FL&B FITZPATRICK LENTZ & BUBBA ATTORNEYS AT LAW

Advance Planning In Pennsylvania for "Being Mortal" from a Legal Prospective

Attached are:

- Form Pennsylvania Health Care Power of Attorney/Living Will
- Form Pennsylvania Durable General Power of Attorney

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FORM -- DO NOT USE WITHOUT CONSULTING WITH COUNSEL AND/OR OTHER ADVISORS

DURABLE HEALTH CARE POWER OF ATTORNEY AND HEALTH CARE TREATMENT INSTRUCTIONS (LIVING WILL)

PART I: INTRODUCTORY REMARKS ON HEALTH CARE DECISION MAKING

You have the right to decide the type of health care you want. Should you become unable to understand, make or communicate decisions about medical care, your wishes for medical treatment are most likely to be followed if you express those wishes in advance by:

1. naming a health care agent to decide treatment for you; and
2. giving health care treatment instructions to your health care agent or health care provider.

An advance health care directive is a written set of instructions expressing your wishes for medical treatment. It may contain a health care power of attorney, where you name a person called a "health care agent" to decide treatment for you, and a living will, where you tell your health care agent and health care providers your choices regarding the initiation, continuation, withholding or withdrawal of life-sustaining treatment and other specific directions.

You may limit your health care agent's involvement in deciding your medical treatment so that your health care agent will speak for you only when you are unable to speak for yourself or you may give your health care agent the power to speak for you immediately. This combined form gives your health care agent the power to speak for you only when you are unable to speak for yourself, unless you have elected broader powers for your agent under Part II, Paragraph 8. A living will cannot be followed unless your attending physician determines that you lack the ability to understand, make or communicate health care decisions for yourself and you are either permanently unconscious or you have an end-stage medical condition, which is a condition that will result in death despite the introduction or continuation of medical treatment. You, and not your health care agent, remain responsible for the cost of your medical care.

If you do not write down your wishes about your health care in advance, and if later you become unable to understand, make or communicate these decisions, those wishes may not be honored because they may remain unknown to others.

A health care provider who refuses to honor your wishes about health care must tell you of its refusal and help to transfer you to a health care provider who will honor your wishes.

You should give a copy of your advance health care directive (a living will, health care power of attorney or a document containing both) to your health care agent, your physicians, family members and others who you expect would likely attend to your needs if you become unable to understand, make or communicate decisions about medical care. If your health care wishes change, tell your physician and write a new advance health care directive to replace your old one. It is important in selecting a health care agent that you choose a person you trust who is likely to be available in a medical situation where you cannot make decisions for yourself. You should inform that person that you have appointed him or her as your health care agent and discuss your beliefs and values with him or her so that your health care agent will understand your health care objectives.

You may wish to consult with knowledgeable, trusted individuals such as family members, your physician or clergy when considering an expression of your values and health care wishes. You are free to create your own advance health care directive to convey your wishes regarding medical treatment. The following form is an example of an advance health care directive that combines a health care power of attorney with a living will.

NOTES ABOUT THE USE OF THIS FORM

If you decide to use this form or create your own advance health care directive, you should consult with your physician and your attorney to make sure that your wishes are clearly expressed and comply with the law.

If you decide to use this form but disagree with any of its statements, you may cross out those statements.

You may add comments to this form or use your own form to help your physician or health care agent decide your medical care.

This form is designed to give your health care agent broad powers to make health care decisions for you whenever you cannot make them for yourself, unless you have elected under Part II, Paragraph 8 to give your agent the ability to make decisions even if you are not incapacitated. It is also designed to express a desire to limit or authorize care if you have an end-stage medical condition or are permanently unconscious. If you do not desire to give your health care agent broad powers, or you do not wish to limit your care if you have an end-stage medical condition or are permanently unconscious, you may wish to use a different form or create your own. **YOU SHOULD ALSO USE A DIFFERENT FORM IF YOU WISH TO EXPRESS YOUR PREFERENCES IN MORE DETAIL THAN THIS FORM ALLOWS.** In These Situations, It Is Particularly Important That You Consult With Your Attorney And Physician To Make Sure That Your Wishes Are Clearly Expressed.

This form allows you to tell your health care agent your goals if you have an end-stage medical condition or other extreme and irreversible medical condition, such as advanced Alzheimer's disease. Do you want medical care applied aggressively in these situations or would you consider such aggressive medical care burdensome and undesirable?

You may choose whether you want your health care agent to be bound by your instructions or whether you want your health care agent to be able to decide at the time what course of treatment the health care agent thinks most fully reflects your wishes and values.

Pennsylvania law protects your health care agent and health care providers from any legal liability for following in good faith your wishes as expressed in the form or by your health care agent's direction. It does not otherwise change professional standards or excuse negligence in the way your wishes are carried out. If you have any questions about the law, consult an attorney for guidance.

This form and explanation is not intended to take the place of specific legal or medical advice for which you should rely upon your own attorney and physician.

PART II - DURABLE HEALTH CARE POWER OF ATTORNEY

I, , of Lehigh County, Pennsylvania, appoint the person named below to be my health care agent to make health and personal care decisions for me.

Effective immediately and continuously until my death or revocation by a writing signed by me or someone authorized to make health care treatment decisions for me, I authorize all health care providers or other covered entities to disclose to my health care agent, upon my agent's request, any information, oral or written, regarding my physical or mental health, including, but not limited to, medical and hospital records and what is otherwise private, privileged, protected or personal health information, such as health information as defined and described in the Health Insurance Portability and Accountability Act of 1996 (Public Law 104-191, 110 Stat. 1936), the regulations promulgated thereunder and any other State or local laws and rules. Information disclosed by a health care provider or other covered entity may be redisclosed and may no longer be subject to the privacy rules provided by 45 C.F.R. Pt. 164.

The remainder of this document (unless I have elected to give my agent broader powers in Paragraph 8 of this Part II) will take effect when and only when I lack the ability to understand, make or communicate a choice regarding a health or personal care decision as verified by my attending physician. My health care agent may not delegate the authority to make decisions. In the event of the adjudication of my incapacity, I hereby appoint my health care agent to serve as guardian of my person.

My health care agent has all of the following powers subject to the health care treatment instructions that follow in PART III (Cross out any powers you do not want to give your health care agent, and initial Paragraph 8. if you wish to grant your agent these powers even if you have capacity):

1. To authorize, withhold or withdraw medical care and surgical procedures.

2. To authorize, withhold or withdraw nutrition (food) or hydration (water) medically supplied by tube through my nose, stomach, intestines, arteries or veins.

3. To authorize my admission to or discharge from a medical, nursing, residential or similar facility and to make agreements for my care and health insurance for my care, including hospice and/or palliative care.

4. To hire and fire medical, social service and other support personnel responsible for my care.

5. To take any legal action necessary to do what I have directed.

6. To request that a physician responsible for my care issue a do-not-resuscitate (DNR) order, including an out-of-hospital DNR order, and sign any required documents and consents.

7. Notwithstanding the enactment of Chapter 58 of the Pennsylvania Probate, Estates and Fiduciaries Code (or any similar or successor statute) regarding Mental Health Care Declarations and Powers of Attorney, I intend for the powers conferred upon my health care agent hereunder to be construed broadly to include the authority to make all decisions about my mental health care. Mental health care includes any care, treatment, service or procedure (including my voluntary commitment) to maintain, diagnose, treat, or provide for my mental health, including (but not limited to) any medication program and therapeutic treatment.

8. [____] Even if I am not incapacitated, I elect to grant my health care agent all the applicable powers set forth in this document, including those in Paragraphs 1. through 7. above.

APPOINTMENT OF HEALTH CARE AGENT

I appoint the following health care agent:

Health Care Agent: _____
(Name and Relationship)
Address: _____
_____

Telephone No.(Home): _____
(Work): _____
(Cell): _____
E-Mail: _____

If you do not name a health care agent, health care providers will ask your family or an adult who knows your preferences and values for help in determining your wishes for treatment. Note that you may not appoint your doctor or other health care provider as your health care agent unless related to you by blood, marriage or adoption.

If my health care agent is not readily available or if my health care agent is my spouse and an action for divorce is filed by either of us after the date of this document, I appoint the person named below. (It is helpful, but not required, to name alternative health care agents).

Alternative
Health Care Agent: _____
(Name and Relationship)
Address: _____
_____

Telephone No.(Home): _____
(Work): _____
(Cell): _____
E-Mail: _____

GUIDANCE FOR HEALTH CARE AGENT (OPTIONAL)

Goals:

If I have an end-stage medical condition or other extreme irreversible medical condition, my goals in making medical decisions are as follows (insert your personal priorities such as comfort, care, preservation of mental function, etc.):

_____

_____

_____

_____

_____

_____

_____

_____

Severe Brain Damage or Brain Disease:

If I should suffer from severe and irreversible brain damage or brain disease with no realistic hope of significant recovery, I would consider such a condition intolerable and the application of aggressive medical care to be burdensome. I therefore request that my health care agent respond to any intervening (other and separate) life-threatening conditions in the same manner as directed for an end-stage medical condition or state of permanent unconsciousness as I have indicated below.

Initials____ I agree
Initials ____ I disagree

PART III - HEALTH CARE TREATMENT INSTRUCTIONS IN THE EVENT OF END-STAGE MEDICAL CONDITION OR PERMANENT UNCONSCIOUSNESS (LIVING WILL)

The following health care treatment instructions exercise my right to make my own health care decisions. These instructions are intended to provide clear and convincing evidence of my wishes to be followed when I lack the capacity to understand, make or communicate my treatment decisions:

If I have an end-stage medical condition (which will result in my death, despite the introduction or continuation of medical treatment) or am permanently unconscious such as an irreversible coma or an irreversible vegetative state and there is no realistic hope of significant recovery as determined by my attending physician and one other physician (cross out "and one other physician" if you want the attending physician to have sole authority as suggested under Pennsylvania law), all of the following apply (cross out any treatment instructions with which you do not agree):

1. I direct that I be given health care treatment to relieve pain and provide comfort even if such treatment might shorten my life, suppress my appetite or my breathing, or be habit forming.

2. I direct that all life prolonging procedures be withheld or withdrawn.

3. I specifically do not want any of the following as life prolonging procedures: (If you wish to receive any of these treatments, write "I do want" after the treatment):

Heart-Lung Resuscitation (CPR)

Mechanical Ventilator (Breathing Machine)

Dialysis (Kidney Machine)

Surgery

Chemotherapy

Radiation Treatment

Antibiotics

Please indicate whether you want nutrition (food) or hydration (water) medically supplied by a tube into your nose, stomach, intestine, arteries, or veins if you have an end-stage medical condition or are permanently unconscious and there is no realistic hope of significant recovery. (Initial only one statement.)

Tube Feedings:

____ I want tube feedings to be given

OR

____ I do not want tube feedings to be given.

Health care agent's use of instructions:
(Initial one option only).

____ My health care agent must follow these instructions.

OR

____ These instructions are only guidance. My health care agent shall have final say and may override any of my instructions. (Indicate any exceptions).

If I did not appoint a health care agent, these instructions shall be followed.

Legal Protection:

Pennsylvania law protects my health care agent and health care providers from any legal liability for their good faith actions in following my wishes as expressed in this form or in complying with my health care agent's direction. On behalf of myself, my executors and heirs, I further hold my health care agent and my health care providers harmless and indemnify them against any claim for their good faith actions in recognizing my health care agent's authority or in following my treatment instructions.

Organ Donation (Initial one option only):

____ I consent to donate my organs and tissues at the time of my death for the purpose of transplant, medical study or education. (Insert any limitations you desire on donation of specific organs or tissues or uses for donation of organs and tissues.)

OR

____ I do not consent to donate my organs or tissues at the time of my death.

SIGNATURE

Having carefully read this document, I have signed it this day of , 2017, revoking all previous health care powers of attorney and health care treatment instructions.

_____

SIGN FULL NAME HERE FOR HEALTH CARE POWER OF ATTORNEY AND HEALTH CARE TREATMENT INSTRUCTIONS.

WITNESS: _____

WITNESS: _____

Two witnesses at least 18 years of age are required by Pennsylvania law and should witness your signature in each other's presence. A person who signs this document on behalf of and at the direction of a principal may not be a witness. (It is preferable if the witnesses are not your heirs, nor your creditors, nor employed by any of your health care providers.)

COMMONWEALTH OF PENNSYLVANIA :

: **SS.**

COUNTY OF LEHIGH :

On the day of , 2017, before me, a Notary Public, personally appeared and in due form of law acknowledged the foregoing Power of Attorney to be his act and deed and desired that the same might be recorded as such.

WITNESS my hand and notarial seal.

_____

Notary Public

FORM ATTACHED -- DO NOT USE
WITHOUT CONSULTING WITH COUNSEL

DURABLE GENERAL POWER OF ATTORNEY

NOTICE

THE PURPOSE OF THIS POWER OF ATTORNEY IS TO GIVE THE PERSON YOU DESIGNATE (YOUR "AGENT") BROAD POWERS TO HANDLE YOUR PROPERTY, WHICH MAY INCLUDE POWERS TO SELL OR OTHERWISE DISPOSE OF ANY REAL OR PERSONAL PROPERTY WITHOUT ADVANCE NOTICE TO YOU OR APPROVAL BY YOU.

THIS POWER OF ATTORNEY DOES NOT IMPOSE A DUTY ON YOUR AGENT TO EXERCISE GRANTED POWERS, BUT WHEN POWERS ARE EXERCISED, YOUR AGENT MUST USE DUE CARE TO ACT FOR YOUR BENEFIT AND IN ACCORDANCE WITH THIS POWER OF ATTORNEY.

YOUR AGENT MAY EXERCISE THE POWERS GIVEN HERE THROUGHOUT YOUR LIFETIME, EVEN AFTER YOU BECOME INCAPACITATED, UNLESS YOU EXPRESSLY LIMIT THE DURATION OF THESE POWERS OR YOU REVOKE THESE POWERS OR A COURT ACTING ON YOUR BEHALF TERMINATES YOUR AGENT'S AUTHORITY.

YOUR AGENT MUST ACT IN ACCORDANCE WITH YOUR REASONABLE EXPECTATIONS TO THE EXTENT ACTUALLY KNOWN BY YOUR AGENT AND, OTHERWISE, IN YOUR BEST INTEREST, ACT IN GOOD FAITH AND ACT ONLY WITHIN THE SCOPE OF AUTHORITY GRANTED BY YOU IN THE POWER OF ATTORNEY.

THE LAW PERMITS YOU, IF YOU CHOOSE, TO GRANT BROAD AUTHORITY TO AN AGENT UNDER POWER OF ATTORNEY, INCLUDING THE ABILITY TO GIVE AWAY ALL OF YOUR PROPERTY WHILE YOU ARE ALIVE OR TO SUBSTANTIALLY CHANGE HOW YOUR PROPERTY IS DISTRIBUTED AT YOUR DEATH. BEFORE SIGNING THIS DOCUMENT, YOU SHOULD SEEK THE ADVICE OF AN ATTORNEY AT LAW TO MAKE SURE YOU UNDERSTAND IT.

A COURT CAN TAKE AWAY THE POWERS OF YOUR AGENT IF IT FINDS YOUR AGENT IS NOT ACTING PROPERLY.

THE POWERS AND DUTIES OF AN AGENT UNDER A POWER OF ATTORNEY ARE EXPLAINED MORE FULLY IN 20 Pa. C.S. Ch. 56.

IF THERE IS ANYTHING ABOUT THIS FORM THAT YOU DO NOT UNDERSTAND, YOU SHOULD ASK A LAWYER OF YOUR OWN CHOOSING TO EXPLAIN IT TO YOU.

I HAVE READ OR HAD EXPLAINED TO ME THIS NOTICE AND I UNDERSTAND ITS CONTENTS.

_____ _____, 2017 (Date)

, PRINCIPAL

DURABLE GENERAL POWER OF ATTORNEY

KNOW ALL PERSONS BY THESE PRESENTS, That I, (the "principal"), of Lehigh County, Pennsylvania, do hereby appoint my wife, (referred to hereinafter as "my Agent"), my true and lawful agent for me and on my behalf to perform all such acts as my Agent in my Agent's absolute discretion may deem advisable, as fully as I could do if personally present. If she is unable to act as my Agent for any reason (and my lawyer's or a physician's written certification that my primary Agent is unable to act shall be conclusive proof that my successor Agent is authorized to act hereunder), I appoint my brother, , as my Agent in her place. In the event of the adjudication of my incapacity, I hereby appoint my Agent to serve as guardian of my estate.

DURABLE POWER.

Power Not Affected by Disability.

This Power of Attorney shall not be affected by my subsequent disability or incapacity.

SPECIFIC POWERS DEFINED BY STATUTE AND INCLUDED IN GENERAL POWER.

Without limiting the general powers hereby already conferred, my Agent shall have the following specific powers which are granted pursuant to Chapter 56 of the Pennsylvania Probate, Estates and Fiduciaries Code, as further defined therein:

1. Real Property and Tangible Personal Property.

   (a) To engage in real property transactions.

   (b) To engage in tangible personal property transactions.

2. Banking and General Financial Powers.

(a) To engage in stock, bond and other security transactions.

(b) To engage in commodity and option transactions.

(c) To engage in banking and financial transactions.

(d) To borrow money.

(e) To enter safe deposit boxes.

(f) To engage in insurance transactions.

(g) To engage in retirement plan transactions.

(h) To handle interests in estates and trusts.

(i) To receive government benefits.

(j) To create a trust for my benefit.

(k) To make additions to an existing trust for my benefit (including any Revocable "Living" Trust created by me even though the principal does not revert to my estate).

(l) To renounce fiduciary positions.

(m) To withdraw and receive the income or corpus of a trust.

(n) To claim an elective share of the estate of my deceased spouse.

(o) To access, handle, distribute and/or dispose of my digital assets (including digital assets that I have access to from time to time) or to engage someone to assist in accessing, handling, distributing and/or disposing of such digital assets.

(p) To operate a business or an entity.

(q) To provide for personal and family maintenance.

3. Claims and Lawsuits.

To pursue claims and litigation.

4. Tax Matters.

To pursue tax matters.

SPECIFIC ADDITIONAL POWERS INCLUDED IN GENERAL POWER.

1. Power to Delegate.

To delegate any or all of the powers granted hereunder to any person or persons whom my Agent may select.

2. Power Regarding Investments.

To invest in any form of property as permitted in the preceding specific powers, keeping such cash reserves as, in my Agent's discretion, are necessary or desirable to meet conditions as they may exist from time to time. In the exercise of this power, my Agent shall not be limited to so-called "legal investments," but may invest in any variety of real or personal property as in my Agent's discretion may appear to be good and safe investments, and my Agent shall not be liable to me for any error of judgment in the making or continuing of any investment.

GRANT OF SPECIFIC ADDITIONAL AUTHORITY (OPTIONAL).

My Agent MAY NOT do any of the following specific acts for me **UNLESS I** have **INITIALED** the specific authority listed below. You should **INITIAL ONLY** the specific authority you **WANT** to give your Agent:

CAUTION: Granting any of the following Optional Specific Additional Powers to your Agent will give your Agent the authority to take actions that could significantly reduce your property or change how your property is distributed at your death.

1. Powers with Respect to *Inter Vivos* Trusts.

[____] To create, amend, revoke or terminate an *inter vivos* trust, even beyond that permitted by and provided for under items 2. (j), 2. (k), and 2. (m) above under Specific Powers Defined by Statute.

2. Power to Make Gifts.

[____] To make a "limited gift", including a limited gift to my Agent, regardless whether my Agent is not my spouse, my issue or the spouse of my issue.

[____] Notwithstanding the specific authority granted to my Agent to make a "limited gift" hereinabove, the class of permissible donees shall be limited to my spouse, my issue and the spouse of my issue (including my Agent, if a member of any such class).

[____] Notwithstanding the foregoing, I authorize unlimited gifts to my spouse.

3. Rights of Survivorship.

[____] To create or change rights of survivorship.

4. Beneficiary Designations.

[____] To create or change a beneficiary designation.

5. Waive Rights to Be a Beneficiary.

[____] To waive my right to be a beneficiary of a joint and survivor annuity, including a survivor benefit under a retirement plan.

6. Power to Disclaim.

[____] To disclaim property, including a power of appointment.

DURATION OF POWER, RELIEF FROM LIABILITY, REVOCATION.

1. This power shall not expire by reason of lapse of time.

2. I hereby ratify and confirm all that my Agent shall do or cause to be done under this General Power of Attorney. I specifically direct that my Agent shall not be subject to any liability by reason of any of my Agent's decisions, acts or failures to act, all of which shall be conclusive and binding upon me, my personal representatives, heirs and assigns. Furthermore, except in the case of malfeasance of office (malfeasance shall include my Agent's failure: (a) to keep my assets separate from my Agent's; or (b) to keep a record of receipts, disbursements and transactions made on my behalf, unless any act or omission in clause (a) or (b) is otherwise specifically permitted by 20 Pa.C.S. Ch. 56 or another provision of this Power of Attorney), I agree to indemnify my Agent, and hold my Agent harmless, from all claims that may be made against my Agent as a result of my Agent's service hereunder, and I hereby agree to reimburse my Agent in the amount of any damages, costs and expenses that may be incurred as a result of any such claim.

3. This Power of Attorney shall be revoked by my giving to my Agent written notification of the revocation, which notice shall not be considered binding unless actually received.

This Power of Attorney revokes all my previous financial powers of attorney (but does not revoke any contemporaneous or prior Living Will or power relating to health care) and is executed in triplicate. A copy of this signed power shall be deemed to be an original.

LIMITATION ON AGENT'S AUTHORITY

EXCEPT AS PROVIDED IN A GRANT OF SPECIFIC ADDITIONAL AUTHORITY ABOVE OR IN THE SPECIAL INSTRUCTIONS BELOW, AN AGENT THAT IS NOT MY ANCESTOR, SPOUSE, OR DESCENDANT MAY NOT USE MY PROPERTY TO BENEFIT THE AGENT OR A PERSON TO WHOM THE AGENT OWES AN OBLIGATION OF SUPPORT.

SPECIAL INSTRUCTIONS (OPTIONAL)

You may give special instructions on the following lines:

STATEMENT OF UNDERSTANDING

THIS POWER OF ATTORNEY IS EFFECTIVE IMMEDIATELY. I UNDERSTAND THAT THIS DURABLE GENERAL POWER OF ATTORNEY IS AN IMPORTANT LEGAL DOCUMENT, THAT IT GIVES MY AGENT BROAD POWERS OVER MY ASSETS, THAT THESE POWERS BECOME EFFECTIVE AS OF THE SIGNING OF THIS DOCUMENT AND THAT THESE POWERS WILL CONTINUE TO EXIST NOTWITHSTANDING MY SUBSEQUENT INCAPACITY. I UNDERSTAND THAT THESE POWERS REMAIN IN EFFECT UNLESS AND UNTIL I REVOKE OR OTHERWISE TERMINATE THIS POWER OF ATTORNEY.

IN WITNESS WHEREOF, and intending to be legally bound, I have hereunto set my hand and seal this day of , 2017.

Signed, sealed and delivered
in the presence of:

_____ _____(SEAL)

_____

COMMONWEALTH OF PENNSYLVANIA :

: **SS.**

COUNTY OF LEHIGH :

On the day of , 2017, before me, a Notary Public, personally appeared and in due form of law acknowledged the foregoing Power of Attorney to be his act and deed and desired that the same might be recorded as such.

WITNESS my hand and notarial seal.

_____

Notary Public

General Power of Attorney of , the Principal,
dated , 2017

ACKNOWLEDGMENT OF AGENT

I, the undersigned Agent, have read the foregoing Power of Attorney and am the person identified as the Agent for the Principal. I hereby acknowledge that when I act as Agent:

I shall act in accordance with the Principal's reasonable expectations to the extent actually known by me and, otherwise, in the Principal's best interest, act in good faith and act only within the scope of authority granted to me by the Principal in the Power of Attorney.

_____ _____(Date)
, Agent

(sign above and print name below signature line)