~South Carolina~
Health Care Power of Attorney
Christian Version

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 decision for yourself. This 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 the persons sign as witnesses. Each of these persons must either witness your signing of the power of attorney or witness your acknowledgment 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 persons 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.

STATE OF SOUTH CAROLINA
HEALTH CARE POWER OF ATTORNEY

Written in accordance with South Carolina 1992 Act 306; S.B. 541; § 62-5-504

Document made this _____ day of _____, _____.
Month Year

1. DESIGNATION OF HEALTH CARE AGENT

I, _____, hereby appoint _____,
Principal Health care agent

_____, (____) _____,
Address Home phone

(____) _____, (____) _____, as my agent to make health care decisions for me as
Work phone Mobile
authorized in this document.

SUCCESSOR HEALTH CARE AGENT(S)

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 successors to my agent, each to act alone and successively, in the order named:

First Alternate Agent: _____, _____
Address

_____, (____) _____, (____) _____,
City, State, Zip Home phone Work phone

(____)_____.
Mobile

Second Alternate Agent: _____, _____
Address

_____, (____) _____, (____) _____,
City, State, Zip Home phone Work phone

(____)_____.
Mobile

Unavailability of Agent(s): If at any relevant time the agent or successor agents named here 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.

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 Paragraph 3 below.

3. HIPAA AUTHORIZATION

When considering or making health care decisions for me, 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) may have requested. Without limiting the generality of the forgoing, 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; is effective whether or not I am mentally competent; 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.

4. AGENT'S POWERS

I grant to my agent full authority to make decisions for me regarding my health care. In exercising this authority, my agent shall follow my desires as stated in this document or otherwise expressed by me or known to my agent. In making any decision, my agent shall attempt to discuss the proposed decision with me, my hospital, nursing care facility, or similar facility or service; to determine my desires if I am able to communicate in any way. If my agent cannot determine the choice I would want made, then my agent shall make a choice for me based upon what my agent believes to be in my best interests. My agent's authority to interpret my desires is intended to be as broad as possible, except for any limitations I may state below. Accordingly, unless specifically limited by Section E below, my agent is authorized as follows:

A. To consent, refuse, or withdraw consent to any and all types of medical care, treatment, surgical procedures, diagnostic procedures, medication, and the use of mechanical or other procedures that affect any bodily function, including, but not limited to, artificial respiration, nutritional support and hydration, and cardiopulmonary resuscitation;

B. To authorize, or refuse to authorize, any medication or procedure intended to relieve pain, even though such use may lead to physical damage, addiction, or hasten the moment of, but not intentionally cause, my death;

C. To authorize my admission to or discharge, even against medical advice, from any hospital, nursing care facility, or similar facility or service;

D. To take any other action necessary to making, documenting, and assuring implementation of decisions concerning my health care, including, but not limited to, granting any waiver or release from liability required by any hospital, physician, nursing care provider, or other health care provider; signing any documents relating to refusals of treatment or the leaving of a facility against medical advice, and pursuing any legal action in my name, and at the expense of my estate to force compliance with my wishes as determined by my agent, or to seek actual or punitive damages for the failure to comply;

E. The powers granted above do not include the following powers or are subject to the following rules or limitations *(attach additional pages, if needed):*

_____

_____

_____

_____

[Attach additional pages, if needed]

5. ORGAN DONATION

Initial only one

My agent may _____; may not _____ consent to the donation of all or any of my tissue or organs for purposes of transplantation.

6. EFFECT ON DECLARATION OF A DESIRE FOR A NATURAL DEATH

Living Will

I understand that if I have a valid Declaration of a Desire for a Natural Death, the instructions contained in the Declaration will be given effect in any situation to which they are applicable. My agent will have authority to make decisions concerning my health care only in situations to which the Declaration does not apply.

7. STATEMENT OF DESIRES CONCERNING LIFE SUSTAINING TREATMENT

With respect to any Life-Sustaining Treatment, I direct the following **(INITIAL <u>ONLY ONE</u> OF THE FOLLOWING FOUR PARAGRAPHS)**:

(1) _____ GRANT OF DISCRETION TO AGENT. I do not want my life to be prolonged nor do I want life-sustaining treatment to be provided or continued if my agent believes the burdens of the treatment outweigh the expected benefits. I want my agent to consider the relief of suffering, my personal beliefs, the expense involved and quality as well as the possible extension of my life in making decisions concerning life-sustaining treatment.

OR

(2) _____ DIRECTIVE TO WITHHOLD OR WITHDRAW TREATMENT. I do not want my life to be prolonged and I do not want life-sustaining treatment:

a. if I have a condition that is incurable or irreversible and, without the administration of life-sustaining procedures, expected to result in death within a relatively short period of time; or

b. if I am in a state of permanent unconsciousness.

OR

(3) _____ DIRECTIVE FOR MAXIMUM TREATMENT. I want my life to be prolonged to the greatest extent possible, within the standards of accepted medical practice, without regard to my condition, the chances I have for recovery, or the cost of the procedures.

OR

(4) _____ DIRECTIVE IN MY OWN WORDS:

_____

_____

_____

_____

_____

[Attach additional pages, if needed]

8. STATEMENT OF DESIRES REGARDING TUBE FEEDING

With respect to Nutrition and Hydration provided by means of a nasogastric tube or tube into the stomach, intestines, or veins, I wish to make clear that in situations where life sustaining treatment is being withheld or withdrawn pursuant to Item 7, **(INITIAL ONE OF THE FOLLOWING THREE PARAGRAPHS)**:

_____ GRANT OF DISCRETION TO AGENT. I do not want my life to be prolonged by tube feeding if my agent believes the burdens of tube feeding outweigh the expected benefits. I want my agent to consider the relief of suffering, my personal beliefs, the expense involved, and the quality as well as the possible extension of my life in making this decision.

OR

_____ DIRECTIVE TO WITHHOLD OR WITHDRAW TUBE FEEDING. I do not want my life prolonged by tube feeding.

OR

_____ DIRECTIVE FOR PROVISION OF TUBE FEEDING. I do want tube feeding to be provided within the standards of accepted medical practice, without regard to my condition, the chances I have for recovery, or the cost of the procedure, and without regard to whether other forms of life-sustaining treatment are being withheld or withdrawn.

IF YOU DO NOT INITIAL ANY OF THE STATEMENTS IN PARAGRAPH 8, YOUR AGENT WILL NOT HAVE AUTHORITY TO DIRECT THAT NUTRITION AND HYDRATION NECESSARY FOR COMFORT CARE OR ALLEVIATION OF PAIN BE WITHDRAWN.

9. ADMINISTRATIVE PROVISIONS

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

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

10. ADMINISTRATIVE PROVISIONS

I provide the following additional instructions for the guidance of my agent:

_____

_____

_____

_____

_____

_____

_____

_____

_____

[Attach additional pages, if needed]

STATEMENT OF PRINCIPAL

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 _____, _____.
Month Year

My current home address is: _____

_____

Principal's Signature: _____

Print Name of Principal: _____

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/her 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 #1

Signature: _____ Date: _____

Print name: _____ Telephone: (_____) _____

Address: _____

Witness #2

Signature: _____ Date: _____

Print name: _____ Telephone: (_____) _____

Address: _____

NOTARIZATION

A notary public must complete this portion of the form who is present when you and the qualified witnesses sign the document.

STATE OF SOUTH CAROLINA

COUNTY OF _____

The foregoing instrument was acknowledged before me by Principal on _____, _____, 20____.
Day Month Year

Notary Public for South Carolina _____

My Commission Expires: _____

ADDENDUM TO
THE STATE OF SOUTH CAROLINA
HEALTH CARE POWER OF ATTORNEY

MY HEALTH CARE STATEMENT OF BELIEFS

My philosophy regarding the health care decisions I would make, if I were able to participate in medical treatment decisions, is based on my belief in the inherent value of human life and that life is a gift from God. It is my desire that all reasonable efforts be made to sustain my life and health.

I believe that death is the normal end of earthly life, and that God takes life by his decision. Therefore, I reject any attempt to end my life when God would sustain it, regardless of any diminished state of quality to my life, even if I have a disability. Similarly, I reject any attempt to lengthen my life when it is clear God intends to take it.

I believe life begins at conception. Therefore, if I have been diagnosed as pregnant and my physician knows of this diagnosis, I request that every effort be made to save the life of my unborn child in full recognition that two lives are at stake, both equal in value and worthy of protection.

HEALTH CARE DIRECTIVES

1. I direct my health care agent to consent to the following health care:
   a. Health care that is intended to relieve pain or to make me comfortable.
   b. Health care to cure or improve any physical or mental condition which can be cured or improved. This includes health care that is intended to be used temporarily or because it is potentially effective.

2. My health care agent has no authority to consent to any act or omission intended to cause or hasten my death.

3. I instruct my health care agent to ensure that my attending physician and other health care providers provide my health care based on my health care philosophy and my health care directives as set forth in this document.

4. Should it become clear that God wishes to take my life, namely that I am diagnosed to have a terminal illness or injury where death is imminent, I direct that life–sustaining procedures be withheld or withdrawn, and that I be permitted to die in God's time. I do *not* give consent for the withholding or withdrawal of nutrition or hydration, even if I am diagnosed to have a terminal illness or injury, if doing so would cause my death by starvation or dehydration rather than from the terminal condition or injury.

5. If God allows the quality of my life to be diminished but gives me strength to continue living for an indeterminate amount of time, I request that reasonable care be administered to me to sustain my life and ease discomfort as much as possible.

EXCEPTIONS TO HEALTH CARE DIRECTIVES

1. My health care agent may refuse consent to health care that would not be effective in terms of my survival.

2. If I have an incurable terminal illness or injury where I am in the final stages of dying, and it is medically certain that my death will occur within hours or a few days, my health care agent may consent to the withholding or withdrawal of any health care that is not intended to relieve pain or make me comfortable.

3. If I have an incurable terminal illness or injury, and it is medically certain that my death will occur within six (6) months, my health care agent may consent to the withholding or withdrawal of life–sustaining health care. However, I still desire health care for easily treatable acute and chronic conditions, and health care that is intended to relieve pain or make me comfortable.

4. If I have a total, chronic, and irreversible loss of consciousness, and this condition has been diagnosed with medical certainty by two physicians, one of whom is my attending physician and the other is an expert in diagnosing my condition, my health care agent may consent to the withholding or withdrawal of life–sustaining health care. However, I still desire health care for easily treatable acute and chronic conditions, and health care that is intended to relieve pain or make me comfortable.

LIMITATIONS ON MENTAL HEALTH TREATMENT

My agent may not admit or commit me on an inpatient basis to an institution for mental diseases, a state treatment facility, or a treatment facility. My agent may not consent to experimental mental health research or psychosurgery, electroconvulsive treatment, or drastic mental health treatment procedures for me.

STATEMENT OF ADDITIONAL DESIRES

In exercising authority under this document, my agent shall act consistently with my following stated desires, if any, and is subject to any special provisions or limitations that I specify. The following are any specific desires, provisions, or limitations that I wish to state (add more items as appropriate):

1. I request that the attached Addendum (pages 7-12) be included as a valid part of this Health Care Power of Attorney document.

2. I request, but not as a requirement, that my agent consult my clergy regarding health care decisions.

3. _____

_____

_____

_____

_____

[Add additional pages, if needed]

ADMISSION TO NURSING HOMES

My agent may admit me to a nursing home for short–term stays for recuperative care or respite care.

If I have checked "Yes" to the following, my agent may admit me for a purpose other than recuperative care or respite care, but if I have checked "No" to the following, my agent may not so admit me:

A nursing home **Yes** ❑ **No** ❑

If I have not checked either "Yes" or "No" immediately above, my agent may only admit me for short–term stays for recuperative care or respite care.

PREGNANT WOMEN

If I am pregnant, the following applies:

1. My health care agent is authorized to make health care decisions on behalf of my unborn child as an individual patient.

2. Health care necessary to sustain the life or health of my unborn child should be provided unless it is medically certain that my unborn child would not survive even if the health care were provided.

3. It is my desire that all reasonable efforts be made to sustain both my life and health and the life and health of my unborn child.

4. Even if I have an incurable illness or injury, or I am legally determined to be brain dead, it is my desire to receive all health care, to remain on any necessary life support systems, and to receive nutrition and hydration until my unborn child can sustain life apart from my body, unless it is medically certain that my unborn child would not survive even if I receive such health care.

5. No one is authorized to consent to an abortion for me unless it is directly and medically necessary to prevent my death.

HEALTH CARE DECISIONS FOR PREGNANT WOMEN

If I have checked "Yes" to the following, my agent may make health care decisions for me even if my agent knows I am pregnant. If I have checked "No" to the following, my agent may not make health care decisions for me if my agent knows I am pregnant.

Health care decision if I am pregnant **Yes ❑** **No ❑**

If I have not checked either "Yes" or "No" immediately above, my agent may not make health care decisions for me if he or she knows I am pregnant.

In no event is my agent authorized to make medical treatment decisions to withhold or withdraw treatment for me if I am pregnant that would result in my death.

INSPECTION AND DISCLOSURE OF INFORMATION RELATING TO MY PHYSICAL OR MENTAL HEALTH

Subject to any limitations in this document, my agent has the authority to do all of the following:

1. Request, review and receive any information, verbal or written, regarding my physical or mental health, including medical and hospital records.

2. Execute on my behalf any documents that may be required in order to obtain this information.

3. Consent to the disclosure of this information.

ANATOMICAL GIFTS

Optional

Upon my death:

_____ I wish to donate only the following organs or parts:

_____

_____

_____

_____ I wish to donate any needed organ or part.

_____ I wish to donate my body for anatomical study if needed.

_____ I refuse to make an anatomical gift. (If this revokes a prior commitment that I have made to make an anatomical gift to a designated donee, I will attempt to notify the donee to which or to whom I agreed to donate.)

Failure to check any of the lines immediately above creates no presumption about my desire to make or refusal to make an anatomical gift.

Signature: _____ Date: _____

STATEMENT OF PRINCIPAL

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 _____, _____.
Month Year

My current home address is: _____

_____

Principal's Signature: _____

Print Name of Principal: _____

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/her 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 #1

Signature: _____ Date: _____

Print name: _____ Telephone: (_____) _____

Address: _____

Witness #2

Signature: _____ Date: _____

Print name: _____ Telephone: (_____) _____

Address: _____

NOTARIZATION

A notary public must complete this portion of the form who is present when you and the qualified witnesses sign the document.

STATE OF SOUTH CAROLINA

COUNTY OF _____

The foregoing instrument was acknowledged before me by Principal on _____, _____, 20____.
Day Month Year

Notary Public for South Carolina _____

My Commission Expires: _____

STATEMENT OF HEALTH CARE AGENT

I understand that _____ has designated me to be his or her health care agent
Name of principal
if he or she is ever found to have incapacity and unable to participate in making health care decisions himself or herself.

_____ has discussed his or her desires regarding health care decisions with me.
Name of principal

Agent's signature: _____

Address: _____

STATEMENT OF SUCCESSORS

We understand that _____ has designated us to be his or her alternate
Name of principal
health care agents if he or she is ever found to have incapacity and unable to make health care decisions himself or herself and if the person designated as health care agent is unable or unwilling to make those decisions.

_____ has discussed his or her desires regarding health care decisions with us.
Name of principal

First alternate agent's signature: _____

Second alternate agent's signature: _____

CLERGY
Optional

The principal has requested that the agent consult me, as the principal's clergy, regarding any health care decisions. I understand that this request has been made and am willing to work with the agent to help meet the directives as described in this Health Care Power of Attorney document and attached Addendum.

Clergy's signature: _____ Phone: (_____) _____

Church address: _____

I have given copies of this Health Care Power of Attorney – Christian Version to:

_____

_____

_____

_____

_____

_____