South Carolina
Health Care Power of Attorney

(Roman Catholic Faith-Based)

INFORMATION ABOUT THIS DOCUMENT

THIS IS AN IMPORTANT LEGAL DOCUMENT. BEFORE SIGNING THIS DOCUMENT, YOU SHOULD KNOW THESE IMPORTANT FACTS:

1. THIS DOCUMENT GIVES THE PERSON YOU NAME AS YOUR AGENT THE POWER TO MAKE HEALTH CARE DECISIONS FOR YOU IF YOU CANNOT MAKE THE DECISIONS FOR YOURSELF. THIS POWER INCLUDES THE POWER TO MAKE DECISIONS ABOUT LIFE-SUSTAINING TREATMENT. UNLESS YOU STATE OTHERWISE, YOUR AGENT WILL HAVE THE SAME AUTHORITY TO MAKE DECISIONS ABOUT YOUR HEALTH CARE AS YOU WOULD HAVE.

2. THIS POWER IS SUBJECT TO ANY LIMITATIONS OR STATEMENTS OF YOUR DESIRES THAT YOU INCLUDE IN THIS DOCUMENT. YOU MAY STATE IN THIS DOCUMENT ANY TREATMENT YOU DO NOT DESIRE OR TREATMENT YOU WANT TO BE SURE YOU RECEIVE. YOUR AGENT WILL BE OBLIGATED TO FOLLOW YOUR INSTRUCTIONS WHEN MAKING DECISIONS ON YOUR BEHALF. YOU MAY ATTACH ADDITIONAL PAGES IF YOU NEED MORE SPACE TO COMPLETE THE STATEMENT.

3. AFTER YOU HAVE SIGNED THIS DOCUMENT, YOU HAVE THE RIGHT TO MAKE HEALTH CARE DECISIONS FOR YOURSELF IF YOU ARE MENTALLY COMPETENT TO DO SO. AFTER YOU HAVE SIGNED THIS DOCUMENT, NO TREATMENT MAY BE GIVEN TO YOU OR STOPPED OVER YOUR OBJECTION IF YOU ARE MENTALLY COMPETENT TO MAKE THAT DECISION.

4. YOU HAVE THE RIGHT TO REVOKE THIS DOCUMENT, AND TERMINATE YOUR AGENT'S AUTHORITY, BY INFORMING EITHER YOUR AGENT OR YOUR HEALTH CARE PROVIDER ORALLY OR IN WRITING.

5. IF THERE IS ANYTHING IN THIS DOCUMENT THAT YOU DO NOT UNDERSTAND, YOU SHOULD ASK A SOCIAL WORKER, LAWYER, OR OTHER PERSON TO EXPLAIN IT TO YOU.

6. THIS POWER OF ATTORNEY WILL NOT BE VALID UNLESS TWO PERSONS SIGN AS WITNESSES. EACH OF THESE PERSONS MUST EITHER WITNESS YOUR SIGNING OF THE POWER OF ATTORNEY OR WITNESS YOUR ACKNOWLEDGMENT, WHILE COMPETENT, THAT THE SIGNATURE ON THE POWER OF ATTORNEY IS YOURS.

THE FOLLOWING PERSONS MAY NOT ACT AS WITNESSES:

A. YOUR SPOUSE, YOUR CHILDREN, GRANDCHILDREN, AND OTHER LINEAL DESCENDANTS; YOUR PARENTS, GRANDPARENTS, AND OTHER LINEAL ANCESTORS; YOUR SIBLINGS AND THEIR LINEAL DESCENDANTS; OR A SPOUSE OF ANY OF THESE PERSONS.

B. A PERSON WHO IS DIRECTLY FINANCIALLY RESPONSIBLE FOR YOUR MEDICAL CARE.

C. A PERSON WHO IS NAMED IN YOUR WILL, OR, IF YOU HAVE NO WILL, WHO WOULD INHERIT YOUR PROPERTY BY INTESTATE SUCCESSION.

D. A BENEFICIARY OF A LIFE INSURANCE POLICY ON YOUR LIFE.

E. THE PERSONS NAMED IN THE HEALTH CARE POWER OF ATTORNEY AS YOUR AGENT OR SUCCESSOR AGENT.

F. YOUR PHYSICIAN OR AN EMPLOYEE OF YOUR PHYSICIAN.

G. ANY PERSON WHO WOULD HAVE A CLAIM AGAINST ANY PORTION OF YOUR ESTATE (PERSONS TO WHOM YOU OWE MONEY).

IF YOU ARE A PATIENT IN A HEALTH FACILITY, NO MORE THAN ONE WITNESS MAY BE AN EMPLOYEE OF THAT FACILITY.

7. YOUR AGENT MUST BE A PERSON WHO IS 18 YEARS OLD OR OLDER AND OF SOUND MIND. IT MAY NOT BE YOUR DOCTOR OR ANY OTHER HEALTH CARE PROVIDER THAT IS NOW PROVIDING YOU WITH TREATMENT; OR AN EMPLOYEE OF YOUR DOCTOR OR PROVIDER; OR A SPOUSE OF THE DOCTOR, PROVIDER, OR EMPLOYEE; UNLESS THE PERSON IS A RELATIVE OF YOURS.

8. YOU SHOULD INFORM THE PERSON THAT YOU WANT HIM OR HER TO BE YOUR HEALTH CARE AGENT. YOU SHOULD DISCUSS THIS DOCUMENT WITH YOUR AGENT AND YOUR PHYSICIAN AND GIVE EACH A SIGNED COPY. IF YOU ARE IN A HEALTH CARE FACILITY OR A NURSING CARE FACILITY, A COPY OF THIS DOCUMENT SHOULD BE INCLUDED IN YOUR MEDICAL RECORD.

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1. DESIGNATION OF HEALTH CARE AGENT

I, _____ , hereby appoint _____
Principal's name Agent's name

_____
Address

Home number: _____ Work number: _____

Cell number: _____

as my agent to make health care decisions for me as authorized in this document.

SUCCESSOR AGENT: If an agent named by me dies, becomes legally disabled, resigns, refuses to act, becomes unavailable, or if an agent who is my spouse is divorced or separated from me, I name the following as successor to my agent, each to act alone and successively, in the order named.

A. First Alternate Agent: _____

Address: _____

Telephone: _____

B. Second Alternate Agent: _____

Address: _____

Telephone: _____

2. EFFECTIVE DATE AND DURABILITY

By this document I intend to create a durable power of attorney effective upon, and only during, any period of mental incompetence, except as provided in **Section 5** below.

3. FAITH-BASED STATEMENT

I believe that all life is a gift from God. I direct that all medical decisions for me be made according to my Catholic religious beliefs and in conformity to Catholic moral teaching as found in the *Ethical and Religious Directives for Catholic Health Care Services* promulgated by the United States Conference of Catholic Bishops. All provisions of this document shall be interpreted in accordance with this **Section 3**.

4. PROTECTION FROM LIABILITY FOR PEOPLE RELYING ON THIS DOCUMENT

No person who may act in reliance upon the representations of my attorney-in-fact for the scope of authority granted to the attorney-in-fact shall incur any liability as to me or to my estate as a result of permitting the attorney-in-fact to exercise this authority, nor is any such person who deals with my attorney-in-fact responsible to determine or ensure the proper application of funds or property.

5. HIPAA AUTHORIZATION

When considering or making health care decisions for me when I am no longer competent, all individually identifiable health information and medical records shall be released without restriction to my health care agent(s) and/or my alternate health care agent(s) named above including, but not limited to, (i) diagnostic, treatment, other health care, and related insurance and financial records and information associated with any past, present, or future physical or mental health condition including, but not limited to, diagnosis or treatment of HIV/AIDS, sexually transmitted disease(s), mental illness, and/or drug or alcohol abuse and (ii) any written opinion relating to my health that such health care agent(s) and/or alternate health care agent(s) may have requested. Without limiting the generality of the foregoing, this release authority applies to all health information and medical records governed by the Health Insurance Portability and Accountability Act of 1996 (HIPAA), 42 USC 1320d and 45 CFR 160-164; has no expiration date; and shall terminate only in the event that I revoke the authority in writing and deliver it to my health care provider.

6. ADVANCE DIRECTIVES: GENERAL PRESUMPTION FOR LIFE

A. **Life Preservation.** I direct my health care provider(s) to provide health care, and health care agent(s) to make health care decisions, consistent with my general desire for the use of medical treatment that would preserve my life. I do not authorize any action or omission that is *intended* to cause or hasten my death.

B. **Life-Sustaining Procedures.** The term "Life-Sustaining Procedures" as used in this document refers to the definition of Life-Sustaining Procedures provided in S.C. Code Ann. Section 62-5-501, which is as follows:

"Life-Sustaining Procedure means a medical procedure or intervention that serves ***only*** to prolong the dying process. Life-Sustaining Procedures ***do not include*** the administration of medication or other treatment for comfort care or alleviation of pain."

I intend for Life-Sustaining Procedures to be administered only as specifically provided in this document.

C. Nutrition and Hydration. I intend for the term Life-Sustaining Procedures to *exclude* the providing of nutrition and hydration. I specifically direct my health care provider(s) and health care agent(s) to cause nutrition and hydration to be provided to me by any methods necessary, including but not limited to oral, intravenous or tube, when they can reasonably be expected to prolong my life and can be administered in a manner that does not create a disproportionate burden to me or cause me significant physical discomfort.

D. CPR. I intend for the term Life-Sustaining Procedures to *exclude* the administration of cardiopulmonary resuscitation (CPR). I specifically direct my health care provider(s) and health care agent(s) to administer CPR to me if it offers a reasonable hope of benefit to me without entailing an excessive burden to me from the means employed to resuscitate me.

E. Medication. I specifically direct that medication and/or other treatment for comfort care or alleviation of pain be provided to me in all instances. I have no moral objection to the use of medication or procedures necessary for my comfort even if they may indirectly and unintentionally shorten my life. *However, I do not authorize* the administration of any medication or other treatment *for the intended purpose of causing or hastening my death*.

F. Nursing Care. I specifically direct that I be provided basic nursing care and procedures to provide comfort care.

G. Abortion/Stem Cells. I *do not authorize* any treatments that are derived from any tissue, organ or other substance from a directly aborted unborn child, including but not limited to embryonic stem cells.

H. Attempted Suicide. The instructions in this document are intended to be followed even if suicide is attempted or alleged to be attempted.

I. Discrimination. I direct that medical treatment and care be provided to me to preserve my life as described herein without discrimination based on my age or physical or mental disability or the purported or perceived quality of my life.

J. Pregnancy. S.C. Code Ann. Section 62-5-507 provides that Life-Sustaining Procedures may not be withheld or withdrawn if I am pregnant. In accordance with that provision, I specifically direct that all lifesaving procedures, including Life-Sustaining Procedures, be used for me in order to allow my child to be born alive. This direction is to remain in force even if I am determined to be brain dead.

7. AGENT'S POWERS

I grant to my agent authority to make decisions for me regarding my health care, however in accordance with the terms, conditions and limitations contained in this document. In exercising this authority, my agent shall follow my desires as stated in this document.

8. ORGAN DONATION *(INITIAL ONLY ONE CHOICE)*

My agent [may _____ ***or*** may not _____] consent to the donation of any of my tissue or organs, except for any reproductive organs or tissue, for purposes of transplantation.

9. OTHER ADVANCE DIRECTIVES

A. Revocation of Prior Living Will. I hereby revoke any prior advance directives under the South Carolina Death with Dignity Act (S.C. Code Ann. Section 44-77-10, et seq.), such as a Living Will or Declaration for Desire of a Natural Death. The advanced directives contained in this document shall be control and be effective.

B. Agent's Power Limited. My agent shall not have the power to revoke this **Section 9**, or make any decisions for me inconsistent with this **Section 9**.

C. Terminal Condition. S.C. Code Ann. Section 44-77-20(4) defines "Terminal Condition" as an incurable or irreversible condition that, within reasonable medical judgment, could cause death within a reasonably short period of time if Life-Sustaining Procedures, as defined herein, are not used.

If at any time I have a condition certified to be a *Terminal Condition* by two (2) physicians who have personally examined me, one of whom is my attending physician, and the physicians have determined that my death could occur within a reasonably short period of time without the use of Life-Sustaining Procedures, as defined herein, and where the application of Life-Sustaining Procedures would serve only to prolong the dying process:

(Initial only one choice below.)

_____ I direct that the Life-Sustaining Procedures be **withheld or withdrawn.**

OR

_____ I direct that the **maximum amount** of Life-Sustaining Procedures **be administered unless they become futile to prolonging my life.**

[The remainder of this page intentionally left blank.]

D. **Permanent Unconsciousness.** S.C. Code Ann. Section 44-77-20(7) defines "Permanent Unconsciousness" as a medical diagnosis, consistent with accepted standards of medical practice, that a person is in a persistent vegetative state or some other irreversible condition in which the person has no neocortical functioning, but only involuntary vegetative or primitive reflect functions controlled by the brain stem.

If at any time I have been diagnosed as being in a state of ***Permanent Unconsciousness*** by two (2) physicians who have personally examined me, one of whom is my attending physician, and the physicians have determined that my death could occur within a reasonably short period of time without the use of Life-Sustaining Procedures and where the application of Life-Sustaining Procedures would serve only to prolong the dying process:

(Initial only one choice below.)

_____ I direct that the Life-Sustaining Procedures be **withheld or withdrawn.**

OR

_____ I direct that the **maximum amount** of Life-Sustaining Procedures **be administered**.

10. ADMINISTRATIVE PROVISIONS

A. I revoke any prior Health Care Power of Attorney and any provisions relating to health care of any other prior power of attorney.

B. This power of attorney is intended to be valid in any jurisdiction in which it is presented.

11. MISCELLANEOUS PROVISIONS:

(Do not leave these lines blank. Either write in them or cross through them. Do not write in anything that conflicts with another provision in this document.)

_____

_____

_____

_____

_____

_____

_____

12. UNAVAILABILITY OF AGENT

If at any relevant time the Agent or Successor Agents named herein are unable or unwilling to make decisions concerning my health care, and those decisions are to be made by a guardian, by the Probate Court, or by a surrogate pursuant to the Adult Health Care Consent Act, it is my intention that the guardian, Probate Court, or surrogate make those decisions in accordance with my directions as stated in this document. Pursuant to S.C. Code Ann. Section 62-5-511(c), this power of attorney shall not terminate upon the appointment of a guardian and/or conservator, and any such guardian and/or conservator shall be bound by the provisions of this document.

BY SIGNING HERE I INDICATE THAT I UNDERSTAND THE CONTENTS OF THIS DOCUMENT AND THE EFFECT OF THIS GRANT OF POWERS TO MY AGENT.

I sign my name to this Health Care Power of Attorney on this _____ day of _____, _____.

My current home address is:

_____

Street, City, State

_____

Signature of Principal

[The remainder of this page is intentionally left blank.]

Witness Statement

I declare, on the basis of information and belief, that the person who signed or acknowledged this document (the principal) is personally known to me, that he/she signed or acknowledged this Health Care Power of Attorney in my presence, and that he/she appears to be of sound mind and under no duress, fraud, or undue influence. I am not related to the principal by blood, marriage, or adoption, either as a spouse, a lineal ancestor, descendant of the parents of the principal, or spouse of any of them. I am not directly financially responsible for the principal's medical care. I am not entitled to any portion of the principal's estate upon his decease, whether under any will or as an heir by intestate succession, nor am I the beneficiary of an insurance policy on the principal's life, nor do I have a claim against the principal's estate as of this time. I am not the principal's attending physician, nor an employee of the attending physician. No more than one witness is an employee of a health facility in which the principal is a patient. I am not appointed as Health Care Agent or Successor Health Care Agent by this document.

Witness No. 1

Signature: _____ Date: _____

Print Name: _____

Telephone: _____

Address: _____

Witness No. 2

Signature: _____ Date: _____

Print Name: _____

Telephone: _____

Address: _____

(The notary portion of the document is optional and is not required to create a valid health care power of attorney.)

STATE OF SOUTH CAROLINA, COUNTY OF _____

The foregoing instrument was acknowledged before me by Principal on _____.

_____ My commission expires: _____

Notary Public for South Carolina