of a residential facility in which you live, unless you are related to that person by blood, marriage or adoption, or you are members of the same religious order.

WHEN DOES MY DURABLE POWER OF ATTORNEY FOR HEALTH CARE EXPIRE?

The answer to this question depends on what you have written in your **DURABLE POWER OF ATTORNEY FOR HEALTH CARE**. If the document does not contain an expiration date, it will not expire unless you execute a new document or you revoke the document.

If your **DURABLE POWER OF ATTORNEY FOR HEALTH CARE** states that it will expire on a certain date or in a certain number of years, then the document will expire on that date, unless on that date you lack the capacity to make informed health care decisions, as determined by your attending physician. In that case, your **DURABLE POWER OF ATTORNEY FOR HEALTH CARE** will continue in effect until you regain the capacity to make your own health care decisions, and then it will expire. You may still revoke your **DURABLE POWER OF ATTORNEY FOR HEALTH CARE**, even if you have lost capacity to make your own health care decisions.

WHAT IS THE LEGAL LANGUAGE AT THE END OF THE DOCUMENT?

The law requires that pre-printed **DURABLE POWER OF ATTORNEY FOR HEALTH CARE** forms include the language of ORC section 1337.17, which describes the legal limits on your agent's authority to make certain kinds of health care decisions.

ARE THERE LIMITS ON MY AGENT'S AUTHORITY TO MAKE HEALTH CARE DECISIONS FOR ME?

Yes, there are limits to your agent's authority. Your agent may not refuse or withdraw life-sustaining treatment *unless*:

- ▶ you are in a "terminal condition" as determined by your attending physician, or you are in a "permanently unconscious state" as determined by your attending physician and verified by a second physician; and
- ▶ in the case of a permanently unconscious state, the consulting second physician must be qualified to make that determination ("qualified to determine" a permanently unconscious state is described in ORC section 2133.13(B)(2)); and
- ▶ the attending physician determines that there is no reasonable possibility that you will regain the capacity to make informed health care decisions.

Similar restrictions apply to refusal or withdrawal of "comfort care" (any treatment that diminishes pain or discomfort). The agent may refuse or withdraw nutrition or hydration only if your **DURABLE POWER OF ATTORNEY FOR HEALTH CARE** includes your express language, printed in capital letters and initialed by you, to allow your agent to refuse or withdraw comfort care.

You can have both a valid **DURABLE POWER OF ATTORNEY FOR HEALTH CARE** and a valid living will at the same time. However, your living will would supersede (it would control or "trump") your **DURABLE POWER OF ATTORNEY FOR HEALTH CARE** wherever the two documents conflict or disagree, if you are in a terminal condition or in a permanently unconscious state.

Other restrictions may apply if you are pregnant. The agent may not refuse or withdraw health care if that would terminate the pregnancy, unless:

- ▶ there is a substantial risk to your life; or
- ▶ your attending physician and a second physician determine that the fetus would not be born alive.

These and other health care treatment issues are difficult for many people to think about and to talk about. It is important to consider these issues and to make sure that you understand what decisions the **DURABLE POWER OF ATTORNEY FOR HEALTH CARE** law allows your agent to make, what decisions it does not allow, and what may happen in case such a decision becomes necessary. You should read and understand the legal notice included in all standardized **DURABLE POWER OF ATTORNEY FOR HEALTH CARE** forms.

PART III - USING YOUR DURABLE POWER OF ATTORNEY FOR HEALTH CARE

WHAT AUTHORITY DOES MY AGENT HAVE TO MAKE DECISIONS FOR ME?

If your attending physician has determined that you lack the capacity to make informed health care decisions for yourself, the general rule is that your agent may do anything you could have done had you not lost decision-making capacity. Your agent may rely on your **DURABLE POWER OF ATTORNEY FOR HEALTH CARE** to make decisions for you, if all of the following conditions are met:

- ▶ a copy of your **DURABLE POWER OF ATTORNEY FOR HEALTH CARE** has been given to the agent, and it is properly completed;
- ▶ your **DURABLE POWER OF ATTORNEY FOR HEALTH CARE** substantially complies with all legal requirements; and
- ▶ you have not revoked your **DURABLE POWER OF ATTORNEY FOR HEALTH CARE**.

An exception to these conditions is when your **DURABLE POWER OF ATTORNEY FOR HEALTH CARE** document states some other conditions and these other conditions are consistent with Ohio law. In that case, the conditions written in your **DURABLE POWER OF ATTORNEY FOR HEALTH CARE** will control.

A second exception is that your agent does not have authority to withdraw informed consent to any health care to which you previously consented, unless at least one of the following applies:

- ▶ a change in your physical condition has significantly decreased the benefit of that health care to you; or
- ▶ the health care is not, or is no longer, significantly effective in achieving the purposes for which you consented to its use.

For more information about your agent's authority to make decisions about life-sustaining treatment, you should read the notice attached to every standardized **DURABLE POWER OF ATTORNEY FOR HEALTH CARE** form.

HOW LONG MAY MY AGENT CONTINUE TO MAKE HEALTH CARE DECISIONS FOR ME?

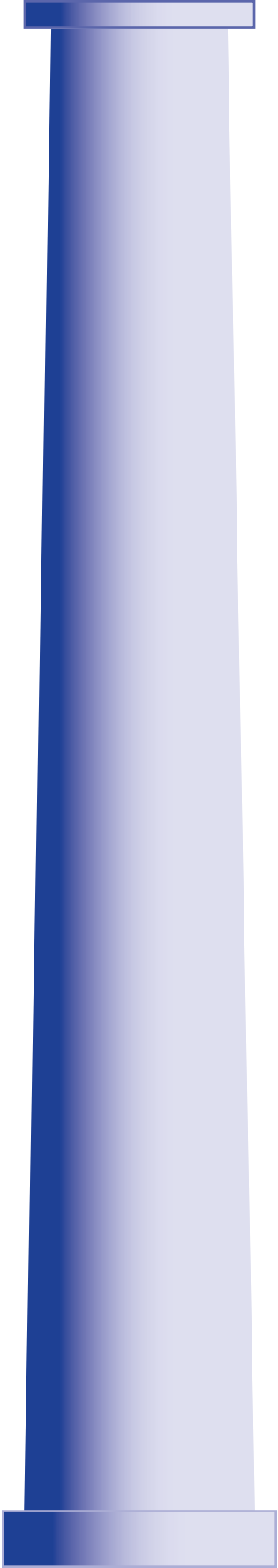
Your agent may continue to make health care decisions for you until one of the following happens:

- ▶ you regain the capacity to make health care decisions for yourself, as determined by your attending physician;
- ▶ you revoke your **DURABLE POWER OF ATTORNEY FOR HEALTH CARE**;
- ▶ you revoke all or part of your agent's authority; or
- ▶ your guardian modifies or revokes your **DURABLE POWER OF ATTORNEY FOR HEALTH CARE**.

Once your attending physician determines that you have regained the capacity to make your own health care decisions, then you resume doing so, and your agent no longer has any legal authority to make those decisions for you.

WHAT ARE HEALTH CARE PROVIDERS' OBLIGATIONS UNDER MY ADVANCE DIRECTIVES?

The federal Patient Self-Determination Act requires hospitals and some other health care providers that receive Medicare or Medicaid



funding to give each patient written information about rights under state law to have advance directives, to ask whether the patient has advance directives, and to record the patient's response in his medical record. If the patient has advance directives, provider staff may advise the patient of the right to produce a copy of the document for the medical record. Providers may not condition care or otherwise discriminate based on whether or not a person has executed an advance directive.

Under Ohio law, once your **DURABLE POWER OF ATTORNEY FOR HEALTH CARE** springs into effect, and if your health care provider has a copy of your document, then the health care provider is required to give your agent all information that your agent needs to make informed health care decisions for you. Your health care provider is required to do all of the following:

- ▶ document your attending physician's determination that you lack the capacity to make informed health care decisions for yourself, if the provider has legal access to that information;
- ▶ if your **DURABLE POWER OF ATTORNEY FOR HEALTH CARE** document is given to the provider, the provider must place it in your medical record;
- ▶ determine whether your **DURABLE POWER OF ATTORNEY FOR HEALTH CARE** substantially complies with ORC section 1337.12;
- ▶ obtain informed consent or refusal of consent from your agent regarding all health care treatment that is offered to you, and to document that consent or refusal in your medical record; and
- ▶ if you have revoked your **DURABLE POWER OF ATTORNEY FOR HEALTH CARE**, to document the revocation in your medical record and no longer rely on the revoked document.

Any instructions that you state in writing in your **DURABLE POWER OF ATTORNEY FOR HEALTH CARE** are instructions to your agent only and are not instructions to your health care providers. Therefore, your health care providers may not rely on your written instructions. The health care provider must, however, allow your agent to make the decisions about your health care.

If you inform a health care provider orally or in writing that you revoke your **DURABLE POWER OF ATTORNEY FOR HEALTH CARE**, then the health care provider may no longer rely on that document. The provider is required to document the revocation in your medical record. A witness to the revocation may also communicate the revocation to your health care provider, with the same effect as if you had notified the provider of the revocation.

ARE MY AGENT'S ACTIONS LEGALLY BINDING?

As long as you lack the capacity to make informed health care decisions for yourself, as determined by your attending physician, all actions of your agent done in good faith while acting under the authority of your **DURABLE POWER OF ATTORNEY FOR HEALTH CARE** are legally binding on you, your heirs and personal representatives to the same extent as if you had the capacity and had done those acts yourself.

WHAT IF MY AGENT REFUSES TO ACT ACCORDING TO MY ADVANCE DIRECTIVES?

If your agent's actions are not consistent with your wishes, then you may either revoke that person's authority to act as your agent, or you may revoke your entire **DURABLE POWER OF ATTORNEY FOR HEALTH CARE** document. You have these options even if your attending

physician has found that you lack capacity to make health care decisions.

By law, your agent is not subject to criminal prosecution or professional disciplinary action, and will not be held liable for money damages in a civil lawsuit, for health care decisions made in good faith while acting under the authority granted by your **DURABLE POWER OF ATTORNEY FOR HEALTH CARE**. You may not sue your agent for health care decisions the agent made in good faith while acting under the authority granted by your **DURABLE POWER OF ATTORNEY FOR HEALTH CARE**.

WHAT IF MY HEALTH CARE PROVIDER REFUSES TO COMPLY WITH THE DECISIONS OF MY AGENT?

Your attending physician or a health care facility in which you are confined may refuse to comply, or to allow compliance, with the decisions of your agent under your **DURABLE POWER OF ATTORNEY FOR HEALTH CARE** based on a “matter of conscience or on another basis.” An employee or agent of the attending physician or of the health care facility may refuse to comply only based on a “matter of conscience” and for no other reason. For more information, see ORC section 1337.16(B)(1).

If either your attending physician or the health care facility is not willing or able to comply, or to allow compliance, with the instructions of your agent regarding your health care, then your agent may have you transferred to the care of another physician or health care facility that is willing and able to comply, or allow compliance. In connection with your transfer, the transferring physician or health care facility may not prevent, attempt to prevent, unreasonably delay, or attempt to delay, your transfer to the care of another physician or facility. ORC section 1337.16(B)(2).

If the instruction of your agent is to use or continue life-sustaining treatment, then the attending physician or health care facility that is not willing or able to comply or allow compliance with that instruction is nevertheless required to use or continue such life-sustaining treatment, or allow it to be used or continued, until you can be transferred to another physician or facility.

A **DURABLE POWER OF ATTORNEY FOR HEALTH CARE** document does not affect or limit the authority of a physician or a health care facility to provide health care to a person in an emergency, consistent with reasonable medical standards that apply to an emergency situation.

MAY MY DOCTOR OR OTHER PROVIDER BE SUED IN CONNECTION WITH ADVANCE DIRECTIVES?

The general rule is that a physician is not subject to criminal prosecution, professional disciplinary action or civil liability in money damages for actions taken in good faith and in reliance upon the health care decisions your agent makes for you according to your **DURABLE POWER OF ATTORNEY FOR HEALTH CARE**. For more information about physician liability, see ORC section 1337.15. However, no health care provider is immune from criminal or civil liability, or from professional disciplinary action, for actions that are outside the scope of the health care provider's authority. A physician or other health care provider, and their employees and agents, may be held civilly liable for money damages if both:

- ▶ the liability arises from a negligent action or omission in connection with the medical diagnosis, care or treatment of a principal under a **DURABLE POWER OF ATTORNEY FOR HEALTH CARE**, or for any deviation from reasonable medical standards; and
- ▶ the negligent action or omission, or the deviation, caused or contributed to the principal's injury or wrongful death.

PART IV - REVOKING OR CHANGING YOUR DURABLE POWER OF ATTORNEY FOR HEALTH CARE

MAY I CHANGE MY DURABLE POWER OF ATTORNEY FOR HEALTH CARE?

You may change your DURABLE POWER OF ATTORNEY FOR HEALTH CARE at any time by either destroying it or by executing a new DURABLE POWER OF ATTORNEY FOR HEALTH CARE. Executing a new DURABLE POWER OF ATTORNEY FOR HEALTH CARE automatically revokes the earlier DURABLE POWER OF ATTORNEY FOR HEALTH CARE, unless the new document states otherwise. Even so, you should destroy the old document in order to avoid the danger of others relying on it in error.

If you have given copies of the old document to your agent, health care providers, relatives, friends or others, you should retrieve those copies and destroy them. If someone will not return the document to you, you should give that person your notice of revocation in writing.

HOW DO I REVOKE MY DURABLE POWER OF ATTORNEY FOR HEALTH CARE?

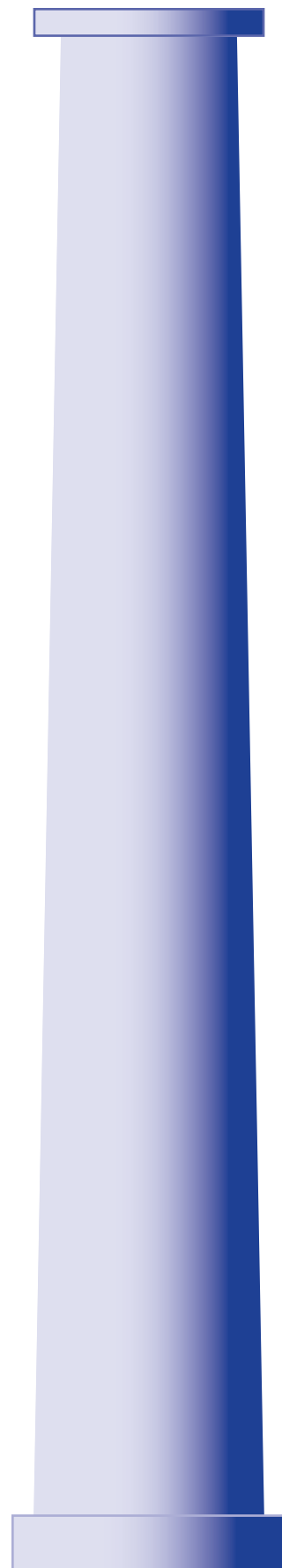
You may revoke your DURABLE POWER OF ATTORNEY FOR HEALTH CARE at any time and in any manner. The general rule is that your revocation is effective when you simply express your intention to revoke your document.

An exception to the general rule for revocation concerns your attending physician. If your attending physician is aware of your DURABLE POWER OF ATTORNEY FOR HEALTH CARE, your physician must be informed by you, or by a witness to your revocation, or by another health care staff person who has been informed by a witness

to your revocation. Absent actual knowledge to the contrary, health care personnel who are informed of the revocation may rely on the revocation and act in accordance with it. Health care personnel who are notified of the revocation must document the revocation in your medical record and may no longer rely on it.

While your written notice of revocation is not required, written notice may make it easier to prove that you revoked your **DURABLE POWER OF ATTORNEY FOR HEALTH CARE**. In your written notice of revocation, you should refer to the date you signed the document in order to be clear about which version of your **DURABLE POWER OF ATTORNEY FOR HEALTH CARE** you have revoked.

Unless your **DURABLE POWER OF ATTORNEY FOR HEALTH CARE** states otherwise, executing a new document automatically revokes an earlier one. If you have a court-appointed guardian, your guardian may also revoke your **DURABLE POWER OF ATTORNEY FOR HEALTH CARE**.



PART V - STANDARDIZED DURABLE POWER OF ATTORNEY FOR HEALTH CARE FORMS

DO I NEED AN ATTORNEY TO WRITE A DURABLE POWER OF ATTORNEY FOR HEALTH CARE?

The answer to this question depends on the kind of **DURABLE POWER OF ATTORNEY FOR HEALTH CARE** you want. If one of the standardized **DURABLE POWER OF ATTORNEY FOR HEALTH CARE** forms meets your needs, then you may complete the form without assistance from an attorney. However, if you have questions about a **DURABLE POWER OF ATTORNEY FOR HEALTH CARE** you should always ask an attorney for assistance.

If you want a customized **DURABLE POWER OF ATTORNEY FOR HEALTH CARE** that offers options not addressed on the standardized form, then you should consult an attorney for assistance.

WHAT IS A STANDARDIZED DURABLE POWER OF ATTORNEY FOR HEALTH CARE FORM?

A standardized **DURABLE POWER OF ATTORNEY FOR HEALTH CARE** form is one that is pre-printed, and you fill in the blanks, date the form, sign it, and have your signature notarized or witnessed by people who satisfy the legal requirements to be a witness or notary.

WHAT STANDARDIZED FORMS ARE AVAILABLE IN OHIO?

The most common form is the one approved by the Ohio State Medical Association (OSMA) and the Ohio State Bar Association (OSBA). This form is easily identifiable because it bears the logos of these two associations in the top corners of page one. This form

is the shortest and most basic **DURABLE POWER OF ATTORNEY FOR HEALTH CARE** form. On this form you name the agent you want to make your medical and mental health care decisions. However, you may not give your agent written instructions about your mental health care treatment preferences on this form.

IS THERE AN ADVANTAGE TO A FORM THAT SPECIFICALLY ADDRESSES MENTAL HEALTH CARE?

Yes, an important advantage of forms that specifically address your instructions for mental health care is that they allow you to give written instructions to your agent about your mental health care directly on the **DURABLE POWER OF ATTORNEY FOR HEALTH CARE** form.

IS THERE AN ADVANTAGE TO THE STANDARD FORM APPROVED BY THE OSBA AND OSMA?

The Ohio State Medical Association and Ohio State Bar Association **DURABLE POWER OF ATTORNEY FOR HEALTH CARE** form has been available for several years, and hospitals and physicians may be more familiar with and willing to accept this form. In contrast, hospitals and physicians may not be willing to rely on another form until their attorneys have reviewed the form to ensure that it complies with legal requirements. The health care provider is responsible for determining that your **DURABLE POWER OF ATTORNEY FOR HEALTH CARE** substantially complies with Ohio law. There may be a time delay while waiting for the health care provider's attorney to approve another form.

PART VI - DEFINITIONS

AGENT

The person you name in your **DURABLE POWER OF ATTORNEY FOR HEALTH CARE** to make health care decisions for you. Also called an attorney-in-fact or proxy. This person does not have to be a lawyer.

CAPACITY

Having the mental competency to execute a will or some other document at the time the will was signed and witnessed. The ability to resist the pressures or domination of any person who may try to use undue influence on the person executing the document.

COMFORT CARE

“(1) Nutrition when administered to diminish the pain or discomfort of a principal, but not to postpone death; (2) Hydration when administered to diminish the pain or discomfort of a principal, but not to postpone death; or (3) Any other medical or nursing procedure, treatment, intervention, or other measure that is taken to diminish the pain or discomfort of a principal, but not to postpone death.” ORC section 1337.11(C)

EXECUTE

With regard to a **DURABLE POWER OF ATTORNEY FOR HEALTH CARE**, execute means doing all of the following: (1) properly completing the document; (2) signing it or acknowledging your signature in the presence of a notary public or two witnesses who meet the legal

requirements to be a notary or witness; (3) having the document signed by either a notary public or two witnesses who meet the legal requirements to be a notary or witness; and (4) dating the document.

HEALTH CARE

“Any care, treatment, service, or procedure to maintain, diagnose, or treat an individual’s physical or mental condition or physical or mental health.” ORC section 1337.11(G)

INCAPACITY

Lacking the ability to understand one’s actions in making a will, executing some other document or entering into an agreement.

INCOMPETENT

Incompetent for purposes of the **DURABLE POWER OF ATTORNEY FOR HEALTH CARE** is defined by ORC section 1337.11(O) to have the same meaning as defined by ORC section 2111.01(D): “any person who is so mentally impaired as a result of a mental or physical illness or disability, or mental retardation, or as a result of chronic substance abuse, that the person is incapable of taking proper care of the person’s self or property or fails to provide for the person’s family or other persons for whom the person is charged by law to provide, or any person confined to a correctional institution within this state.”



OF SOUND MIND

At the present time, you have the capacity to make informed health care decisions for yourself, and you understand the basic purpose of the document you are signing and the consequences of doing so.

PERMANENTLY UNCONSCIOUS STATE

“A state of permanent unconsciousness in a principal that, to a reasonable degree of medical certainty as determined in accordance with reasonable medical standards by the principal’s attending physician and one other physician who has examined the principal, is characterized by both of the following: (1) The principal is irreversibly unaware of himself and his environment; and (2) There is a total loss of cerebral cortical functioning, resulting in the principal having no capacity to experience pain or suffering.” ORC section 1337.11(V)

PRINCIPAL

The person who executes a **DURABLE POWER OF ATTORNEY FOR HEALTH CARE**.

TERMINAL CONDITION

“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.”

ORC section 1337.11(BB)

PART VII - SAMPLE FORM: THE DURABLE POWER OF ATTORNEY FOR HEALTH CARE, INCLUDING STATUTORY NOTICE

Ohio Legal Rights Service has designed a standardized **DURABLE POWER OF ATTORNEY FOR HEALTH CARE** form with clauses to specify instructions for mental health treatment. You may call Ohio Legal Rights Service to order copies or download the form from the Ohio Legal Rights Service web site at <http://olrs.ohio.gov>. You may make copies of the form for personal and other non-profit use.

This standardized **DURABLE POWER OF ATTORNEY FOR HEALTH CARE** form is designed to help you direct your care if your doctor decides that you lack capacity to make your own medical decisions. The form is not intended as legal advice. You should consult a lawyer if you have questions about this form and your own particular circumstances.

Ohio Legal Rights Service's Durable Power of Attorney for Health Care Form

This form helps you to direct your care should your doctor decide that you lack capacity to make your own medical decisions. It is not intended as a substitute for legal advice, and you should contact a lawyer if you have questions about this document or what it does.

Introduction

There are two types of advance directives for mental health treatment. One type is the Declaration for Mental Health Treatment under Revised Code chapter 2135. The second type is the Durable Power of Attorney for Health Care under Revised Code chapter 1337. The following form is an advance directive under Revised Code chapter 1337, a Durable Power of Attorney for Health Care form.

Ohio Legal Rights Service is partially funded by, and this form was prepared through, a grant under the Protection and Advocacy for Mentally Ill Individuals Act administered through the Center for Mental Health Services of the United States Department of Human Services.

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Instructions for filling out this form

In this document you name one or more people as your "agent" or "attorney-in-fact". You authorize your agent to make all physical and mental health care decisions for you, but only if your attending physician determines that you have lost the capacity to make informed health care decisions for yourself. You should review each section of this form. You must fill in your name and county of residence; the section appointing an agent; and the signature and date. You must sign the form in the presence of the witnesses and/or notary public. The declarations should be filled out only if you want to provide specific instructions to your agent about your treatment.

I. Appointment of Agent

I, _____, am an adult of sound mind who currently resides in _____ County, Ohio. After careful consideration, I knowingly and voluntarily make this durable power of attorney for health care and declaration of treatment preferences. I understand that this is a legally binding document.

I understand that this document will take effect only if my attending physician determines that my ability to receive and evaluate information is impaired to such an extent that I have lost the capacity to make informed health care decisions for myself. My agent can then begin making all physical and mental health care decisions for me. My agent will continue making all health care decisions for me until my attending physician determines that I have regained the capacity to make those decisions for myself.

Designation of my agent

I appoint the following person(s) to act as my agent to make health care decisions for me if my attending physician determines that I have lost the capacity to make informed health care decisions for myself. My agent has authority to make all physical and mental health care decisions for me, including the right to give, to refuse to give, or to withdraw informed consent to any health care treatment, as allowed by law.

I instruct my agent to make health care decisions for me consistent with my wishes as expressed in this document or, if not expressed here, as otherwise made known to my agent by me. If my agent does not know and is not able to determine what I want, I instruct my agent to act in what my agent believes to be my best interest.

I intend each of the individuals named below to succeed to the authority of and serve under this appointment, in the order named, if at any time the prior agent is not readily available or is unwilling to serve or to continue to serve, or is removed by me.

First choice:

I appoint _____, address _____,
daytime phone _____, evening phone _____,
as my agent to make all health care decisions for me.

Second choice:

I appoint _____, address _____,
daytime phone _____, evening phone _____,

Third choice:

I appoint _____, address _____,
daytime phone _____, evening phone _____,

My ability to revoke this document

I understand that I can revoke this document at any time and in any manner merely by expressing my intention to revoke it. This can be done verbally or in writing. If I have given a copy of this document to a physician, my revocation will not be effective as to that physician until the fact of my revocation is communicated to that physician (or the physician's staff) by me or by a witness to the revocation. I understand that if I execute a new durable power of attorney for health care, the new document will automatically replace this one.

Expiration date

(Initial one)

___ This durable power of attorney for health care has no expiration date, and shall not be affected by my disability or by the passage of time.

___ This durable power of attorney for health care shall expire at Midnight on the ___ day of _____ 20___, but otherwise is not affected by my disability or by the passage of time.

Severability

If a court finds any provision of this document to be invalid or unenforceable, that provision shall be severed from this document without affecting any other power or provision of this document, or the appointment of my agent to make health care decisions for me.

II. Declaration of Treatment Instructions

You may provide your agent with specific instructions about the choices you want made for you should this POA take effect. If you do not instruct your agent, either in this document or otherwise, the agent will still make choices about your health care and will decide based on your best interests. If you wish to provide instructions about your care to your agent, then fill out those sections of the form below that provide the direction you want to give. If you do not wish to provide instructions to your agent, then go to the signature section at page 11 at the end of this document.

Attending physician

I name the following doctor as my “attending physician”. Under the law, this is the only physician who can make the determination as to whether I have lost the capacity to make informed health care decisions for myself for the purpose of this document.

Name: _____ Phone: _____

Address: _____

Other physicians I choose to provide treatment to me

In addition to the attending physician named above, I prefer to be treated by the following doctors, and I instruct my agent to request medical services for me from the following doctors:

Name: _____ Phone: _____

Address: _____

Specialty (if any): _____

Name: _____ Phone: _____

Address: _____

Specialty (if any): _____

I do not want to be treated by the following doctors, psychiatrists, or other mental health professionals, and I instruct my agent not to consent to my treatment by these individuals:

Name: _____ Phone: _____

Address: _____

Name: _____ Phone: _____

Address: _____

Medical conditions

I may have the following medical condition(s), which may cause or contribute to, or may appear similar to, psychiatric symptoms. I instruct that my agent have these medical conditions ruled out prior to authorizing psychiatric care or treatment. These medical conditions are:

Medication

If my physician proposes that I be given medication, I instruct my agent to (choose one and initial):

___ consent to the medication proposed by my physician

___ consent to medication, except for _____, which I do not take because

(you may wish to explain why you do not wish to take this medication) _____ .

___ not consent to any medications

___ (other) _____ .

Allergies, other physical conditions, health problems, or medications that I want my agent to know about and consider before giving informed consent to medication: _____ .

I understand that, if I have instructed my agent not to consent to medication, and if I am involuntarily committed by a court order, it is possible that someone may file an application for forced medication with the probate court and request a court hearing on the question of whether I need to be medicated by court order. If there is a court hearing on the question of whether I am in need of medication, I instruct my agent to inform the court of my instructions as expressed in this document. However, I understand that the court is not required to follow my wishes as expressed in this document.

Electroconvulsive therapy

Note that ECT is not available in any hospitals operated by the Ohio Department of Mental Health.

If my physician proposes that I be given electro-convulsive therapy (ECT), I instruct my agent to (choose one and initial):

___ not consent to ECT under any circumstances

___ consent to ECT only after all other treatment options have been tried without success

___ consent to ECT

___ (other) _____ .

Restraint or seclusion

If it becomes necessary in the opinion of the hospital that I be placed in seclusion or restrained, either physically or chemically, I instruct my agent to (choose one and initial):

___ notwithstanding any other instructions about medication in this document, consent to medication rather than allow me to be placed in physical restraint

___ direct that I be secluded rather than medicated or restrained physically

___ consent only to such seclusion or restraint as is necessary to prevent me from harming myself or others, and this consent should be withdrawn at the point where I am no longer at such risk

___ (other) _____ .

Hospitalization

If it is determined that I need to be hospitalized, I instruct my agent as follows.

In a general medical hospital

If my physician determines that I need care or treatment in a general medical hospital, I instruct my agent to consent to my admission to the following general medical hospital(s):

First Choice: _____ Second Choice: _____

I instruct my agent not to consent to my admission to the following general medical hospital(s):

_____ .

In a psychiatric hospital (or licensed unit)

If my physician determines that I need care or treatment in a psychiatric hospital, I instruct my agent to consent to my admission to the following psychiatric hospital(s):

First Choice: _____ Second Choice: _____

I instruct my agent not to consent to my admission to the following psychiatric hospital(s):

_____ .

I understand that, by instructing my agent not to consent to my voluntary admission to the psychiatric hospital(s) named above, it is possible that someone may file with the probate court an affidavit of mental illness and request a court hearing on the question of whether I need to be admitted to a psychiatric hospital by court order, and if so, to which hospital. If there is a court hearing, I understand that the court is not required to follow my wishes as expressed in this document. If there is a court hearing on the question of whether I am in need of psychiatric hospitalization, I instruct my agent to inform the court of my instructions as expressed in this document.

Other directions to my agent

I instruct my agent to consider the following treatment preferences:

_____ .

I do not want the following treatments, and I instruct my agent not to consent to them:

_____ .

(Optional) The reason that I do not want these treatments is:

_____ .

(initial) ____ I wish to be treated by spiritual means through prayer alone, in accordance with a recognized religious method of healing. The recognized religious method of healing is: _____ .

I instruct my agent as follows concerning other medical or psychiatric care and treatment, or related issues:

_____ .

Withdrawal of nutrition and hydration when in a permanently unconscious state (required by law to be in capital letters).

[] ____ IF I HAVE MARKED THE FOREGOING BOX AND HAVE PLACED MY INITIALS ON THE LINE ADJACENT TO IT, MY AGENT MAY REFUSE, OR IN THE EVENT TREATMENT HAS ALREADY COMMENCED, WITHDRAW INFORMED CONSENT TO THE PROVISION OF ARTIFICIALLY OR TECHNOLOGICALLY SUPPLIED NUTRITION AND HYDRATION IF I AM IN A PERMANENTLY UNCONSCIOUS STATE AND IF MY ATTENDING PHYSICIAN AND AT LEAST ONE OTHER PHYSICIAN WHO HAS EXAMINED ME DETERMINE, TO A REASONABLE DEGREE OF MEDICAL CERTAINTY AND IN ACCORDANCE WITH REASONABLE MEDICAL STANDARDS, THAT SUCH NUTRITION OR HYDRATION WILL NOT OR NO LONGER WILL SERVE TO PROVIDE COMFORT TO ME OR ALLEVIATE MY PAIN.

Notification

If I am hospitalized, I request that my agent notify the following people of the fact of my hospitalization, and the hospital's name, address and telephone number (for example, family members, friends and employer):

Name: _____, address _____,
daytime phone _____, evening phone _____.

Name: _____, address _____,
daytime phone _____, evening phone _____.

I instruct my agent not to contact the following people:

_____, _____, _____.

Nomination of Guardian

If I need a guardian, I would like the following person to become my guardian, and I make this nomination pursuant to Revised Code Sec. 1337.09 and 2111.02. If there is a guardianship hearing, I instruct my agent to notify the court of my wishes, but I understand that the court is not required to follow my wishes.

Name: _____, address _____,
daytime phone _____, evening phone _____.

III. Principal's Acknowledgement and Signature

If I have signed an earlier durable power of attorney for health care, it will be automatically revoked by this document. If I have signed a declaration under Revised Code Chapter 2133 (commonly called a "Living Will"), it will not be revoked by this document.

I understand that if I should execute a Declaration for Mental Health Treatment under Revised Code chapter 2135, that the Declaration for Mental Health Treatment will revoke any provisions for mental health treatment previously stated in a Durable Power of Attorney for Health Care. Any provisions previously stated in the Durable Power of Attorney for Health Care specifically for physical or medical (non-mental health) care will remain in effect.

I understand that I should give copies of this document to the agent and alternate agents I have named in this document. I may also give a copy to my physician, psychiatrist, or other health care provider. However, I understand that if I give a copy of this document to my physician or psychiatrist and later revoke this document, my revocation does not become effective as to the physician or psychiatrist until I or a witness to the revocation notifies him/her (or his/her staff) that I have revoked this document. I understand that both my revocation and notice of revocation to my physician or psychiatrist can be done either orally or in writing. However, it may be easier to prove I revoked it if I do so in writing.

I can make changes to this document before I sign it, and I agree to write my initials beside those changes. I understand that I cannot make changes to this document after I have signed it. Instead I must execute a new document.

Ohio law requires that I be given the notice printed at the end of this document. I have read this notice before signing this document.

I understand that this document will not be valid unless I sign it in the presence of either a notary public or two witnesses who meet the law's requirements.

THIS DURABLE POWER OF ATTORNEY WILL NOT BE VALID UNLESS IT IS EITHER (1) SIGNED BY TWO QUALIFIED WITNESSES WHO ARE PRESENT WHEN YOU SIGN OR ACKNOWLEDGE YOUR SIGNATURE OR (2) ACKNOWLEDGED BEFORE A NOTARY PUBLIC.

I understand the terms and purpose of this document, and I sign my name after carefully considering this matter on this ____ day of _____ 200____, at _____ County, Ohio.

Signature of Principal

Principal's typed or printed name

Witnesses

I attest that the principal signed or acknowledged this Durable Power of Attorney for Health Care in my presence, that the principal appears to be of sound mind and not subject to duress, fraud, or undue influence. I also attest that I am not an agent named in this document, I am not the attending physician of the principal, I am not the administrator of a nursing home in which the principal is receiving care, and that I am an adult who is not related to the principal by blood, marriage or adoption.

Signature: _____ Date: _____

Print name: _____ Residence Address: _____

Signature: _____ Date: _____

Print name: _____ Residence Address: _____

Notary Acknowledgement

State of Ohio

County of _____ ss:

On this the _____ day of _____, 200__,

_____, who is known to me or who has provided me with satisfactory proof of identity as the person whose name is subscribed above as the principal, personally appeared before me and acknowledged that s/he executed this document for the purposes described in the document. I attest that the principal appears to be of sound mind and not under or subject to duress, fraud or undue influence.

My Commission Expires: _____

Notary Public

IV. Statutory Notice

Ohio law requires Ohio Revised Code section 1337.17 (Use of printed form; notice to principle) to be included in all Durable Power of Attorney for Health Care forms. The text of that statute follows:

1337.17. Use of printed form; notice to principal.

A printed form of durable power of attorney for health care may be sold or otherwise distributed in this state for use by adults who are not advised by an attorney. By use of such a printed form, a principal may authorize an attorney in fact to make health care decisions on the principal's behalf, but the printed form shall not be used as an instrument for granting authority for any other decisions. Any printed form that is sold or otherwise distributed in this state for the purpose described in this section shall include the following notice:

Notice to Adult Executing This Document (R.C. Sec.1337.17)

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 he 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 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 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 his 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 him 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.

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 generally 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 communicate 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 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.

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