

# **Living Will And Durable Power of Attorney for Health Care**

**Provided as a public service by  
the Health Law Section of the Arkansas Bar Association**

Please read the Advance Directive Information available on the Arkansas Bar Association's website at <http://www.arkbar.com/> carefully before completing these forms.

**NOTE: The form Living Will and Durable Power of Attorney for Health Care are being provided to you as a public service. The attached forms are provided "as is" and are not the substitute for the advice of an attorney. By providing these forms and the Advance Directive Information, neither the Arkansas Bar Association nor its Health Law Section is providing legal advice to you. Consult an attorney if you need legal advice of any nature.**

# DECLARATION OF LIVING WILL OF

\_\_\_\_\_  
*[Name of Declarant]*

If I should have an incurable or irreversible condition with no hope of recovery that will cause my death within a relatively short time, and I am no longer able to make decisions regarding my medical treatment, I direct my attending physician, pursuant to the Common Law and the Arkansas Rights of the Terminally Ill or Permanently Unconscious Act, to withhold or withdraw treatment that only prolongs the process of dying and is not necessary to my comfort or to alleviate pain.

Additionally, if I should become permanently unconscious, I direct my attending physician, pursuant to the Arkansas Rights of the Terminally Ill or Permanently Unconscious Act, to withhold or withdraw life-sustaining treatments that are no longer necessary to my comfort or to alleviate pain.

**Section 1: Life-Sustaining Treatments**

The life-sustaining treatments which **may be withheld or withdrawn** are (check all that apply):

- Cardiopulmonary Resuscitation.
- Mechanical Breathing.
- Major Surgery.
- Kidney Dialysis.
- Chemotherapy.
- Minor Surgery (unless necessary for my comfort or to alleviate pain).
- Invasive Diagnostic Tests.
- Antibiotics.
- Blood Products.
- Other Medications not Necessary for Alleviation of Pain.

Add other medical directives, if any \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Section 2: Artificial Nutrition and Hydration**

I understand that Arkansas law requires me to make my wishes regarding artificial nutrition and hydration known separately from the above directions. Therefore, by initialing the appropriate line(s) below, I specifically:

\_\_\_\_\_ DIRECT that **artificial nutrition may be withheld** or withdrawn after consultation with my attending physician.

\_\_\_\_\_ DIRECT that **artificial hydration may be withheld** or withdrawn after consultation with my attending physician.

SIGNED this \_\_\_\_\_ day of \_\_\_\_\_, 20\_\_\_\_.

\_\_\_\_\_  
Signature

We, the undersigned, do hereby certify that the Declarant, \_\_\_\_\_ subscribed this Declaration of Living Will in our presence, and we, at his or her request, in his or her presence, and in the presence of each other, signed as attesting witnesses, and we do further certify that the Declarant appeared to be eighteen years of age or older, of sound mind, and acting without undue influence, fraud or restraint and that his or her signature was voluntary.

\_\_\_\_\_  
Witness

\_\_\_\_\_  
Witness

\_\_\_\_\_  
Address

\_\_\_\_\_  
Address

\_\_\_\_\_  
City, State and Zip Code

\_\_\_\_\_  
City, State and Zip Code

**DURABLE POWER OF ATTORNEY FOR HEALTH CARE  
OF**

\_\_\_\_\_  
*[Name of Declarant]*

Pursuant to the Arkansas Durable Power of Attorney for Health Care Act (Ark. Code Ann. § 20-13-104) (the “Act”), I hereby designate and appoint \_\_\_\_\_ as my agent, or attorney in fact, to make decisions regarding my health care during periods when my health care provider has determined that I lack capacity to decide for myself. Specifically, and not to limit any other rights prescribed under the Act, my attorney-in-fact shall have the power to have access to my medical records for treatment or payment decisions; to disclose medical records to others for purposes of treatment, payment, or health care operations; to employ and discharge physicians; to consent to or refuse to consent to medical procedures, including the withholding or withdrawal of life-sustaining treatment, and nutrition and hydration, according to my wishes expressed in my Living Will, or, if my wishes are unclear under the then existing circumstances of my medical condition, then upon consideration of my best interests as determined by my physician in consultation with my agent; to admit me to hospitals, including psychiatric hospitals, nursing homes, or hospice care; and to sign all appropriate forms, consents and releases in connection with any of said matters.

If \_\_\_\_\_ resigns, or is not able or available to make health care decisions for me, or if an agent named by me is divorced from me or is my spouse and legally separated from me, I appoint \_\_\_\_\_ as successor, with all of the rights and powers and authority herein stated. The term “health care” shall have the meaning set forth in Ark. Code Ann. § 20-13-104(c). This Durable Power of Attorney for Health Care shall not be affected by my subsequent disability or incapacity.

SIGNED this \_\_\_\_\_ day of \_\_\_\_\_, 20\_\_\_\_\_.

\_\_\_\_\_  
Signature

We, the undersigned, do hereby certify that the Declarant, \_\_\_\_\_ subscribed this Durable Power of Attorney for Health Care in our presence, and we, at his or her request, in his or her presence, and in the presence of each other, signed as attesting witnesses, and we do further certify that the Declarant appeared to be eighteen years of age or older, of sound mind, and acting without undue influence, fraud or restraint and that his or her signature was voluntary.

\_\_\_\_\_  
Witness  
  
\_\_\_\_\_  
Address  
  
\_\_\_\_\_  
City, State and Zip Code

\_\_\_\_\_  
Witness  
  
\_\_\_\_\_  
Address  
  
\_\_\_\_\_  
City, State and Zip Code

**Other Legal Oversight** - Use this category for any other program in your state whereby someone other than the resident participates in or makes decisions about the resident's health care and treatment.

**Durable Power of Attorney/Health Care** - Documentation that someone other than the resident is legally responsible for health care decisions if the resident becomes unable to make decisions. This document may also provide guidelines for the agent or proxy decision-maker, and may include instructions concerning the resident's wishes for care. Unlike a guardianship, durable power of attorney/health care proxy terms can be revoked by the resident at any time.

**Durable Power of Attorney/Financial** - Documentation that someone other than the resident is legally responsible for financial decisions if the resident becomes unable to make decisions.

**Family Member Responsible** - Includes immediate family or significant other(s) as designated by the resident. Responsibility for decision-making may be shared by both resident and family.

**Resident Responsible for Self** - Resident retains responsibility for decisions. In the absence of guardianship or legal documents indicating that decision-making has been delegated to others, always assume that the resident is the responsible party.

**g. NONE OF ABOVE**

**Process:** Legal oversight such as guardianship, durable power of attorney, and living wills are generally governed by State law. The descriptions provided here are for general information only. Refer to the law in your state and to the facility's legal counsel, as appropriate, for additional clarification.

Consult the resident and the resident's family. Review records. Where the legal oversight or guardianship is court ordered, a copy of the legal document must be included in the resident's record in order for the item to be checked on the MDS form.

**Coding:** Check all that apply.

## A10. Advanced Directives

**Intent:** To record the legal existence of directives regarding treatment options for the resident, whether made by the resident or a legal proxy. Documentation must be available in the record for a directive to be considered current and binding. The absence of pre-existing directives for the resident should prompt discussion by clinical staff with the resident and family regarding the resident's wishes. Any

discrepancies between the resident's current stated wishes and what is said in legal documents in the resident's file should be resolved immediately.

**Definition: a. Living Will** -A document specifying the resident's preferences regarding measures used to prolong life when there is a terminal prognosis.

**Do Not Resuscitate** -In the event of respiratory or cardiac failure, the resident, family or legal guardian has directed that no cardiopulmonary resuscitation (CPR) or other life-saving methods will be used to attempt to restore the resident's respiratory or circulatory function.

**Do Not Hospitalize** -A document specifying that the resident is not to be hospitalized even after developing a medical condition that usually requires hospitalization.

**Organ Donation** - Instructions indicating that the resident wishes to make organs available for transplantation, research, or medical education upon death.

**Autopsy Request** - Document indicating that the resident, family or legal guardian has requested that an autopsy be performed upon death. The family or responsible party must still be contacted upon the resident's death and re-asked if they want an autopsy to be performed.

**Feeding Restrictions** - The resident or responsible party (family or legal guardian) does not wish the resident to be fed by artificial means (e.g., tube, intravenous nutrition) if unable to be nourished by oral means.

**Medication Restrictions** - The resident or responsible party (family or legal guardian) does not wish the resident to receive life-sustaining medications (e.g., antibiotics, chemotherapy). These restrictions may not be appropriate, however, when such medications could be used to ensure the resident's comfort. In these cases, the directive should be reviewed with the responsible party.

**Other Treatment Restrictions** - The resident or responsible party (family or legal guardian) does not wish the resident to receive certain medical treatments. Examples include, but are not limited to, blood transfusion, tracheotomy, respiratory intubation, and restraints. Such restrictions may not be appropriate to treatments given for palliative reasons (e.g., reducing pain or distressing physical symptoms such as nausea or vomiting). In these cases, the directive should be reviewed with the responsible party.

***NONE OF ABOVE***

**Process:** You will need to familiarize yourself with the legal status of each type of directive in your state. In some states only a health care proxy is formally recognized; other jurisdictions allow for the formulation of living wills and the appointment of individuals with durable power of attorney for health care decisions. Facilities should develop a policy regarding documents drawn in other states, respecting them as important expressions of the resident's wishes until their legal status is determined.

Review the resident's record for documentation of the resident's advance directives. Documentation must be available in the record for a directive to be considered current and binding.

Some residents at the time of admission may be unable to participate in decision-making. Staff should make a reasonable attempt to determine whether or not the new resident has ever created an advance directive (e.g., ask family members, check with the primary physician). Lacking any directive, treatment decisions will likely be made in concert with the resident's closest family members or, in their absence or in case of conflict, through legal guardianship proceedings.

**Coding:** The following comments provide further guidance on how to code these directives. You will also need to consider State law, legal interpretations, and facility policy.

- The resident (or proxy) should always be involved in the discussion to ensure informed decision-making. If the resident's preference is known and the attending physician is aware of the preference, but the preference is not recorded in the record, check the MDS item only after the preference has been documented.
- If the resident's preference is in areas that require supporting orders by the attending physician (e.g., do not resuscitate, do not hospitalize, feeding restrictions, other treatment restrictions), check the MDS item only if the document has been recorded or after the physician provides the necessary order. Where a physician's current order is recorded, but resident's or proxy's preference is not indicated, discuss with the resident's physician and check the MDS item only after documentation confirming that the resident's or proxy's wishes have been entered into the record.
- If your facility has a standard protocol for withholding particular treatments from all residents (e.g., no facility staff member may resuscitate or perform CPR on any resident; facility does not use feeding tubes), check the MDS item only if the advanced directive is the individual preference of the resident (or legal proxy), regardless of the facility's policy or protocol.

Check all that apply. If none of the directives are verified by documentation in the medical records, check *NONE OF ABOVE*.

42 CFR 483.10 requires facilities to protect and promote the rights of each resident, including the right to “formulate an advanced directive.” There is no regulatory text specifying a location for advanced directive information. Unless there are State codes or regulations regarding this matter, the method of communicating the information is up to the facility. If documentation is not available in the resident’s clinical record, facility staff should be the source of this information, and surveyors will assess whether or not the staff knowledge and actions are in agreement with resident/family wishes. Some facilities elect to maintain the information in the resident’s clinical record and may even verify the advanced directive was properly prepared, i.e., not witnessed by someone who will benefit from the resident’s death. Make sure you are well aware of your facility’s policies.