JACKSONWHITE
ATTORNEYS AT LAW

Advance Directive Packet

Health Care Power of Attorney

Mental Health Care power of Attorney

Financial Power of Attorney

Living Will

This packet is provided as a courtesy by JacksonWhite Elder Law Attorneys. It is not intended to be legal advice. If you do not understand the forms, or their implications, please contact an attorney before signing.

For more information or to request more packets please contact JacksonWhite Elder Law
1-800-243-1160
www.ArizonaSeniorLaw.com

STATE OF ARIZONA
DURABLE HEALTH CARE POWER OF ATTORNEY

Instructions and Form

GENERAL INSTRUCTIONS: Use this Durable Health Care Power of Attorney form if you want to select a person to make future health care decisions for you so that if you become too ill or cannot make those decisions for yourself the person you choose and trust can make medical decisions for you. Talk to your family, friends, and others you trust about your choices. Also, it is a good idea to talk with professionals such as your doctor, clergyperson and a lawyer before you sign this form.

Be sure you understand the importance of this document. If you decide this is the form you want to use, complete the form. **Do not sign this form until** your witness or a Notary Public is present to witness the signing. There are further instructions for you about signing this form on page three.

1. Information about me (the Principal):

My Name: _____
My Address: _____
_____

My Age: _____
My Date of Birth: _____
My Telephone: _____

2. Selection of my health care representative and alternate ("agent" or "surrogate")

I choose the following person to act as my representative to make health care decisions for me:

Name: _____
Address: _____
_____

Home Phone: _____
Work Phone: _____
Cell Phone: _____

I choose the following person to act as an alternate representative to make health care decisions on my behalf if the first representative is unavailable, unwilling, or unable to make decisions for me:

Name: _____
Address: _____
_____

Home Phone: _____
Work Phone: _____
Cell Phone: _____

3. I AUTHORIZE if I am unable to make medical care decisions for myself:

I authorize my health care representative to make health care decisions for me when I cannot make or communicate my own health care decisions due to mental or physical illness, injury, disability, or incapacity. I want my

representative to make all such decisions for me except those decisions that I have expressly stated in Part 4 below that I do not authorize him/her to make. If I am able to communicate in any manner, my representative should discuss my health care options with me. My representative should explain to me any choices he or she made if I am able to understand. I further authorize my representative to have all access to and copies of my "personal protected health care information and medical records". This appointment is effective unless and until it is revoked by me or by an order of a court.

The types of health care decisions I authorize to be made on my behalf include but are not limited to the following:

- To consent or to refuse medical care, including diagnostic, surgical, or therapeutic procedures;
- To authorize the physicians, nurses, therapists, and other health care providers of his/her choice to provide care for me, and to obligate my resources or my estate to pay reasonable compensation for these services;
- To approve or deny my admittance to health care institutions, nursing homes, assisted living facilities, or other facilities or programs. By signing this form I understand that I allow my representative to make decisions about my mental health care except that he or she cannot have me admitted to a structured treatment setting with 24-hour-a-day supervision and an intensive treatment program – called a "level one" behavioral health facility – using just this grant of authority;
- To have access to and control over my medical records and to have the authority to discuss those records with health care providers.

4. DECISIONS I EXPRESSLY DO NOT AUTHORIZE my Representative to make for me:

I do not want my representative to make the following health care decisions for me (describe or write in "not applicable"):

5. My specific desires about autopsy:

NOTE: Under Arizona law, an autopsy is not required unless the county medical examiner, the county attorney, or a superior court judge orders it to be performed. See the General Information document for more information about this topic. Initial or put a check mark by one of the following choices.

_____Upon my death I DO NOT consent to a voluntary autopsy.
_____Upon my death I DO consent to a voluntary autopsy.
_____My representative may give or refuse consent for an autopsy.

6. My specific desires about organ donation ("anatomical gift"):

NOTE: Under Arizona law, you may donate all or part of your body. If you do not make a choice, your representative or family can make the decision when you die. You may indicate which organs or tissues you want to donate and where you want them donated. Initial or put a check mark by A or B below. If you select B, continue with your choices.

____ **A.** I DO NOT WANT to make an organ or tissue donation, and I do not want this donation authorized on my behalf by my representative or my family.
____ **B.** I DO WANT to make an organ or tissue donation when I die. Here are my directions:

1. What organs/tissues I choose to donate: (Select a or b below)

○ **a.** Whole body
○ **b.** Any needed parts or organs:
○ **c.** These parts or organs only:
1) _____
2) _____
3) _____

2. What purposes I donate organs/tissue for: (Select a, b, or c below)

○ **a. Any** legally authorized purpose (transplantation, therapy, medical and dental evaluation, education or research, and/or advancement of medical and dental science).
○ **b.** Transplant or therapeutic purposes only.
○ **c.** Research Only
d. Other: _____

3. Which organization or person I want my parts or organs to go to:

○ **a.** I have already signed a written agreement or donor card regarding organ and tissue donation with the following individual or institution:(name) _____
_____

○ **b.** I would like my tissues or organs to go to the following individual or institution:
_____

○ **c**. I authorize my representative to make this decision.

7. Funeral and Burial Disposition (Optional):

My agent has authority to carry out all matters relating to my funeral and burial disposition wishes in accordance with this power of attorney, which is effective upon my death. My wishes are reflected below:

NOTE: If you choose whole body donation, cremation is the only burial disposition available.

Place your initials by those choices you wish to select.

_____ Upon my death, I direct my body to be buried. (As opposed to cremated)
_____ Upon my death, I direct my body to be buried in _____
_____. (Optional directive)
_____ Upon my death, I direct my body to be cremated.
_____ Upon my death, I direct my body to be cremated with my ashes to be _____
_____. (Optional directive)
_____ My agent will make all funeral and burial disposition decisions. (Optional directive)

8. About a Living Will

NOTE: If you have a Living Will and a Durable Health Care Power of Attorney, **you must attach** the Living Will to this form. A Living Will form is available on the Attorney General (AG) web site. Initial or put a check mark by box A or B.

_____ **A.** I have SIGNED AND ATTACHED a completed Living Will in addition to this Durable Health Care Power of Attorney to state decisions I have made about end of life health care if I am unable to communicate or make my own decisions at that time.
_____ **B.** I have NOT SIGNED a Living Will.

9. About a Prehospital Medical Care Directive or Do Not Resuscitate Directive:

NOTE: A form for the Prehospital Medical Care Directive or Do Not Resuscitate Directive is available on the AG Web site. Initial or put a check mark by box A or B.

____ A. I and my doctor or health care provider HAVE SIGNED a Prehospital Medical Care Directive or a Do Not Resuscitate Directive on Paper with ORANGE background in the event that 911 of Emergency Medical Technicians or hospital emergency personnel are called and my heart or breathing has stopped.

____ B. I have NOT SIGNED a Prehospital Medical Care Directive or Do Not Resuscitate Directive.

10. HIPAA WAIVER OF CONFIDENTIALITY FOR MY AGENT/REPRESENTATIVE

_____ (Initial) I intend for my agent to be treated as I would with respect to my rights regarding the use and disclosure of my individually identifiable health information or medical records. This release authority applies to information governed by the Health Insurance Portability and Accountability Act (HIPAA) of 1996, 42 USC 1320d, 45 CFR 160-164.

SIGNATURE OR VERIFICATION

A. I am signing this Durable Health Care Power of Attorney as follows:

My Signature:_____ Date: _____

B. I am physically unable to sign this document, so a witness is verifying my desires as follows:

Witness Verification: I believe that this Durable Health Care Power of Attorney accurately expresses the wishes communicated to me by the principal of this document. He/she intends to adopt this Durable Health Care Power of Attorney at this time. He/she is physically unable to sign or mark this document at this time, and I verify that he/she directly indicated to me that the Durable Health Care Power of Attorney expresses his/her wishes and that he/she intends to adopt the Durable Health Care Power of Attorney at this time.

Witness Name (printed):_____

Signature:_____ Date:_____

SIGNATURE OF WITNESS OR NOTARY PUBLIC:

NOTE: At least one adult witness OR a Notary Public must witness the signing of this document and then sign it. The witness or Notary Public CANNOT be anyone who is: (a) under the age of 18; (b) related to you by blood, adoption, or marriage; (c) entitled to any part of your estate; (d) appointed as your representative; or (e) involved in providing your health care at the time this form is signed.

A. Witness: I certify that I witnessed the signing of this document by the Principal. The person who signed this Durable Health Care Power of Attorney appeared to be of sound mind and under no pressure to make specific choices or sign the document. I understand the requirements of being a witness and I confirm the following:

- I am not currently designated to make medical decisions for this person.
- I am not directly involved in administering health care to this person.
- I am not entitled to any portion of this person's estate upon his or her death under a will or by operation of law.
- I am not related to this person by blood, marriage or adoption.

Witness Name (printed): _____

Signature:_____ Date:_____

Address: _____

_____

Notary Public (NOTE: If a witness signs your form, you DO NOT need a notary to sign):

STATE OF ARIZONA) ss
COUNTY OF _____)

The undersigned, being a Notary Public certified in Arizona, declares that the person making this Durable Health Care Power of Attorney has dated and signed or marked it in my presence and appears to me to be of sound mind and free from duress. I further declare I am not related to the person signing above by blood, marriage or adoption, or a person designated to make medical decisions on his/her behalf. I am not directly involved in providing health care to the person signing. I am not entitled to any part of his/her estate under a will now existing or by operation of law. In the event the person acknowledging this Durable Health Care Power of Attorney is physically unable to sign or mark this document, I verify that he/she directly indicated to me that this Durable Health Care Power of Attorney expresses his/her wishes and that he/she intends to adopt the Durable Health Care Power of Attorney at this time.

WITNESS MY HAND AND SEAL this_____day of_____, 20_____

Notary Public_____My Commission Expires: _____

OPTIONAL:
STATEMENT THAT YOU HAVE DISCUSSED YOUR HEALTH CARE CHOICES FOR THE FUTURE WITHYOUR PHYSICIAN

NOTE: Before deciding what health care you want for yourself, you may wish to ask your physician questions regarding treatment alternatives. This statement from your physician is not required by Arizona law. If you do speak with your physician, it is a good idea to have him or her complete this section. Ask your doctor to keep a copy of this form with your medical records.

On this date I reviewed this document with the Principal and discussed any questions regarding the probable medical consequences of the treatment choices provided above. I agree to comply with the provisions of this directive, and I will comply with the health care decisions made by the representative unless a decision violates my conscience. In such case I will promptly disclose my unwillingness to comply and will transfer or try to transfer patient care to another provider who is willing to act in accordance with the representative's direction.

Doctor Name (printed):_____

Signature:_____Date:_____

Address:_____

_____

STATE OF ARIZONA
DURABLE MENTAL HEALTH CARE POWER OF ATTORNEY

Instructions and Form

GENERAL INSTRUCTIONS: Use this Durable Mental Health Care Power of Attorney form if you want to appoint a person to make future mental health care decisions for you if you become incapable of making those decisions for yourself. The decision about whether you are incapable can only be made by a specialist in neurology or an Arizona licensed psychiatrist or psychologist who will evaluate whether you can give informed consent. Be sure you understand the importance of this document. Talk to your family members, friends, and others you trust about your choices. Also, it is a good idea to talk with professionals such as your doctor, clergyperson, and a lawyer before you sign this form. If you decide this is the form you want to use, complete the form. Do not sign this form until your witness or a Notary Public is present to witness the signing. There are more instructions about signing this form on page 3.

1. Information about me: (I am called the "Principal")

My Name:_____ My Age: _____
My Address:_____ My Date of Birth: _____
_____ My Telephone: _____

2. Selection of my health care representative and alternate: (Also called an "agent" or "surrogate")

I choose the following person to act as my representative to make mental health care decisions for me:

Name: _____ Home Phone:_____
Address: _____ Work Phone:_____
_____ Cell Phone:_____

I choose the following person to act as an alternate representative to make mental health care decisions for me if my first representative is unavailable, unwilling, or unable to make decisions for me:

Name: _____ Home Phone:_____
Address: _____ Work Phone:_____
_____ Cell Phone:_____

3. Mental health treatments that I AUTHORIZE if I am unable to make decisions for myself:

Here are the mental health treatments I authorize my mental health care representative to make on my behalf if I become incapable of making my own mental health care decisions due to mental or physical illness, injury, disability, or incapacity. If my wishes are not clear from this Durable Mental Health Care Power of Attorney or are not otherwise known to my representative, my representative will, in good faith, act in accordance with my best interests. This appointment is effective unless and until it is revoked by me or by an order of a court. My representative is authorized to do the following which I have initialed or marked:

DURABLE MENTAL HEALTH CARE POWER OF ATTORNEY (Cont'd)

☐ **A. About my records:** To receive information regarding mental health treatment that is proposed for me and to receive, review, and consent to disclosure of any of my medical records related to that treatment.

☐ **B. About medications:** To consent to the administration of any medications recommended by my treating physician.

☐ **C. About a structured treatment setting:** To admit me to a structured treatment setting with 24hour-a-day supervision and an intensive treatment program licensed by the Department of Health Services, which is called an inpatient psychiatric facility.

☐ **D. Other:** .

4. Durable Mental health treatments that I expressly DO NOT AUTHORIZE if I am unable to make decisions for myself: (Explain or write in "None") _____

5. Revocability of this Durable Mental Health Care Power of Attorney: This mental health care power of attorney or any portion of it may not be revoked and any designated agent may not be disqualified by me during times that I am found to be unable to give informed consent. However, at all other times I retain the right to revoke all or any portion of this mental health care power of attorney or to disqualify any agent designated by me in this document.

6. Additional information about my mental health care treatment needs (consider including mental or physical health history, dietary requirements, religious concerns, people to notify and any other matters that you feel are important): _____

HIPAA WAIVER OF CONFIDENTIALITY FOR MY AGENT/REPRESENTATIVE

_____ **(Initial)** I intend for my agent to be treated as I would be with respect to my rights regarding the use and disclosure of my individually identifiable health information or other medical records. This release authority applies to any information governed by the Health Insurance Portability and Accountability Act of 1996 (aka HIPAA), 42 USC 1320d and 45 CFR 160-164.

SIGNATURE OR VERIFICATION

A. I am signing this Durable Mental Health Care Power of Attorney as follows:

My Signature: _____ Date: _____

DURABLE MENTAL HEALTH CARE POWER OF ATTORNEY (Last Page)

B. I am physically unable to sign this document, so a witness is verifying my desires as follows:

Witness Verification: I believe that this Durable Mental Health Care Power of Attorney accurately expresses the wishes communicated to me by the Principal of this document. He/she intends to adopt this Durable Mental Health Care Power of Attorney at this time. He/she is physically unable to sign or mark this document at this time. I verify that he/she directly indicated to me that the Durable Mental Health Care Power of Attorney expresses his/her wishes and that he/she intends to adopt the Durable Mental Health Care Power of Attorney at this time.

Witness Name (printed): _____

Signature: _____ Date: _____

SIGNATURE OF WITNESS OR NOTARY PUBLIC

NOTE: At least one adult witness OR a Notary Public must witness the signing of this document and then sign it. The witness or Notary Public CANNOT be anyone who is: (a) under the age of 18; (b) related to you by blood, adoption, or marriage; (c) entitled to any part of your estate; (d) appointed as your representative; or (e) involved in providing your health care at the time this document is signed.

A. Witness: I affirm that I personally know the person signing this Durable Mental Health Care Power of Attorney and that I witnessed the person sign or acknowledge the person's signature on this document in my presence. I further affirm that he/she appears to be of sound mind and not under duress, fraud, or undue influence. He/she is not related to me by blood, marriage, or adoption and is not a person for whom I directly provide care in a professional capacity. I have not been appointed to make medical decisions on his/her behalf.

Witness Name (printed): _____

Signature: _____ Date: _____

Address: _____

_____

B. Notary Public: (NOTE: If a witness signs your form, you DO NOT need a notary to sign)

STATE OF ARIZONA) ss
COUNTY OF _____)

The undersigned, being a Notary Public certified in Arizona, declares that the person making this Durable Mental Health Care Power of Attorney has dated and signed or marked it in my presence and appears to me to be of sound mind and free from duress. I further declare I am not related to the person signing above, by blood, marriage or adoption, or a person designated to make medical decisions on his/her behalf. I am not directly involved in providing care as a professional to the person signing. I am not entitled to any part of his/her estate under a will now existing or by operation of law. In the event the person acknowledging this Durable Mental Health Care Power of Attorney is physically unable to sign or mark this document, I verify that he/she directly indicated to me that the Durable Mental Health Care Power of Attorney expresses his/her wishes and that he/she intends to adopt the Durable Mental Health Care Power of Attorney at this time

WITNESS MY HAND AND SEAL this____ day of_____, 20___

Notary Public: _____ My commission expires: _____

OPTIONAL: REPRESENTATIVE'S ACCEPTANCE OF APPOINTMENT

I accept this appointment and agree to serve as agent to make mental health treatment decisions for the Principal. I understand that I must act consistently with the wishes of the person I represent as expressed in this Durable Mental Health Care Power of Attorney or, if not expressed, as otherwise known by me. If I do not know the Principal's wishes, I have a duty to act in what I, in good faith, believe to be that person's best interests. I understand that this document gives me the authority to make decisions about mental health treatment only while that person has been determined to be incapacitated which means under Arizona law that a specialist in neurology or a licensed psychiatrist or psychologist has the opinion that the Principal is unable to give informed consent.

Representative Name (printed): _____

Signature: _____ Date: _____

FINANCIAL DURABLE GENERAL POWER OF ATTORNEY

Advisory Notice to Agent: ARS § 14-5506 governs the exercise of powers of attorney. Under that statute, an agent cannot receive ANY benefits from the principal unless those benefits are specifically identified in detail within this instrument or within a written contract. Otherwise, the agent could be subject to criminal prosecution or subject to the penalty provisions of ARS § 46-456, which authorizes the loss of the agent's right to inherit from the principal as well as payment of treble damages and attorneys' fees. An agent should carefully review these statutes or consult with a knowledgeable attorney prior to exercising the authority granted by this power of attorney.

ARTICLE ONE
GRANT OF POWERS

I, the undersigned principal, _____ currently residing at _____, hereby appoint _____, currently residing at _____, (hereinafter referred to as the "Agent"), as my attorney in fact, hereby granting the Agent full power and authority, as though the Agent were the absolute owner of my assets and liabilities, to perform those acts for me and in my name, place, and stead as expressly provided below as fully as I could perform if personally present and not disabled, incapacitated or incompetent.

THIS POWER OF ATTORNEY SHALL BECOME EFFECTIVE AS OF THE DATE I SIGN THIS DOCUMENT AND SHALL NOT BE AFFECTED BY MY DISABILITY, INCAPACITY OR INCOMPETENCY OR BY LAPSE OF TIME.

By placing my initials following the description of each selected power set forth below, and by causing the witness to place his or her initials below my initials for each selected power, the principal acknowledges that [s/he] has reviewed and expressly approved of the delegation hereunder of each selected power to my Agent):

1. Power to Buy and Sell. To transfer, sell, purchase, lease, encumber, assign, exchange and convey, or exercise any option, election, privilege or power with respect to any or all property, real and personal, tangible and intangible, within or without the State of Arizona, as the Agent in his or her sole discretion determines, and to disclaim any interest in any property to which I would otherwise succeed.

Initials: _____ _____
Principal Witness

2. Power with Respect to Bank Accounts. To establish accounts of all kinds, including, without limitation, checking and savings accounts, for me with financial institutions of any kind, including banks and other similar financial institutions; to modify, terminate, make deposits to or write checks on or make withdrawals from and grant security interests in all accounts in my name or with respect to which I am an authorized signatory (except any accounts held by me in a fiduciary capacity), whether or not such account was established by me or for me by the Agent, to negotiate, endorse or transfer any checks or other instruments with respect to any such accounts; and to contract for any services rendered by any

bank or financial institution.

Initials: _____ _____
Principal Witness

3. Power with Respect to Safe Deposit Boxes. To contract with any institution for the maintenance of a safe deposit box in my name; to have access to all safe deposit boxes in my name or with respect to which I am an authorized signatory, whether or not the contract for such safe deposit box was executed by me (either alone or jointly with others) or by the Agent in my name; to add to and remove from the contents of any such safe deposit box and to terminate any and all contracts for such boxes.

Initials: _____ _____
Principal Witness

4. Power to Demand, Receive, Prosecute or Defend. To ask, demand, sue for and receive all sums of money which are or shall become due, owing or payable to me, or which belong or shall belong to me, whether social security benefits, pension payments, individual retirement accounts, dividends, interests, annuities, debts, or any other receivables, and to use all lawful ways and means in my name for the recovery thereof, and to prosecute or defend actions, claims or proceedings in any jurisdiction. and to defend suits at law.

Initials: _____ _____
Principal Witness

5. Brokerage Accounts. With respect to any account with any brokerage firm: (a) to effect purchases and sales (including short sales), to subscribe for and to trade in stocks, bonds, options, or other securities, or limited partnership interests or investments and trust units, whether or not in negotiable form, issued or unissued, foreign exchange, commodities, and contracts relating to same (including commodity futures), on margin or otherwise, for my account(s) and risk; (b) to deliver to any third party securities for my account(s), and to instruct any third party to deliver securities from my account(s) to any other brokerage firm or to others, and in such name and form as the Agent may direct; (c) to instruct any third party to make payment of moneys from my account(s) with any third party, and to receive and direct payments there from payable to me or to others; (d) to sell, assign, endorse and transfer any stocks, bonds, options or other securities of any nature, at any time standing in my name and to execute any documents necessary to effectuate the foregoing; (e) to receive statements of transactions made for my account(s); (f) to approve and confirm the same, to receive any and all notices, calls for margin, or other demands with reference to my account(s); and (g) to make any and all agreements with any third party with reference thereto for me and on my behalf.

Initials: _____ _____
Principal Witness

6. Employ Consultants. To employ, compensate and terminate the services of financial, investment and legal advisors and consultants.

Initials: _____ _____
Principal Witness

7. Power with Respect to Insurance. To purchase, maintain, surrender, collect or cancel (a) life insurance or annuities of any kind on my life or the life of any one in whom I have an insurable interest, (b) liability insurance protecting me and my estate against third party claims, (c) hospital insurance, medical insurance, Medicare supplement insurance, custodial care insurance, and disability income insurance for me or any of my dependents, and (d) casualty insurance insuring assets of mine against loss or damage due to fire, theft, or other commonly insured risk; to pay all insurance premiums, to select any options under such policies, to increase coverage under any such policy, to borrow against any such policy, to pursue all insurance claims on my behalf, to adjust insurance losses; and the foregoing powers shall apply to private and public plans, including, without limitation, Medicare, Medicaid, and Workers' Compensation.

Initials: _____ _____
Principal Witness

8. Power to Provide for Principal's Support. To do all acts necessary for maintaining my customary standard of living, to provide living quarters by purchase, lease or other arrangement, or by payment of the operating costs of my existing living quarters, including interest, amortization payments, repairs and taxes, to provide normal domestic help for the operation of my household, to provide clothing, transportation, medicine, food and incidentals, and if necessary to make all necessary arrangements, contractual or otherwise, for me at any hospital, hospice, nursing home, convalescent home or similar establishment, or in my own residence should I desire it, and to assure that all of my essential needs are provided for at such a facility or in my own residence, as the case may be.

Initials: _____ _____
Principal Witness

9. Income Tax Returns. To prepare and file any federal, state or local income tax return on my behalf and to deal with any governmental agency with respect to any of my tax returns.

Initials: _____ _____
Principal Witness

10. Nomination of Guardian/Conservator. While I hope that by executing this instrument I will have obviated the need for a guardianship and conservatorship of my person and of my estate, if it should become necessary for a guardian or conservator to be appointed for my person or for my estate, I nominate the Agent to so serve.

11. Alternate Agents. If the Agent designated in the introductory paragraph of Article One above cannot serve or continue to serve or is unavailable to serve, I appoint _____, to serve as my Alternate Agent ("Alternate Agent"). No Alternate Agent shall be liable for any act or omission of the initial Agent.

12. Benefit to Agent. My agent shall be entitled to reasonable compensation for any services provided as my Agent, which compensation shall be up to $_____ per hour. My agent shall be entitled to reimbursement of all reasonable expenses incurred as a result of carrying out any provision of

this Power of Attorney.

Initials: _____ _____
Principal Witness

13. General Power of Appointment. Nothing in this instrument shall be construed as creating in the Agent a general power of appointment exercisable in its own behalf, or for the benefit of the Agent's estate, the Agent's creditors, or creditors of the estate of the Agent.

14. Limitations on Authority. The Agent shall not have any power to amend, alter, or revoke any will or codicil.

15. Revocation of Prior Powers of Attorney. I hereby revoke all powers of attorney, whether general or limited, previously granted by me as principal and terminate all agency relationships created thereunder, including, without limitation, those relationships of all successor agents named therein, if any, except any powers granted by me on forms provided by financial institutions granting the right to write checks or deposit funds to or withdraw funds from accounts to which I am a signatory or granting access to a safe deposit box shall not be hereby revoked, but shall continue to be in full force and effect.

16. Ratification. I hereby ratify and approve any act or failure to act of the Agent in good faith and any such act done by the Agent at any time, including but not limited to, any act done at any time at which I am disabled, incompetent or incapacitated or at any time at which there is uncertainty as to whether I am dead or alive, shall, unless otherwise invalid or unenforceable, have the same effect and bind me, my guardian, heirs, distributees, legatees, devisees, assignees, and personal representatives to the same extent as if I had been alive and not disabled, incapacitated, or incompetent at the time of such act.

17. Protection for Third Parties. Any person or entity acting without negligence and in good faith in reasonable reliance on this power of attorney shall not incur any liability thereby, nor shall the fact that time has elapsed since its execution prevent such persons or entity from reasonably relying on this instrument. Persons and entities shall place reasonable reliance on this power of attorney regardless of whether it has been filed for record and may request the issuance of an affidavit by the Agent on which the third party may rely.

18. Governing Law. The laws of the State of Arizona shall govern this power of attorney in all respects.

I, _____, the principal, sign my name to this Financial Durable General Power of Attorney this ___ day of _____, 20__, and being first duly sworn, do declare to the undersigned authority that I sign and execute this instrument as my Power of Attorney and that I sign it willingly, or willingly direct another to sign for me, that I execute it as my free and voluntary act for the purposes expressed in the Financial Durable General Power of Attorney and I declare that I am eighteen

years of age or older, of sound mind and under no constraint or undue influence.

_____

Principal

WITNESS: I, **_____,** the witness, sign my name to the foregoing Financial Durable General Power of Attorney being first duly sworn and I do declare to the undersigned authority that the principal has signed and executed this instrument as his/ her power of attorney and that he/she signed it willingly, and that I, in the presence and hearing of the principal, signed this power of attorney as a witness to the principal's signing and that to the best of my knowledge the principal is eighteen years of age or older, of sound mind and under no constraint or undue influence.

Dated: _____ _____

Signature of Witness

_____

Printed Name of Witness

STATE OF ARIZONA)
) ss.
County of _____)

Subscribed, sworn to, and acknowledged before me, the undersigned Notary Public, by _____, the principal, and subscribed, sworn to, and acknowledged before me by _____, witness, this ____ day of _____, 20__.

_____

Notary Public

LIVING WILL (End of Life Care)
Instructions and Form

GENERAL INSTRUCTIONS: Use this Living Will form to make decisions now about your medical care if you are ever in a terminal condition, a persistent vegetative state or an irreversible coma. You should talk to your doctor about what these terms mean. The Living Will states what choices you would have made for yourself if you were able to communicate. It is your written directions to your health care representative if you have one, your family, your physician, and any other person who might be in a position to make medical care decisions for you. Talk to your family members, friends, and others you trust about your choices. Also, it is a good idea to talk with professionals such as your doctor, clergyperson and a lawyer before you complete and sign this Living Will.

If you decide this is the form you want to use, complete the form. **Do not sign the Living Will until** your witness or a Notary Public is present to watch you sign it. There are further instructions for you about signing on page 2.

IMPORTANT: If you have a Living Will and a Durable Health Care Power of Attorney, you must attach the Living Will to the Durable Health Care Power of Attorney.

1. **My information:** (the "Principal")
   Name:_____ Age:_____
   Address: _____ Date of birth: _____
   _____ Phone: _____

2. My decisions about end of life care:

NOTE: Here are some general statements about choices you have as to health care you want at the end of your life. They are listed in the order provided by Arizona law. You can initial any combination of paragraphs A, B, C, and D. **If you initial Paragraph E, do not initial any other paragraphs.** Read all of the statements carefully before initialing to indicate your choice. You can also write your own statement concerning life-sustaining treatments and other matters relating to your health care at Heading 3 of this form.

_____ **A. Comfort Care Only:** If I have a terminal condition I do not want my life to be prolonged, and I do not want life- sustaining treatment, beyond comfort care, that would serve only to artificially delay the moment of my death. (NOTE: "Comfort care" means treatment in an attempt to protect and enhance the quality of life without artificially prolonging life.)

_____ **B. Specific Limitations on Medical Treatments I Want:** (NOTE: Initial or mark one or more choices, talk to your doctor about your choices.) If I have a terminal condition, or am in an irreversible coma or a persistent vegetative state that my doctors reasonably believe to be irreversible or incurable, I do want the medical treatment necessary to provide care that would keep me comfortable, but **I do not want the following:**

_____1.) Cardiopulmonary resuscitation, for example, the use of drugs, electric shock, and artificial breathing.
_____ 2.) Artificially administered food and fluids.
_____ 3.) To be taken to a hospital if it is at all avoidable.

_____ **C. Pregnancy:** Regardless of any other directions I have given in this Living Will, if I am known to be pregnant I do not want life-sustaining treatment withheld or withdrawn if it is possible that the embryo/fetus will develop to the point of live birth with the continued application of life-sustaining treatment.

_____ **D. Treatment Until My Medical Condition is Reasonably Known:** Regardless of the directions I have made in this Living Will, I do want the use of all medical care necessary to treat my condition until my doctors reasonably conclude that my condition is terminal or is irreversible and incurable, or I am in a persistent vegetative state.

_____ **E. Direction to Prolong My Life:** I want my life to be prolonged to the greatest extent possible.

3. Other Statements Or Wishes I Want Followed For End of Life Care:

NOTE: You can attach additional provisions or limitations on medical care that have not been included in this Living Will form. Initial or put a check mark by box A or B below. Be sure to include the attachment if you check B.

___ **A.** I have not attached additional special provisions or limitations about End of Life Care I want.
___ **B.** I have attached additional special provisions or limitations about End of Life Care I want.

SIGNATURE VERIFICATION

A. I am signing this Living Will as follows:

Signature:_____ Date:_____

B. I am physically unable to sign this Living Will, so a witness is verifying my desires as follows:

Witness Verification: I believe that this Living Will accurately expresses the wishes communicated to me by the principal of this document. He/she intends to adopt this Living Will at this time. He/she is physically unable to sign or mark this document at this time. I verify that he/she directly indicated to me that the Living Will expresses his/her wishes and that he/she intends to adopt the Living Will at this time.

Witness Name (printed):_____

Signature: _____Date:_____

SIGNATURE OF WITNESS OR NOTARY PUBLIC

NOTE: At least one adult witness OR a Notary Public must witness you signing this document. The witness or Notary Public CANNOT be anyone who is: (a) under the age of 18; (b) related to you by blood, adoption, or marriage; (c) entitled to any part of your estate; (d) appointed as your representative; or (e) involved in providing your health care at the time this document is signed.

A. Witness: I certify that I witnessed the signing of this document by the Principal. The person who signed this Living Will appeared to be of sound mind and under no pressure to make specific choices or sign the document. I understand the requirements of being a witness. I confirm the following:

- I am not currently designated to make medical decisions for this person.
- I am not directly involved in administering health care to this person.
- I am not entitled to any portion of this person's estate upon his or her death under a will or by operation of law.
- I am not related to this person by blood, marriage, or adoption.

Witness Name (printed):_____

Signature:_____Date: _____

Address:_____

STATE OF ARIZONA LIVING WILL ("End of Life Care") (Last Page)

B. Notary Public: (NOTE: a Notary Public is only required if no witness signed above)

STATE OF ARIZONA) ss
COUNTY OF_____)

The undersigned, being a Notary Public certified in Arizona, declares that the person making this Living Will has dated and signed or marked it in my presence and appears to me to be of sound mind and free from duress. I further declare I am not related to the person signing above, by blood, marriage or adoption, or a person designated to make medical decisions on his/her behalf. I am not directly involved in providing care as a professional to the person signing. I am not entitled to any part of his/her estate under a will now existing or by operation of law. In the event the person acknowledging this Living Will is physically unable to sign or mark this document, I verify that he/she directly indicated to me that the Living Will expresses his/her wishes and that he/she intends to adopt the Living Will at this time.

WITNESS MY HAND AND SEAL this _ day of _____, 20 _

Notary Public:_____My commission expires: _____