Horizon
Infusions

Dear New Patient,

Welcome to Horizon Infusions and thank you for choosing us as your infusion provider. Horizon Infusions is committed to partnering with you, your physician, and other healthcare providers to provide you individualized care per your treatment plan. We will do all we can to ensure you achieve the most successful treatment outcome in the most convenient and comfortable setting.

The trust and confidence you have in Horizon Infusions is most appreciated. We provide our patients with timely specialty services as prescribed by your physician. Our mission is to help you better understand your specific disease state so you can achieve the best results and maintain optimal health over the long-term.

While receiving treatment at Horizon Infusions, our services will include these key benefits:

1. Educate every patient on your unique disease process and prescribed treatment
2. Provide excellent care safely and effectively while respecting that your time is valuable
3. Provide you with courteous, educated staff members
4. Provide your referral physician with important details of your care for faster intervention, as required
5. Offer appointment times to meet your busy schedule, early mornings, and evening hours, outside of the Horizon Infusions business hours Monday through Thursday, 8am-5pm, and Friday 8am-3pm

It is a great pleasure to welcome you to Horizon Infusions, and we look forward to being your infusion provider. Thank you for allowing us to serve you.

Sincerely,

Jody L. Huss, ACNP

Director of Clinical

Operations

PATIENT'S RIGHTS & RESPONSIBLITIES

As a patient of Horizon Infusions, you have the right to:

- Be informed of your rights and responsibilities prior to treatment and care.
- Ask for assistance and further explanation in understanding your rights and responsibilities.
- Be treated with dignity and respect.
- The confidentiality of your identifiable health information.
- Enjoy personal privacy and a safe, clean environment for care.
- Be free from all forms of abuse and neglect.
- Have your cultural, psychological, spiritual, and personal values, beliefs, and preferences respected.
- Be free from any form of discrimination based on race, ethnicity, culture, language, socioeconomic status, religion, gender identity or expression, age, national origin, sexual orientation, disability, or method of payment.
- Have the presence of a support individual of your choice, unless that person's presence infringes on others' rights, safety, or interferes with medical care.
- Be informed regarding a surgery or procedure before you agree to it, including what will happen if you decline.
- Seek a second opinion from another doctor.
- Be informed of unanticipated adverse outcomes.
- Get information in words you can understand, including the use of a language or hearing interpreter when needed, at no charge.
- Request a list of disclosures regarding your health information.
- Know the name and role of your caregivers.
- Be involved in your own care, treatment, and services.
- Express concerns or complaints to the Compliance Officer or the U.S. Department of Health and Human Services.
- An explanation of your bill.
- Medical Grievances/Complaints can contact ACHC: 855-937-2243
    - MCR/CMS: 1-800-MEDICARE (1-800-633-4227)
    - Ohio Board of Pharmacy: 614-466-4143

As a patient of Horizon Infusions, it is your responsibility to:

- Provide complete and accurate information regarding your health, and to inform us of any changes in your condition or symptoms.
- Inform us if you do not understand information provided to you regarding your medical care.
- Cooperate with our staff in your diagnosis and treatment.
- Be responsible for your actions if you refuse treatment or do not follow medical instructions.
- Pay your bill in a timely manner, meeting the financial obligations of your medical care.
- Keep your scheduled appointments or let us know if you are unable to keep them.
- Be considerate of others.

_____

Patient Name (please print)

_____ _____

Patient/Guardian Signature Date

Consent to Receive Text Messages Adult Client or Parent/Guardian

By consenting to receive SMS messages, you are agreeing to be contacted by Horizon Infusions on behalf of your healthcare providers via text (SMS) messages to your mobile phone and other wireless devices, and the use of an automatic telephone dialing system, artificial voice, and prerecorded messages, for the purpose of providing appointment services.

You may opt-out of receiving text (SMS) messages at any time by replying with the word STOP from the mobile device receiving the messages. Horizon Infusions will not share, sell or use your contact information for other purposes.

☐ YES, email notifications only
☐ YES, email and text (SMS) message notifications
☐ YES, voice notifications only
☐ YES, email, text (SMS) message, and voice message notifications

_____ _____
Print Name of Adult Client or Parent's/Guardian of Child Client Date of Birth

_____ _____
Print Client or Parent/Guardian Name Date of Birth

SMS Texting Services Terms and Conditions

Horizon Infusions

This SMS Texting Services provision is applicable when You have subscribed and expressly consented to receive text messages from Us. By subscribing and providing such consent, You have granted Us express permission to send automated text messages to the enrolled mobile phone number(s) through Your wireless phone carrier unless and until such permission is revoked in accordance with these Terms and Conditions.

When You opt-in to SMS Texting Services, We will send You a text message to confirm Your signup.

We offer SMS Texting Services to provide information or resources on topics including, but not limited to the following:

a. Operational alerts/reminders such as appointment reminders, intake, billing/payment

b. Health-related information provided is not meant to replace professional medical advice and does not establish a patient-provider relationship

Text messages will vary in frequency, by texting program. As part of enrollment in an SMS Texting Service, You may send the text message "HELP" to Us for assistance. Additionally, You may opt-out of an SMS Texting Service by replying “STOP” from Your mobile phone. After You send the text message "STOP" to Us, We will send You a text message to confirm that You have been unsubscribed. After this, You will no longer receive text messages from Us. If You want to join again, You must enroll as You did the first time and We will start sending text messages to You again. Text messages will be sent using an automatic dialing system to the mobile phone number provided to Us.

Operational information provided is valid only at the time the text message is sent and may change at a later time.

Age restrictions apply to SMS Texting Services. To participate, You must be 18 years of age or older and own and control the mobile phone number provided to Us. Individuals between the ages of 14 and 18 must have parental consent. Individuals between 14 and 18 years of age who do not have parental consent, or individuals under 14 years of age, must unsubscribe from the SMS Texting Services.

You must immediately notify Us if Your mobile phone number changes. We are not liable for any communication or transmission of information via text message which occurs as a result of a change to a mobile phone number that is not reported. Using password-protected mobile devices and enabling encryption, if available, is recommended.

Depending on the SMS Texting Service that You have enrolled in, You may receive marketing messages. We are committed to building Your trust and confidence by promoting and complying with the use of business practices that help protect the privacy and the security of You and Your data.

If You are dissatisfied with the SMS Texting Services or with these Terms and Conditions, Your sole and exclusive remedy is to discontinue enrollment in the SMS Texting Services. We do not guarantee the successful delivery of text messages. Messages sent via text may not be delivered if the mobile phone number is not in range of a transmission site, or if sufficient network capacity is not available at a particular time. Even within a coverage area, factors beyond the control of wireless carriers may interfere with message delivery, including Your equipment, the terrain, and proximity to buildings, foliage, and weather. We will not be liable for losses or damages arising from (a) non-delivery, delayed delivery, or misdirected delivery of a text message; (b) inaccurate or incomplete content in a text message; or (c) use or reliance on the contents of any text message for any purposes.

Content may not be available via all carriers. Participating carriers may include, but are not limited to: AT&T, Verizon Wireless, Sprint, T-Mobile, MetroPCS, U.S. Cellular, Alltel, Boost Mobile, Nextel, and Virgin Mobile, Alaska Communications Systems (ACS), Appalachian Wireless (EKN), Bluegrass Cellular, Cellular One of East Central IL (ECIT), Cellular One of Northeast Pennsylvania, Cincinnati Bell Wireless, Cricket, Coral Wireless (Mobi PCS), COX, Cross, Element Mobile (Flat Wireless), Epic Touch (Elkhart Telephone), GCI, Golden State, Hawkeye (Chat Mobility), Hawkeye (NW Missouri), Illinois Valley Cellular, Inland Cellular, iWireless (Iowa Wireless), Keystone Wireless (Immix Wireless/PC Man), Mosaic (Consolidated or CTC Telecom), Nex-Tech Wireless, NTelos, Panhandle Communications, Pioneer, Plateau (Texas RSA 3 Ltd), Revol, RINA, Simmetry (TMP Corporation), Thumb Cellular, Union Wireless, United Wireless, Viaero Wireless, and West Central (WCC or 5 Star Wireless). ***Carriers are not liable for delayed or undelivered messages***

Message and data rates may apply for any messages sent to You from Us and to Us from You. If You have any questions about Your text plan or data plan, it is best to contact Your wireless provider. If You have any questions regarding privacy, please read our Privacy Policy.

VERIFICATION OF NON-INSTITUTIONAL SERVICES' COMPLIANCE WITH TITLE VI OF THE FEDERAL CIVIL RIGHTS ACT OF 1964 AND THE KENTUCKY CIVIL RIGHTS ACT OF 1966 AND AMENDMENTS THERETO

42 USC 2000d. Prohibition against exclusion from participation in, denial of benefits of, and discrimination under federally assisted programs on ground of race, color or national origin.

No person in the United States shall, on the ground of race, color, or national origin, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any program or activity receiving Federal financial assistance.

Pub. L. 88-352, Title VI, 601, July 02, 1964, 78 Stat: 252.

KRS 344.120 Refusal to rent or sell public accommodations unlawful.

Except as otherwise provided in KRS 344.140 and 344.145, it is an unlawful practice for a person to deny an individual the full and equal enjoyment of the goods, services, facilities, privileges, advantages, and accommodations of a place of public accommodation, resort, or amusement, as defined in KRS 344.130, on the ground of disability, race, color, religion, or national origin.

Effective: July 14, 1992

History: Amended 1992 Ky. Acts ch. 282, sec. 12, effective July 14, 1992. -- Created 1966 Ky. Acts ch. 2, Art. 4, sec. 401.

214.620 Cabinet for Health and Family Services, in consultation with professional associations, to develop instructional material on HIV -- Comprehensive information to be presented to any person receiving treatment.

(1) The Cabinet for Health and Family Services shall develop instructional material on the human immunodeficiency virus, including information related to methods of transmission, education, and infection control. To expeditiously and economically develop, produce, and distribute the instructional material required under this section, the Cabinet for Health and Family Services shall consult with the professional associations of professions to determine whether suitable instructional materials already exist that may be lawfully reproduced or reprinted.

(2) Information on the human immunodeficiency virus infection shall be presented to any person who receives treatment at any hospital, however named, skilled-nursing facilities, primary-care centers, rural health clinics, outpatient clinics, ambulatorycare facilities, ambulatory surgical centers, and emergency-care centers licensed pursuant to KRS Chapter 216B. The information shall include but not be limited to methods of transmission and prevention and appropriate behavior and attitude change.

Effective: June 24, 2015
History: Amended 2015 Ky. Acts ch. 113, sec. 2, effective June 24, 2015. -- Amended 2010 Ky. Acts ch. 85, sec. 20, effective July 15, 2010. -- Amended 2005 Ky. Acts ch. 99, sec. 466, effective June 20, 2005. -- Amended 2002 Ky. Acts ch. 211, sec. 49, effective July 15, 2002. -- Amended 2001 Ky. Acts ch. 61, sec. 3, effective June 21, 2001. -- Amended 1998 Ky. Acts ch. 426, sec. 413, effective July 15, 1998. -- Created 1990 Ky. Acts ch. 443, sec. 30, effective July 13, 1990.

WHAT YOU SHOULD KNOW ABOUT HIV & AIDS^

WHAT IS HIV?

Human Immunodeficiency Virus (HIV) is a virus that weakens your immune system by destroying specific cells that fight infection and disease. HIV is an infection that progresses in three stages:

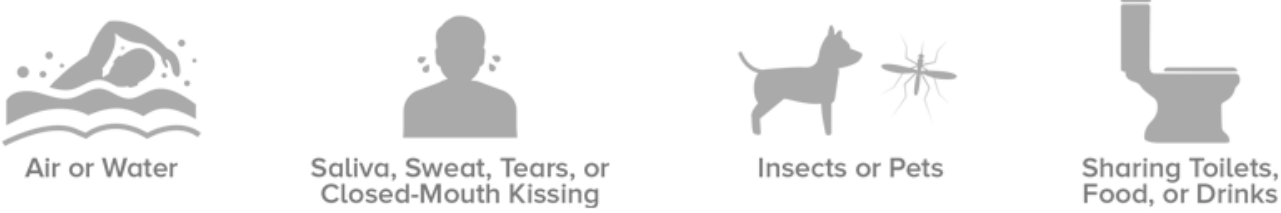
STAGE 1	Acute HIV infection	A person with acute HIV may develop flu-like symptoms within 2-4 weeks of infection, with symptoms that may last for several weeks.
STAGE 2	Chronic HIV infection	Once a person's body is infected, it is infected for life. However, with proper medical care, a person with HIV may live nearly as long as someone who does not have HIV. Untreated HIV can progress to AIDS, typically 8-10 years after testing positive for HIV.
STAGE 3	AIDS	**Acquired Immunodeficiency Syndrome (AIDS)** is the most severe phase of HIV infection. AIDS is diagnosed when the CD4 T cell count falls below 200, or a person experiences an AIDS-defining complication (e.g., serious infection or cancer). Antiretroviral therapy (ART) can prevent HIV from destroying the immune system and advancing to AIDS. Without treatment, people with AIDS can survive about 3 years.

WHAT IS AIDS?

HOW IS HIV TRANSMITTED?

- Sexual contact (oral, anal, or vaginal intercourse) with an infected person when blood, pre-ejaculation fluid, semen, cervical/vaginal, and/or anal mucus secretions are exchanged
- Sharing syringes, needles, cotton, cookers, and other drug injecting equipment with someone who is infected
- Receiving contaminated blood or blood products (very unlikely after March 1985)
- An infected mother, not on ART, can pass HIV to her unborn child before or during childbirth, or through breastfeeding
- Receipt of transplant, tissue/organs, or artificial insemination from an infected donor (very rare)
- Needle stick or other sharps injury in a health care setting involving an infected person (very rare)

HIV IS NOT TRANSMITTED BY



EARLY DIAGNOSIS OF HIV INFECTION IS IMPORTANT!

GETTING TESTED FOR HIV:

Everyone should be tested at least once for HIV.
The Centers for Disease Control and Prevention (CDC) recommends persons who report any of the activities listed below should be tested at least yearly:

- A man who has had sex with another man*
- Injecting not medically prescribed drugs and sharing needles or other drug equipment
- Exchanging sex for money or drugs
- Diagnosed with or treated for another sexually transmitted infection, hepatitis, or tuberculosis
- Having more than one sexual partner since their last HIV test
- Having unprotected sex or sex with someone who has had unprotected sex

* Sexually active men who have sex with men may benefit from more frequent testing (e.g., every 3–6 months)

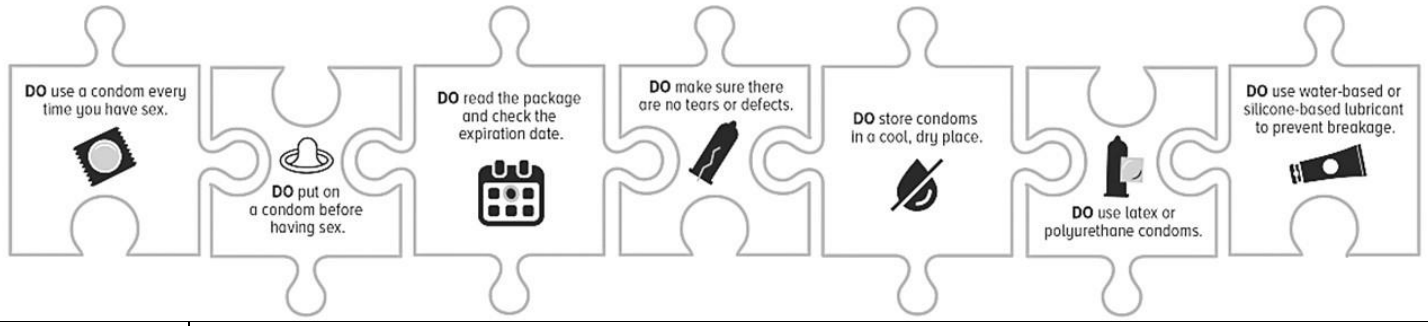
New infections may be identified as early as 4 weeks with new advances in screening tests. Free anonymous and confidential testing and counseling is available at every health department in Kentucky. If you have HIV, seek care immediately and a provider will help determine the best treatment plan. In many cases, early treatment can enhance a person's ability to remain healthy as long as possible.

Remember, you cannot tell whether someone has HIV just by looking at them!

HOW CAN I PREVENT HIV?

- Educate yourself and others about HIV infection and AIDS
- Do not share needles or other drug paraphernalia
- Practice "safer" sex:
  - ✓ Abstinence (not having sex of any kind)
  - ✓ Sex only with a person who does not have HIV, does not practice unsafe sex, or inject drugs
  - ✓ Using either a male or female condom or dental dam (for oral sex)
  - ✓ Do not share sex toys
- Persons at higher risk can help prevent HIV infections through the use of pre-exposure prophylaxis (PrEP)
- Exercise universal precautions when coming into contact with HIV infected blood, semen, or vaginal fluid

HOW TO CORRECTLY USE A MALE CONDOM:



WHAT IS PrEP?

PrEP means taking HIV medications daily (i.e., Truvada, Descovy) by persons who have not been diagnosed with HIV, but who are at risk of acquiring HIV via sex or injection drug use. When taken daily, this medication can effectively stop HIV infection. Persons taking PrEP should continue to use condom for maximum protection.

WHAT IS PEP?

Post-exposure prophylaxis (PEP) is an HIV medication taken within 72 hours (3 days) of a potential exposure to HIV. Once prescribed, PEP will be dosed 1-2 times daily for 28 days. PEP is intended for persons who have tested negative for HIV or are uncertain of their HIV status and should only be used in emergency situations.

WOMEN AND HIV/AIDS

All pregnant women should have blood tests to check for HIV infection.
Women diagnosed with HIV who are not on treatment can pass HIV infection to their babies during pregnancy, labor and delivery, and through breastfeeding of passing HIV to the baby to 1% or less if they practice all of the following:

- Take ART daily
- Give HIV treatment to her baby for 4-6 weeks after giving birth
- Do not breastfeed or pre-chew her baby's food

UNDETECTABLE = UNTRANSMISSIBLE

Persons with HIV who take their HIV medicine as prescribed may remain virally suppressed or undetectable and healthy, with effectively no risk of sexually transmitting HIV to their HIV-negative partners.

LIVING HEALTHY WITH HIV

Begin treatment as soon as possible and take prescribed medications daily. Maintaining an undetectable viral load is the key to living a longer, healthier life.

- Healthy living behaviors for the general public are even more important for those living with HIV:
  - ✓ A healthy diet provides energy and nutrients a person's body needs to fight disease and infections (It may also improve absorption of prescribed medications and may help offset potential side effects.)
  - ✓ Exercise strengthens the immune system to better combat infections
- Discordant couples are at higher risk of HIV transmission:

HIV Negative Partner Should:	○ Be routinely tested for HIV ○ Ask their health care provider about PrEP
HIV Positive Partner Should:	○ Take ART daily as prescribed
Both Partners Should:	○ Use condoms during sex ○ Not engage in sex with other people

THIS AGENCY PROVIDES QUALITY SERVICES TO ALL PATIENTS, REGARDLESS OF HIV STATUS.

IF YOU NEED MORE INFORMATION CALL:

1-800-CDC-INFO (232-4636) | 1-888-232-6348 TTY

Kentucky HIV/AIDS Program 502-564-6539

-or-

Your local health department's HIV/AIDS Coordinator

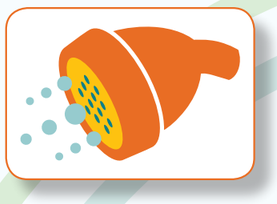
^retrieved 6/17/2020 from: https://www.cdc.gov/hiv/basics/

Infection Prevention and You

You are an important part of infection prevention!

Wash your hands with soap and water or use hand sanitizer often.

Ask healthcare workers and your visitors to do the same.



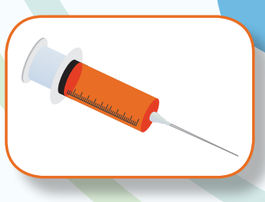
If you are having surgery, ask if you should shower with a germ-killing soap ahead of time.

Speak up for your care!

Clean your hands and make sure everyone around you does too.

Take medications as directed.

Sneeze and cough into your elbow, not your hand.



Ask about safe injection practices. Remember: ***One Needle, One Syringe, only One Time.***

Every day, ask if you still need your catheter.

If your room looks dirty, ask to have it cleaned.

Who are infection preventionists?

Infection preventionists use their detective skills to find the bad germs and make sure everyone is doing the right things to keep you safe.

Catheters or other devices will be placed in your body after your skin receives proper cleaning.

Healthcare workers will clean their hands before and after they care for you.

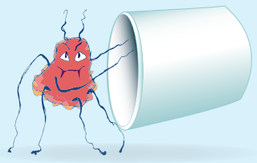
Your healthcare workers will wear gloves, gowns, and masks at the right times.

If you are in isolation, you and your visitors may need to do this too.

Your room and any equipment that is used on you will be clean.

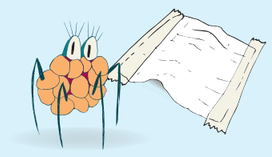
What are healthcare-associated infections?

Healthcare-associated infections are a result of germs entering your body during medical care.



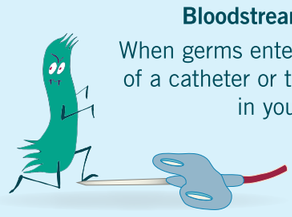
Catheter-associated urinary tract infections

When germs travel along a urinary catheter and cause an infection in your bladder or kidney.



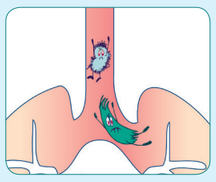
Surgical site infections

An infection that happens after surgery in the part of the body where the surgery took place.



Bloodstream infections

When germs enter the blood by way of a catheter or tube that is placed in your vein.



Pneumonia

Infection of the lungs.

APIC

Association for Professionals in Infection Control and Epidemiology

Learn more **www.apic.org/InfectionPreventionAndYou** **www.facebook.com/APICInfectionPreventionandYou** **twitter.com/apic**

OHIO Advance Directive
Planning for Important Health Care Decisions

CaringI nfo
1731 King St., Suite 100, Alexandria, VA 22314
www.caringinfo.org
800/658-8898

CaringInfo, a program of the National Hospice and Palliative Care Organization (NHPCO), is a national consumer engagement initiative to improve care at the end of life.

It's About How You LIVE

It's About How You LIVE is a national community engagement campaign encouraging individuals to make informed decisions about end-of-life care and services. The campaign encourages people to:

Learn about options for end-of-life services and care
Implement plans to ensure wishes are honored
Voice decisions to family, friends and health care providers
Engage in personal or community efforts to improve end-of-life care

Note: The following is not a substitute for legal advice. While Caring Info updates the following information and form to keep them up-to-date, changes in the underlying law can affect how the form will operate in the event you lose the ability to make decisions for yourself. If you have any questions about how the form will help ensure your wishes are carried out, or if your wishes do not seem to fit with the form, you may wish to talk to your health care provider or an attorney with experience in drafting advance directives. **If you have other questions regarding these documents, we recommend contacting your state attorney general's office.**

Using these Materials

BEFORE YOU BEGIN

1. Check to be sure that you have the materials for each state in which you may receive health care.

2. These materials include:
    - Instructions for preparing your advance directive, please read all the instructions.
    - Your state-specific advance directive forms, which are the pages with the gray instruction bar on the left side.

ACTION STEPS

1. You may want to photocopy or print a second set of these forms before you start so you will have a clean copy if you need to start over.

2. When you begin to fill out the forms, refer to the gray instruction bars — they will guide you through the process.

3. Talk with your family, friends, and physicians about your advance directive. Be sure the person you appoint to make decisions on your behalf understands your wishes.

4. Once the form is completed and signed, photocopy the form and give it to the person you have appointed to make decisions on your behalf, your family, friends, health care providers, and/or faith leaders so that the form is available in the event of an emergency.

5. You may also want to save a copy of your form in an online personal health records application, program, or service that allows you to share your medical documents with your physicians, family, and others who you want to take an active role in your advance care planning.

INTRODUCTION TO YOUR OHIO ADVANCE DIRECTIVE

This packet contains two legal documents that protect your right to refuse medical treatment you do not want, or to request treatment you do want, in the event you lose the ability to make decisions yourself. You may complete one or both documents, depending on your advance-planning needs.

The **Ohio Durable Power of Attorney for Health Care** lets you name someone, called an agent, to make decisions about your medical care—including decisions about life-sustaining treatment—if you can no longer speak for yourself. The durable power of attorney for health care is especially useful because it appoints someone to speak for you any time you are unable to make your own medical decisions, not only at the end of life.

Your durable power of attorney for health care becomes effective when your doctor determines that you have lost the capacity to make informed health care decisions for yourself.

The **Ohio Living Will Declaration** is your state's living will. It lets you state your wishes about health care in the event that you become terminally ill or permanently unconscious and can no longer make your own health care decisions.

Your Ohio Declaration becomes effective when your doctor determines that you have lost the capacity to make informed health care decisions for yourself and you are terminally ill or you are permanently unconscious.

Following your Ohio Declaration is an **Organ Donation Enrollment Form**. This form allows you to register your organ donation choices with the registry, so that your organ donation wishes will be followed, even if your declaration cannot be found.

These forms do not expressly address mental illness. If you would like to make advance care plans regarding mental illness, you should talk to your physician and an attorney about a durable power of attorney tailored to your needs.

Note: These documents will be legally binding only if the person completing them is a competent adult (at least 18 years old).

INSTRUCTIONS FOR COMPLETING YOUR OHIO DURABLE POWER OF ATTORNEY FOR HEALTH CARE

How do I make my Ohio Durable Power of Attorney for Health care legal?

The law requires that you have your Durable Power of Attorney for Health care witnessed. You can do this in either of two ways:

1. Have your signature witnessed by a notary public,

   OR

2. Sign your document, or direct another to sign it, in the presence of two adult witnesses. Your witnesses **cannot** be:
   - related to you,
   - your agent,
   - your doctor, or
   - the administrator of the nursing home in which you are receiving care.

Whom should I appoint as my agent?

Your agent is the person you appoint to make decisions about your health care if you become unable to make those decisions yourself. Your agent may be a family member or a close friend whom you trust to make serious decisions. The person you name as your agent should clearly understand your wishes and be willing to accept the responsibility of making health care decisions for you.

You can appoint a second person as your alternate agent. The alternate will step in if the first person you name as an agent is unable, unwilling, or unavailable to act for you.

The person you appoint as your agent **cannot** be:

- your doctor;
- an administrator of a nursing home in which you are receiving care;
- an employee or agent of your doctor or your treating health care facility, unless he or she is related to you or is a member of your religious order (i.e., you are both monks, nuns, priests, etc.);
- a person you have a civil or criminal protective order against; or
- a person that you are currently divorcing or from whom you are legally separated.

COMPLETING YOUR OHIO DURABLE POWER OF ATTORNEY FOR HEALTH CARE (CONTINUED)

Should I add personal instructions to my Ohio Durable Power of Attorney for Health care?

One of the strongest reasons for naming an agent is to have someone who can respond flexibly as your health care situation changes and deal with situations that you did not foresee. If you add instructions to this document it may help your agent carry out your wishes, but be careful that you do not unintentionally restrict your agent's power to act in your best interest. In any event, be sure to talk with your agent about your future medical care and describe what you consider to be an acceptable "quality of life."

Keep in mind that, if you complete both the Ohio Durable Power of Attorney for Health Care and the Ohio Declaration, and there are any conflicting directions, the directions you give in the Ohio Declaration will control.

What if I change my mind?

You may revoke your Ohio Durable Power of Attorney for Health Care at any time and in any manner. Your revocation becomes effective once your doctor receives notification of your revocation.

What other important facts should I know?

Your agent may make decisions about life-sustaining treatment only if you are terminally ill or permanently unconscious.

Before your agent can consent to the withholding or withdrawal of artificial nutrition and hydration on your behalf, you must check and initial the statement printed in capital letters on page 5 of the Ohio Durable Power of Attorney for Health Care document.

Your agent does not have authority to refuse or withdraw care necessary to provide comfort care.

Your agent does not have the power to consent to the withholding or withdrawal of medical treatment if you are pregnant and if the absence of medical treatment would terminate the pregnancy, unless the pregnancy or continued application of medical treatment would be harmful to you or it is reasonably medically certain that the pregnancy would not result in a live birth.

COMPLETING YOUR OHIO LIVING WILL DECLARATION

How do I make my Ohio Living Will Declaration legal?

The law requires that you have your Living Will Declaration witnessed. You can do this in either of two ways:

1. Have your signature witnessed by a notary public,

   OR

2. Sign your document, or direct another to sign it, in the presence of two adult witnesses. Your witnesses **cannot** be:
   - related to you,
   - your doctor, or
   - the administrator of a nursing home in which you are receiving care.

Can I add personal instructions to my Living Will Declaration?

Yes, there is a section in the Living Will Declaration for you to add additional instructions.

Keep in mind that, if you complete both the Ohio Durable Power of Attorney for Health Care and the Ohio Living Will Declaration, and there are any conflicting directions in the event you are in a terminal condition or are permanently unconscious, the directions you give in the Ohio Living Will Declaration will control. If you have appointed an agent, it may be a good idea to write a statement such as, "Any questions about how to interpret or when to apply my Living Will Declaration are to be decided by my agent."

What if I change my mind?

You may revoke your Living Will Declaration at any time and in any manner. Your revocation becomes effective once your doctor receives notification of your revocation.

What other important facts should I know?

A pregnant patient's Ohio Living Will Declaration will not be honored if the withholding or withdrawal of treatment would terminate the pregnancy, unless it is reasonably medically certain that such treatment would not result in a live birth.

If you are in a terminal condition or a permanently unconscious state, your Living Will Declaration will control your Health Care Power of Attorney if there is any conflict.

PRINT YOUR NAME AND BIRTH DATE

State of Ohio
Health Care Power of Attorney
Of

_____

(Print Full Name)

_____

(Birth Date)

This is my Health Care Power of Attorney. I revoke all prior Health Care Powers of Attorney signed by me. I understand the nature and purpose of this document. If any provision is found to be invalid or unenforceable, it will not affect the rest of this document.

I understand that my agent can make health care decisions for me only whenever my attending physician has determined that I have lost the capacity to make informed health care decisions. However, this does not require or imply that a court must declare me incompetent.

Definitions

DEFINITIONS

Adult means a person who is 18 years of age or older.

Agent or attorney-in-fact means a competent adult who a person (the "principal") can name in a Health Care Power of Attorney to make health care decisions for the principal.

Artificially or technologically supplied nutrition or hydration means food and fluids provided through intravenous or tube feedings. [You can refuse or discontinue a feeding tube or authorize your Health Care Power of Attorney agent to refuse or discontinue artificial nutrition or hydration.]

Bond means an insurance policy issued to protect the ward's assets from theft or loss caused by the Guardian of the Estate's failure to properly perform his or her duties.

Comfort care means any measure, medical or nursing procedure, treatment or intervention, including nutrition and/or hydration, that is taken to diminish a patient's pain or discomfort, but not to postpone death.

DEFINITIONS

CPR means cardiopulmonary resuscitation, one of several ways to start a person's breathing or heartbeat once either has stopped. It does not include clearing a person's airway for a reason other than resuscitation.

Do Not Resuscitate or DNR Order means a physician's medical order that is written into a patient's record to indicate that the patient should not receive cardiopulmonary resuscitation.

Guardian means the person appointed by a court through a legal procedure to make decisions for a ward. A **Guardianship** is established by such court appointment.

Health care means any care, treatment, service or procedure to maintain, diagnose or treat an individual's physical or mental health.

Health care decision means giving informed consent, refusing to give informed consent, or withdrawing informed consent to health care.

Health Care Power of Attorney means a legal document that lets the principal authorize an agent to make health care decisions for the principal in most health care situations when the principal can no longer make such decisions. Also, the principal can authorize the agent to gather protected health information for and on behalf of the principal immediately or at any other time. A Health Care Power of Attorney is NOT a financial power of attorney.

The Health Care Power of Attorney document also can be used to nominate person(s) to act as guardian of the principal's person or estate. Even if a court appoints a guardian for the principal, the Health Care Power of Attorney remains in effect unless the court rules otherwise.

Life-sustaining treatment means any medical procedure, treatment, intervention or other measure that, when administered to a patient, mainly prolongs the process of dying.

Living Will Declaration means a legal document that lets a competent adult ("declarant") specify what health care the declarant wants or does not want when he or she becomes terminally ill or permanently unconscious and can no longer make his or her wishes known. It is NOT and does not replace a will, which is used to appoint an executor to manage a person's estate after death.

Permanently unconscious state means an irreversible condition in which the patient is permanently unaware of himself or herself and surroundings. At least two physicians must examine the patient and agree that the patient has totally lost higher brain function and is unable to suffer or feel pain.

Principal means a competent adult who signs a Health Care Power of Attorney.

Terminal condition means an irreversible, incurable, and untreatable condition caused by disease, illness, or injury from which, to a reasonable degree of medical certainty as determined in accordance with reasonable medical standards by a principal's attending physician and one other physician who has examined the principal, both of the following apply: (1) there can be no recovery and (2) death is likely to occur within a relatively short time if life-sustaining treatment is not administered.

Ward means the person the court has determined to be incompetent. The ward's person, financial estate, or both, is protected by a guardian the court appoints and oversees.

DEFINITIONS

PRINT THE NAME, ADDRESS AND TELEPHONE NUMBERS OF YOUR AGENT

Naming of My Agent. The person named below is my agent who will make health care decisions for me as authorized in this document.

Agent's Name and Relationship:

_____

Agent's Current Address:

_____

Agent's Current Telephone Number:

_____

By placing my initials, signature, check or other mark in this box, I specifically authorize my agent to obtain my protected health care information immediately and at any future time.

Guidance to Agent. My agent will make health care decisions for me based on my instructions in this document and my wishes otherwise known to my agent. If my agent believes that my wishes conflict with what is in this document, this document will take precedence. If there are no instructions and if my wishes are unclear or unknown for any particular situation, my agent will determine my best interests after considering the benefits, the burdens and the risks that might result from a given decision. If no agent is available, this document will guide decisions about my health care.

Naming of Alternate Agent(s). If my agent named above is not immediately available or is unwilling or unable to make decisions for me, then I name, in the following order of priority, the persons listed below as my alternate agents [cross out any unused lines]:

PRINT THE NAME, ADDRESS AND TELEPHONE NUMBERS OF YOUR ALTERNATE AGENTS

First Alternate Agent: Second Alternate Agent:

Name: _____ Name: _____

Address: _____Address: _____

_____ _____

Telephone: _____ Telephone:_____

Any person can rely on a statement by any alternate agent named above that he or she is properly acting under this document and such person does not have to make any further investigation or inquiry.

Authority of Agent. Except for those items I have crossed out and subject to any choices I have made in this Health Care Power of Attorney, my agent has full and complete authority to make all health care decisions for me. This authority includes, but is not limited to, the following:

1. To consent to the administration of pain---relieving drugs or treatment or procedures (including surgery) that my agent, upon medical advice, believes may provide comfort to me, even though such drugs, treatment or procedures may hasten my death.

2. If I am in a terminal condition and I do not have a Living Will Declaration that addresses treatment for such condition, to make decisions regarding life-sustaining treatment, including artificially or technologically supplied nutrition or hydration.

3. To give, withdraw or refuse to give informed consent to any health care procedure, treatment, interventions or other measure.

CROSS OUT AND INITIAL ANY AUTHORITY THAT YOU DO NOT WANT YOUR AGENT TO HAVE

4. To request, review and receive any information, verbal or written, regarding my physical or mental condition, including, but not limited to, all my medical and health care records.

5. To consent to further disclosure of information and to disclose medical and related information concerning my condition and treatment to other persons.

6. To execute for me any releases or other documents that may be required in order to obtain medical and related information.

7. To execute consents, waivers and releases of liability for me and for my estate to all persons who comply with my agent's instructions and decisions. To indemnify and hold harmless, at my expense, any person who acts while relying on this Health Care Power of Attorney. I will be bound by such indemnity entered into by my agent.

8. To select, employ and discharge health care personnel and services providing home health care and the like.

9. To select, contract for my admission to, transfer me to or authorize my discharge from any medical or health care facility, including, but not limited to, hospitals, nursing homes, assisted living facilities, hospices, adult homes and the like.

10. To transport me or arrange for my transportation to a place where this Health Care Power of Attorney is honored, if I am in a place where the terms of this document are not enforced.

11. To complete and sign for me the following:

CROSS OUT ANY AUTHORITY THAT YOU DO NOT WANT YOUR AGENT TO HAVE

(a) Consents to health care treatment, or to the issuing of Do Not Resuscitate (DNR) Orders or other similar orders; and

(b) Requests to be transferred to another facility, to be discharged against health care advice, or other similar requests; and

(c) Any other document desirable or necessary to implement health care decisions that my agent is authorized to make pursuant to this document.

PLACE INITIALS HERE ONLY IF YOU WANT TO AUTHORIZE YOUR AGENT TO REFUSE ARTIFICIAL NUTRITION OR HYDRATION

Special Instructions. By placing my initials, signature, check or other mark on this line, I **specifically authorize my agent to refuse or, if treatment has started, to withdraw consent to, the provision of artificially or technologically supplied nutrition or hydration** if I am in a permanently unconscious state AND my physician and at least one other physician who has examined me have determined, to a reasonable degree of medical certainty, that artificially or technologically supplied nutrition and hydration will not provide comfort to me or relieve my pain: _____

GENERAL LIMITATIONS ON AGENT'S AUTHORITY

Limitations of Agent's Authority. I understand there are limitations to the authority of my agent under Ohio law:

1. My agent does not have authority to refuse or withdraw informed consent to health care necessary to provide comfort care.

2. My agent does not have the authority to refuse or withdraw informed consent to health care if I am pregnant, if the refusal or withdrawal of the health care would terminate the pregnancy, unless the pregnancy or the health care would pose a substantial risk to my life, or unless my attending physician and at least one other physician to a reasonable degree of medical certainty determines that the fetus would not be born alive.

3. My agent cannot order the withdrawal of life---sustaining treatment, including artificially or technologically supplied nutrition or hydration, unless I am in a terminal condition or in a permanently unconscious state and two physicians have determined that life---sustaining treatment would not or would no longer provide comfort to me or alleviate my pain.

4. If I previously consented to any health care, my agent cannot withdraw that treatment unless my condition has significantly changed so that the health care is significantly less beneficial to me, or unless the health care is not achieving the purpose for which I chose the health care.

ADD OTHER INSTRUCTIONS OR LIMITATIONS, IF ANY, REGARDING YOUR ADVANCE CARE PLANS

THESE INSTRUCTIONS CAN FURTHER ADDRESS YOUR HEALTH CARE PLANS, SUCH AS YOUR WISHES REGARDING HOSPICE TREATMENT, BUT CAN ALSO ADDRESS OTHER ADVANCE PLANNING ISSUES, SUCH AS YOUR BURIAL WISHES

ATTACH ADDITIONAL PAGES IF NEEDED

Additional Instructions or Limitations.

I may give additional instructions or impose additional limitations on the authority of my agent. Below are my specific instructions or limitations:

[If the space below is not sufficient, you may attach additional pages. If you do not have any additional instructions or limitations, write "None" below.]

NOMINATION OF GUARDIAN

[You may, but are not required to, use this document to nominate a guardian, should guardianship proceedings be started, for your person or your estate.]

I understand that any person I nominate is not required to accept the duties of guardianship, and that the probate court maintains jurisdiction over any guardianship.

I understand that the court will honor my nominations except for good cause shown or disqualification.

I understand that, if a **guardian of the person** is appointed for me, such guardian's duties would include making day-to-day decisions of a personal nature on my behalf, such as food, clothing, and living arrangements, but this or any subsequent Health Care Power of Attorney would remain in effect and control health care decisions for me, unless determined otherwise by the court. The court will determine limits, suspend or terminate this or any subsequent Health Care Power of Attorney, if they find that the limitation, suspension or termination is in my best interests.

I intend that the authority given to my agent in my Health Care Power of Attorney will eliminate the need for any court to appoint a guardian of my person. However, should such proceedings start, I nominate the person(s) below in the order listed as **guardian of my person.**

INITIAL THE BLANKS TO NOMINATE YOUR AGENT AS GUARDIAN OF YOUR PERSON

By writing my initials, signature, a check mark or other mark on this line, I nominate my agent and alternate agent(s), if any, to be **guardian of my person**, in the order named above.

_____

If I do not choose my agent or an alternate agent to be the **guardian of my person**, I choose the following person(s), in this order:

OTHERWISE, WRITE IN THE GUARDIAN OF YOUR PERSON HERE

Guardian of my person's name and relationship: _____

_____

Address: _____

Telephone number(s): _____

Alternate guardian of my person's name and relationship: _____

Address: _____

_____

Telephone number(s): _____

Guardian of the estate means the person appointed by a court to make financial decisions on behalf of the ward, with the court's involvement. The guardian of the estate is required to be bonded, unless bond is waived in writing or the court finds it unnecessary.

INITIAL THE BLANKS TO NOMINATE YOUR AGENT AS GUARDIAN OF YOUR ESTATE

By placing my initials, signature, check or other mark on this line, I nominate my agent or alternate agent(s), if any, as **guardian of my estate**, in the order named above.

_____

If I do not choose my agent or an alternate agent to be the **guardian of my estate**, I choose the following person(s), in this order:

OTHERWISE, WRITE IN THE GUARDIAN OF YOUR ESTATE HERE

Guardian of my estate's name and relationship: _____

_____

Address: _____

Telephone number(s): _____

Alternate guardian of my estate's name and relationship: _____

Address: _____

_____

Telephone number(s): _____

INITIAL THE BLANKS TO DIRECT THAT BOND BE WAIVED FOR THE GUARDIAN OF YOUR ESTATE

By placing my initials, signature, check or other mark in this box, I direct that bond be waived for guardian or successor **guardian of my estate**.

_____

If I do **not** make any mark on this line, it means that I expect the guardian or successor guardian of my estate to be bonded.

No Expiration Date. This Health Care Power of Attorney will have no expiration date and will not be affected by my disability or by the passage of time.

Enforcement by Agent. My agent may take for me, at my expense, any action my agent considers advisable to enforce my wishes under this document.

Release of Agent's Personal Liability. My agent will not be liable to me or any other person for any breach of duty unless such breach of duty was committed dishonestly, with an improper motive, or with reckless indifference to the purposes of this document or my best interests.

Copies the Same as Original. Any person may rely on a copy of this document.

Out of State Application. I intend that this document be honored in any jurisdiction to the extent allowed by law.

CHECK THE APPROPRIATE BOX TO INDICATE WHETHER YOU HAVE COMPLETED A LIVING WILL

Living Will. I have completed a Living Will:

_____ Yes _____ No

Signature of Principal

I understand that I am responsible for telling members of my family and my physician, my lawyer, my religious advisor and others about this Health Care Power of Attorney. I understand I may give copies of this Health Care Power of Attorney to any person.

I understand that I may file a copy of this Health Care Power of Attorney with the probate court for safekeeping.

I understand that I must sign this Health Care Power of Attorney and state the date of my signing, and that my signing either must be witnessed by two adults who are eligible to witness my signing OR the signing must be acknowledged before a notary public.

I sign my name to this Health Care Power of Attorney

on _____, 20____, at _____, Ohio.

SIGN AND PRINT YOUR NAME, THE DATE, AND LOCATION HERE

_____

Principal

[Choose Witnesses OR a Notary Acknowledgment.]

WITNESSES

The following persons CANNOT serve as a witness to this Health Care Power of Attorney:

- Your agent, if any;
- The guardian of your person or estate, if any;
- Any alternate or successor agent or guardian, if any;
- Anyone related to you by blood, marriage, or adoption (for example, your spouse and children);
- Your attending physician; and
- The administrator of any nursing home where you are receiving care.

WITNESS OR NOTARY ACKNOWLEDGEMENT

[Choose One]

Witnesses.

I attest that the principal signed or acknowledged this Health Care Power of Attorney in my presence, and that the principal appears to be of sound mind and not under or subject to duress, fraud or undue influence.

Witness One

Signature: _____

Print Name: _____

Address: _____

Dated: _____ , 20_____

HAVE YOUR WITNESSES SIGN, DATE AND PRINT THEIR NAMES AND ADDRESSES HERE

Witness Two

Signature: _____

Print Name: _____

Address: _____

Dated: _____ , 20_____

OR

Notary Acknowledgment.

State of Ohio
County of _____ ss.

A NOTARY PUBLIC MUST COMPLETE THIS SECTION

On _____, 20_____, before me, the undersigned notary

public, personally appeared _____, principal of the above Health Care Power of Attorney, and who has acknowledged that (s)he executed the same for the purposes expressed therein. I attest that the principal appears to be of sound mind and not under or subject to duress, fraud or undue influence.

_____
Notary Public

My Commission Expires: _____

THIS NOTICE IS INCLUDED IN THIS PRINTED FORM AS REQUIRED BY OHIO REVISED CODE §1337.17.

Notice to Adult Executing this Document

This is an important legal document. Before executing this document, you should know these facts:

This document gives the person you designate (the agent) the power to make MOST health care decisions for you if you lose the capacity to make informed health care decisions for yourself. This power is effective only when your attending physician determines that you have lost the capacity to make informed health care decisions for yourself and, notwithstanding this document, as long as you have the capacity to make informed health care decisions for yourself, you retain the right to make all medical and other health care decisions for yourself.

You may include specific limitations in this document on the authority of the agent to make health care decisions for you.

Subject to any specific limitations you include in this document, if your attending physician determines that you have lost the capacity to make an informed decision on a health care matter, the agent GENERALLY will be authorized by this document to make health care decisions for you to the same extent as you could make those decisions yourself, if you had the capacity to do so. The authority of the agent to make health care decisions for you GENERALLY will include the authority to give informed consent, to refuse to give informed consent, or to withdraw informed consent to any care, treatment, service, or procedure to maintain, diagnose, or treat a physical or mental condition.

HOWEVER, even if the agent has general authority to make health care decisions for you under this document, the agent NEVER will be authorized to do any of the following:

(1) Refuse or withdraw informed consent to life-sustaining treatment (unless your attending physician and one other physician who examines you determine, to a reasonable degree of medical certainty and in accordance with reasonable medical standards, that either of the following applies:

(a) You are suffering from an irreversible, incurable, and untreatable condition caused by disease, illness, or injury from which (i) there can be no recovery and (ii) your death is likely to occur within a relatively short time if life-sustaining treatment is not administered, and your attending physician additionally determines, to a reasonable degree of medical certainty and in accordance with reasonable medical standards, that there is no reasonable possibility that you will regain the capacity to make informed health care decisions for yourself

(b) You are in a state of permanent unconsciousness that is characterized by you being irreversibly unaware of yourself and your environment and by a total loss of cerebral cortical functioning, resulting in you having no capacity to experience pain or suffering, and your attending physician additionally determines, to a reasonable degree of medical certainty and in accordance with reasonable medical standards, that there is no reasonable possibility that you will regain the capacity to make informed health care decisions for yourself);

(2) Refuse or withdraw informed consent to health care necessary to provide you with comfort care (except that, if the agent is not prohibited from doing so under (4) below, the agent could refuse or withdraw informed consent to the provision of nutrition or hydration to you as described under (4) below). (YOU SHOULD UNDERSTAND THAT COMFORT CARE IS DEFINED IN OHIO LAW TO MEAN ARTIFICIALLY OR TECHNOLOGICALLY ADMINISTERED SUSTENANCE (NUTRITION) OR FLUIDS (HYDRATION) WHEN ADMINISTERED TO DIMINISH YOUR PAIN OR DISCOMFORT, NOT TO POSTPONE YOUR DEATH, AND ANY OTHER MEDICAL OR NURSING PROCEDURE, TREATMENT, INTERVENTION, OR OTHER MEASURE THAT WOULD BE TAKEN TO DIMINISH YOUR PAIN OR DISCOMFORT, NOT TO POSTPONE YOUR DEATH. CONSEQUENTLY, IF YOUR ATTENDING PHYSICIAN WERE TO DETERMINE THAT A PREVIOUSLY DESCRIBED MEDICAL OR NURSING PROCEDURE, TREATMENT, INTERVENTION, OR OTHER MEASURE WILL NOT OR NO LONGER WILL SERVE TO PROVIDE COMFORT TO YOU OR ALLEVIATE YOUR PAIN, THEN, SUBJECT TO (4) BELOW, YOUR AGENT WOULD BE AUTHORIZED TO REFUSE OR WITHDRAW INFORMED CONSENT TO THE PROCEDURE, TREATMENT, INTERVENTION, OR OTHER MEASURE.);

(3) Refuse or withdraw informed consent to health care for you if you are pregnant and if the refusal or withdrawal would terminate the pregnancy (unless the pregnancy or health care would pose a substantial risk to your life, or unless your attending physician and at least one other physician who examines you determine, to a reasonable degree of medical certainty and in accordance with reasonable medical standards, that the fetus would not be born alive);

(4) REFUSE OR WITHDRAW INFORMED CONSENT TO THE PROVISION OF ARTIFICIALLY OR TECHNOLOGICALLY ADMINISTERED SUSTENANCE (NUTRITION) OR FLUIDS (HYDRATION) TO YOU, UNLESS:

(A) YOU ARE IN A TERMINAL CONDITION OR IN A PERMANENTLY UNCONSCIOUS STATE.

THIS NOTICE IS INCLUDED IN THIS PRINTED FORM AS REQUIRED BY OHIO REVISED CODE §1337.17.

(B) YOUR ATTENDING PHYSICIAN AND AT LEAST ONE OTHER PHYSICIAN WHO HAS EXAMINED YOU DETERMINE, TO A REASONABLE DEGREE OF MEDICAL CERTAINTY AND IN ACCORDANCE WITH REASONABLE MEDICAL STANDARDS, THAT NUTRITION OR HYDRATION WILL NOT OR NO LONGER WILL SERVE TO PROVIDE COMFORT TO YOU OR ALLEVIATE YOUR PAIN.

(C) IF, BUT ONLY IF, YOU ARE IN A PERMANENTLY UNCONSCIOUS STATE, YOU AUTHORIZE THE AGENT TO REFUSE OR WITHDRAW INFORMED CONSENT TO THE PROVISION OF NUTRITION OR HYDRATION TO YOU BY DOING BOTH OF THE FOLLOWING IN THIS DOCUMENT:

(I) INCLUDING A STATEMENT IN CAPITAL LETTERS OR OTHER CONSPICUOUS TYPE, INCLUDING, BUT NOT LIMITED TO, A DIFFERENT FONT, BIGGER TYPE, OR BOLDFACE TYPE, THAT THE AGENT MAY REFUSE OR WITHDRAW INFORMED CONSENT TO THE PROVISION OF NUTRITION OR HYDRATION TO YOU IF YOU ARE IN A PERMANENTLY UNCONSCIOUS STATE AND IF THE DETERMINATION THAT NUTRITION OR HYDRATION WILL NOT OR NO LONGER WILL SERVE TO PROVIDE COMFORT TO YOU OR ALLEVIATE YOUR PAIN IS MADE, OR CHECKING OR OTHERWISE MARKING A BOX OR LINE (IF ANY) THAT IS ADJACENT TO A SIMILAR STATEMENT ON THIS DOCUMENT;

(II) PLACING YOUR INITIALS OR SIGNATURE UNDERNEATH OR ADJACENT TO THE STATEMENT, CHECK, OR OTHER MARK PREVIOUSLY DESCRIBED.

(D) YOUR ATTENDING PHYSICIAN DETERMINES, IN GOOD FAITH, THAT YOU AUTHORIZED THE AGENT TO REFUSE OR WITHDRAW INFORMED CONSENT TO THE PROVISION OF NUTRITION OR HYDRATION TO YOU IF YOU ARE IN A PERMANENTLY UNCONSCIOUS STATE BY COMPLYING WITH THE REQUIREMENTS OF (4)(C)(I) AND (II) ABOVE.

(5) Withdraw informed consent to any health care to which you previously consented, unless a change in your physical condition has significantly decreased the benefit of that health care to you, or unless the health care is not, or is no longer, significantly effective in achieving the purposes for which you consented to its use.

THIS NOTICE IS INCLUDED IN THIS PRINTED FORM AS REQUIRED BY OHIO REVISED CODE §1337.17.

Additionally, when exercising authority to make health care decisions for you, the agent will have to act consistently with your desires or, if your desires are unknown, to act in your best interest. You may express your desires to the agent by including them in this document or by making them known to the agent in another manner.

When acting pursuant to this document, the agent GENERALLY will have the same rights that you have to receive information about proposed health care, to review health care records, and to consent to the disclosure of health care records. You can limit that right in this document if you so choose.

Generally, you may designate any competent adult as the agent under this document. However, you CANNOT designate your attending physician or the administrator of any nursing home in which you are receiving care as the agent under this document. Additionally, you CANNOT designate an employee or agent of your attending physician, or an employee or agent of a health care facility at which you are being treated, as the agent under this document, unless either type of employee or agent is a competent adult and related to you by blood, marriage, or adoption, or unless either type of employee or agent is a competent adult and you and the employee or agent are members of the same religious order. Finally, a person you designate as an agent may lose their authority to act as your agent if there is a civil or criminal protective order against them that names you as the alleged victim, or if the agent is your spouse and you are currently going through a divorce or legal separation at the time of your incapacity.

This document has no expiration date under Ohio law, but you may choose to specify a date upon which your durable power of attorney for health care generally will expire. However, if you specify an expiration date and then lack the capacity to make informed health care decisions for yourself on that date, the document and the power it grants to your agent will continue in effect until you regain the capacity to make informed health care decisions for yourself.

You have the right to revoke the designation of the agent and the right to revoke this entire document at any time and in any manner. Any such revocation generally will be effective when you express your intention to make the revocation. However, if you made your attending physician aware of this document, any such revocation will be effective only when you communicate it to your attending physician, or when a witness to the revocation or other health care personnel to whom the revocation is communicated by such a witness communicate it to your attending physician.

THIS NOTICE IS INCLUDED IN THIS PRINTED FORM AS REQUIRED BY OHIO REVISED CODE §1337.17.

If you execute this document and create a valid durable power of attorney for health care with it, it will revoke any prior, valid durable power of attorney for health care that you created, unless you indicate otherwise in this document.

This document is not valid as a durable power of attorney for health care unless it is acknowledged before a notary public or is signed by at least two adult witnesses who are present when you sign or acknowledge your signature. No person who is related to you by blood, marriage, or adoption may be a witness. The agent, your attending physician, and the administrator of any nursing home in which you are receiving care also are ineligible to be witnesses.

IF THERE IS ANYTHING IN THIS DOCUMENT THAT YOU DO NOT UNDERSTAND, YOU SHOULD ASK YOUR LAWYER TO EXPLAIN IT TO YOU.

THIS NOTICE IS INCLUDED IN THIS PRINTED FORM AS REQUIRED BY OHIO REVISED CODE §1337.17.

Courtesy of CaringInfo
1731 King St., Suite 100, Alexandria, VA 22314
www.caringinfo.org, 800/658-8898

STATE OF OHIO LIVING WILL DECLARATION

Notice to Declarant

The purpose of this Living Will Declaration is to document your wish that life-sustaining treatment, including artificially or technologically supplied nutrition and hydration, be withheld or withdrawn if you are unable to make informed medical decisions and are in a terminal condition or in a permanently unconscious state. This Living Will Declaration does not affect the responsibility of health care personnel to provide comfort care to you. Comfort care means any measure taken to diminish pain or discomfort, but not to postpone death.

NOTICE

If you would not choose to limit any or all forms of life-sustaining treatment, including CPR, you have the legal right to so choose and may wish to state your medical treatment preferences in writing in a different document.

Under Ohio law, a Living Will Declaration is applicable **only to individuals in a terminal condition or a permanently unconscious state**. If you wish to direct medical treatment in other circumstances, you should prepare a Health Care Power of Attorney. If you are in a terminal condition or a permanently unconscious state, this Living Will Declaration takes precedence over a Health Care Power of Attorney.

You should consider completing a new Living Will Declaration if your medical condition changes or if you later decide to complete a Health Care Power of Attorney. If you have both a Living Will Declaration and a Health Care Power of Attorney, you should keep copies of these documents together. Bring your document(s) with you whenever you are a patient in a health care facility or when you update your medical records with your physician.

State of Ohio Living Will Declaration of

PRINT YOUR NAME AND DATE OF BIRTH

_____
(Print Full Name)

_____
(Birth Date)

This is my Living Will Declaration. I revoke all prior Living Will Declarations signed by me. I understand the nature and purpose of this document. If any provision is found to be invalid or unenforceable, it will not affect the rest of this document.

I am of sound mind and not under or subject to duress, fraud or undue influence. I am a competent adult who understands and accepts the consequences of this action. I voluntarily declare my direction that my dying not be artificially prolonged.

I intend that this Living Will Declaration will be honored by my family and physicians as the final expression of my legal right to refuse certain health care.

DEFINITIONS

Definitions

Adult means a person who is 18 years of age or older.

Agent or attorney-in-fact means a competent adult who a person (the "principal") can name in a Health Care Power of Attorney to make health care decisions for the principal.

Artificially or technologically supplied nutrition or hydration means food and fluids provided through intravenous or tube feedings. [You can refuse or discontinue a feeding tube or authorize your Health Care Power of Attorney agent to refuse or discontinue artificial nutrition or hydration.]

Comfort care means any measure, medical or nursing procedure, treatment or intervention, including nutrition and/or hydration, that is taken to diminish a patient's pain or discomfort, but not to postpone death.

CPR means cardiopulmonary resuscitation, one of several ways to start a person's breathing or heartbeat once either has stopped. It does not include clearing a person's airway for a reason other than resuscitation.

DEFINITIONS

Declarant means the person signing the Living Will Declaration.

Do Not Resuscitate or DNR Order means a physician's medical order that is written into a patient's record to indicate that the patient should not receive cardiopulmonary resuscitation.

Health care means any care, treatment, service or procedure to maintain, diagnose or treat an individual's physical or mental health.

Health care decision means giving informed consent, refusing to give informed consent, or withdrawing informed consent to health care.

Health Care Power of Attorney means a legal document that lets the principal authorize an agent to make health care decisions for the principal in most health care situations when the principal can no longer make such decisions. Also, the principal can authorize the agent to gather protected health information for and on behalf of the principal immediately or at any other time. A Health Care Power of Attorney is NOT a financial power of attorney.

The Health Care Power of Attorney document also can be used to nominate person(s) to act as guardian of the principal's person or estate. Even if a court appoints a guardian for the principal, the Health Care Power of Attorney remains in effect unless the court rules otherwise.

Life-sustaining treatment means any medical procedure, treatment, intervention or other measure that, when administered to a patient, mainly prolongs the process of dying.

Living Will Declaration means a legal document that lets a competent adult ("declarant") specify what health care the declarant wants or does not want when he or she becomes terminally ill or permanently unconscious and can no longer make his or her wishes known. It is NOT and does not replace a will, which is used to appoint an executor to manage a person's estate after death.

DEFINITIONS

Permanently unconscious state means an irreversible condition in which the patient is permanently unaware of himself or herself and surroundings. At least two physicians must examine the patient and agree that the patient has totally lost higher brain function and is unable to suffer or feel pain.

Principal means a competent adult who signs a Health Care Power of Attorney.

Terminal condition means an irreversible, incurable, and untreatable condition caused by disease, illness, or injury from which, to a reasonable degree of medical certainty as determined in accordance with reasonable medical standards by a principal's attending physician and one other physician who has examined the principal, both of the following apply: (1) there can be no recovery and (2) death is likely to occur within a relatively short time if life-sustaining treatment is not administered.

INSTRUCTIONS

No Expiration Date. This Living Will Declaration will have no expiration date. However, I may revoke it at any time.

Copies the Same as Original. Any person may rely on a copy of this document.

Out of State Application. I intend that this document be honored in any jurisdiction to the extent allowed by law.

I have completed a **Health Care Power of Attorney**: Yes___ No___

Notifications. [Note: You do not need to name anyone. If no one is named, the law requires your attending physician to make a reasonable effort to notify one of the following persons in the order named: your guardian, your spouse, your adult children who are available, your parents, or a majority of your adult siblings who are available.]

In the event my attending physician determines that life-sustaining treatment should be withheld or withdrawn, my physician shall make a reasonable effort to notify one of the persons named below, in the following order of priority [cross out any unused lines]:

First contact's name and relationship: _____

Address: _____

Telephone Number: _____

Second contact's name and relationship: _____

Address: _____

Telephone Number: _____

Third contact's name and relationship: _____

Address: _____

Telephone Number: _____

If I am in a **TERMINAL CONDITION** and unable to make my own health care decisions, OR if I am in a **PERMANENTLY UNCONSCIOUS STATE** and there is no reasonable possibility that I will regain the capacity to make informed decisions, then I direct my physician to let me die naturally, providing me only with **comfort care**.

For the purpose of providing comfort care, I authorize my physician to:

1. Administer no life---sustaining treatment, including CPR;
2. Withhold or withdraw artificially or technologically supplied nutrition or hydration, provided that, if I am in a permanently unconscious state, I have authorized such withholding or withdrawal under Special Instructions below and the other conditions have been met;
3. Issue a DNR Order; and
4. Take no action to postpone my death, providing me with only the care necessary to make me comfortable and to relieve pain.

Special Instructions.

By placing my initials, signature, check or other mark on this line, I specifically authorize my physician to withhold, or if treatment has commenced, to withdraw, consent to the provision of artificially or technologically supplied nutrition or hydration if I am in a permanently unconscious state AND my physician and at least one other physician who has examined me have determined, to a reasonable degree of medical certainty, that artificially or technologically supplied nutrition and hydration will not provide comfort to me or relieve my pain.

_____

IF YOU WANT ARTIFICIAL NUTRITION AND HYDRATION WITHDRAWN OR WITHHELD, YOU MUST SIGN OR INITIAL HERE

ADD OTHER INSTRUCTIONS OR LIMITATIONS, IF ANY, REGARDING YOUR ANATOMICAL GIFT PLANS

ATTACH ADDITIONAL PAGES IF NEEDED

Additional instructions or limitations.
[If the space below is not sufficient, you may attach additional pages. If you do not have any additional instructions or limitations, write "None" below.]

_____

_____

_____

_____

_____

_____

_____

_____

_____

[The "anatomical gift" language provided below is required by ORC §2133.07(C). Donate Life Ohio recommends that you indicate your authorization to be an organ, tissue or cornea donor at the Ohio Bureau of Motor Vehicles when receiving a driver license or, if you wish to place restrictions on your donation, on a Donor Registry Enrollment Form (attached) sent to the Ohio Bureau of Motor Vehicles.]

[If you use this living will to declare your authorization, indicate the organs and/or tissues you wish to donate and cross out any purposes for which you do not authorize your donation to be used. Please see the attached Donor Registry Enrollment Form for help in this regard. In all cases, let your family know your declared wishes for donation.]

ANATOMICAL GIFT (OPTIONAL)

CHECK THE APPROPRIATE BOXES IF YOU WISH TO MAKE AN ANATOMICAL GIFT

Upon my death, the following are my directions regarding donation of all or part of my body: In the hope that I may help others upon my death, I hereby give the following body parts: [Check all that apply.]

☐ All organs, tissue and eyes for any purposes authorized by law.

OR

☐ Heart	☐ Lungs	☐ Liver (and associated vessels)	☐ Pancreas/Islet Cells
☐ Small Bowel	☐ Intestines	☐ Kidneys (and associated vessels)	☐ Eyes/Corneas
☐ Heart Valves	☐ Bone	☐ Tendons	☐ Ligaments
☐ Veins	☐ Fascia	☐ Skin	☐ Nerves

For the following purposes authorized by law:

☐ All purposes ☐ Transplantation ☐ Therapy ☐ Research ☐ Education

If I do not indicate a desire to donate all or part of my body by filling in the lines above, no presumption is created about my desire to make or refuse to make an anatomical gift.

SIGN AND PRINT YOUR NAME, THE DATE, AND LOCATION HERE

SIGNATURE of DECLARANT

I understand that I am responsible for telling members of my family, the agent named in my Health Care Power of Attorney (if I have one), my physician, my lawyer, my religious advisor and others about this Living Will Declaration. I understand I may give copies of this Living Will Declaration to any person.

I understand that I must sign (or direct an individual to sign for me) this Living Will Declaration and state the date of the signing, and that the signing either must be witnessed by two adults who are eligible to witness the signing OR the signing must be acknowledged before a notary public.

I sign my name to this Living Will Declaration

on _____, 20 __, at _____, Ohio.

_____

Signature

_____

Printed Name

[Choose Witnesses OR a Notary Acknowledgment.]

WITNESSES

[The following persons CANNOT serve as a witness to this Living Will Declaration:

- Your agent in your Health Care Power of Attorney, if any;
- The guardian of your person or estate, if any;
- Any alternate agent or guardian, if any;
- Anyone related to you by blood, marriage or adoption (for example, your spouse and children);
- Your attending physician; and
- The administrator of the nursing home where you are receiving care.]

WITNESS OR NOTARY ACKNOWLEDGMENT

[Choose One]

Witnesses. I attest that the Declarant signed or acknowledged this Living Will Declaration in my presence, and that the Declarant appears to be of sound mind and not under or subject to duress, fraud or undue influence.

HAVE YOUR WITNESSES SIGN, DATE AND PRINT THEIR NAMES AND ADDRESSES HERE

Witness 1

Signature: _____

Print Name:

Address: _____

Dated: _____ , 20_____

Witness 2

Signature: _____

Print Name: _____

Address: _____

Dated: _____ , 20_____

OR

OR, if there are no witnesses,

NOTARY ACKNOWLEDGMENT

A NOTARY PUBLIC MUST COMPLETE THIS SECTION

State of Ohio
County of _____ ss.

On _____, 20_____, before me, the undersigned Notary

Public, personally appeared _____, declarant of the above Living Will Declaration, and who has acknowledged that (s)he executed the same for the purposes expressed therein. I attest that the declarant appears to be of sound mind and not under or subject to duress, fraud or undue influence.

_____
Notary Public

My Commission Expires: _____

My Commission is Permanent: _____

Courtesy of CaringInfo
1731 King St., Suite 100, Alexandria, VA 22314
www.caringinfo.org, 800-658-8898

State of Ohio
Donor Registry Enrollment Form
Notice to Declarant

The purpose of the Donor Registry Enrollment Form is to document your wish to donate organs, tissues and/or corneas at the time of your death.

This form should be completed only if you have NOT already registered as a donor with the Ohio Bureau of Motor Vehicles (BMV) when renewing a driver license or state identification card; online through the BMV website; or previously through a paper form. If you wish to make an anatomical gift or modify an existing registration this form must be sent to the BMV to ensure your wishes for organ, tissue and/or cornea donation will be honored. This document will serve as your authorization to recover the organs, tissue and/or corneas indicated at the time of your death, if medically possible.

In submitting this form your wishes will be recorded in the Ohio Donor Registry maintained by the BMV and will be accessible only to the appropriate organ, tissue and cornea recovery agencies at the time of death. You are encouraged to share your wishes with your next of kin so they are aware of your intentions to be a donor.

This form can also be used to amend or revoke your wishes for donation. The completed form should be mailed to:

Ohio Bureau of Motor Vehicles
Attn: Records Request
P. O. Box 16583
Columbus, OH 43216-6583

Frequently asked questions about organ, tissue and cornea donation are addressed on page three of this section. If you have more specific questions, contact information for the state's organ and tissue recovery agencies is also listed, and you are encouraged to contact them or visit their websites.

If you have NOT already registered as a donor with the Ohio Bureau of Motor Vehicles (BMV) when renewing a driver license or state ID, the Ohio Donor Registry Form must be filed with the BMV to ensure your wishes concerning organ and tissue donation will be honored. This document will serve as your authorization to recover the organs and/or tissues indicated at the time of your death, if medically possible. In submitting this form, your wishes will be recorded in the Ohio Donor Registry maintained by the BMV and will be accessible only to the appropriate organ and tissue recovery agencies at the time of death. Be sure to share your wishes with loved ones so they are aware of your intentions. This form can also be used to amend or revoke your wishes for donation.

OHIO DONOR REGISTRY ENROLLMENT - PAGE 2 OF 2

TO ENROLL IN THE OHIO ORGAN DONATION REGISTRY, COMPLETE THIS FORM AND MAIL IT TO THE ADDRESS INDICATED

To register, please complete and mail this enrollment form to:
Ohio Bureau of Motor Vehicles
Attn: Records Request
P.O. BOX 16583
Columbus, OH 43216-6583

PLEASE PRINT

LAST NAME	FIRST	MIDDLE
MAILING ADDRESS		
CITY	STATE	ZIP
PHONE ( ) -	DATE OF BIRTH / /	STATE OF OHIO DL/ID CARD OR SSN

DONOR REGISTRY ENROLLMENT OPTIONS

OPTION 1

☐ Upon my death, I make an anatomical gift of my organs, tissues and eyes for any purpose authorized by law.

OPTION 2

☐ Upon my death, I make an anatomical gift of my organs, tissues and/or eyes selected below.

☐ ALL ORGANS, TISSUES AND EYES

ORGANS

☐ HEART
☐ LUNGS
☐ LIVER (AND ASSOCIATED VESSELS)
☐ KIDNEY (AND ASSOCIATED VESSELS)
☐ PANCREAS/ISLET CELLS
☐ INTESTINES
☐ SMALL BOWEL

TISSUES

☐ EYES/CORNEAS
☐ HEART VALVES
☐ BONE
☐ TENDONS
☐ LIGAMENTS
☐ VEINS
☐ FASCIA
☐ SKIN
☐ NERVES

For the Following Purposes Authorized By Law:

☐ ALL PURPOSES ☐ TRANSPLANTATION ☐ THERAPY ☐ RESEARCH ☐ EDUCATION

OPTION 3

☐ Please take me out of the Ohio Donor Registry.

SIGNATURE OF DONOR REGISTRANT	DATE
X	

Courtesy of CaringInfo
1731 King St., Suite 100, Alexandria, VA 22314
www.caringinfo.org, 800/658-8898

You Have Filled Out Your Health Care Directive, Now What?

1. Your Ohio Durable Power of Attorney for Health Care and Ohio Living Will Declaration are important legal documents. Keep the original signed documents in a secure but accessible place. Do not put the original documents in a safe deposit box or any other security box that would keep others from having access to them.

2. Give photocopies of the signed originals to your agent and alternate agent, doctor(s), family, close friends, clergy, and anyone else who might become involved in your healthcare. If you enter a nursing home or hospital, have photocopies of your document placed in your medical records.

3. Be sure to talk to your agent(s), doctor(s), clergy, family, and friends about your wishes concerning medical treatment. Discuss your wishes with them often, particularly if your medical condition changes.

4. You may also want to save a copy of your form in an online personal health records application, program, or service that allows you to share your medical documents with your physicians, family, and others who you want to take an active role in your advance care planning.

5. If you want to make changes to your documents after they have been signed and witnessed, you must complete new documents.

6. Remember, you can always revoke your Ohio documents.

7. Be aware that your Ohio document will not be effective in the event of a medical emergency. Ambulance and hospital emergency department personnel are required to provide cardiopulmonary resuscitation (CPR) unless they are given a separate directive that states otherwise. These directives called "prehospital medical care directives" or "do not resuscitate orders" are designed for people whose poor health gives them little chance of benefiting from CPR. These directives instruct ambulance and hospital emergency personnel not to attempt CPR if your heart or breathing should stop.

   Currently not all states have laws authorizing these orders. We suggest you speak to your physician if you are interested in obtaining one. **Caring Info does not distribute these forms.**

Congratulations!

You've downloaded **your free, state specific advance directive.**

You are taking important steps to make sure your wishes are known. Please consider helping us keep this resource free.

Your generous support to the National Hospice Foundation allows us to continue to provide FREE resources, tools, and information to educate and empower individuals to access advance care planning, caregiving, hospice and grief services.

Please show your support for our mission and consider making a tax-deductible gift to the National Hospice Foundation today.

Since 1992, the National Hospice Foundation has been dedicated to creating FREE resources for individuals and families facing a life-limiting illness, raising awareness for the need for hospice and palliative care, and providing ongoing professional education and skills development to hospice and palliative care professionals across the nation. To learn more, please visit www.NationalHospiceFoundation.org

You may wonder if a gift of $35, $50 or $100 to the National Hospice Foundation would make a difference, but it is only because of the generosity of others like you that these FREE resources are made available.

Please consider supporting our mission by returning a **generous tax-deductible donation**. Every gift makes a difference! Your gift strengthens the Foundation's ability to provide FREE caregiver and family resources.

Cut along the dotted line and use the coupon below to return a check contribution of the most generous amount you can send. Thank you.

YES! I want to support the important work of the National Hospice Foundation.

$35 helps us provide webinars to hospice professionals

$50 helps us provide free advance directives

$100 helps us maintain our free InfoLine

$_____ to support the mission of the National Hospice Foundation.

Return to:
National Hospice Foundation
PO Box 824401
Philadelphia, PA 19182-4401

OR donate online today: www.NationalHospiceFoundation.org/donate