

WEST VIRGINIA

Advance Directive

Planning for Important Healthcare Decisions

Courtesy of CaringInfo www.caringinfo.org

CaringInfo, a program of the National Alliance for Care at Home (the Alliance), is a national consumer engagement initiative to improve care and the experience of caregiving during serious illness and at the end of life. As part of that effort, CaringInfo provides detailed guidance for completing advance directive forms in all 50 states, the District of Columbia, and Puerto Rico.

This package includes:

- 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.

BEFORE YOU BEGIN

Check to be sure that you have the materials for each state in which you may receive healthcare. Because documents are state-specific, having a state-specific document for each state where you may spend significant time can be beneficial. A new advance directive is not necessary for ordinary travel into other states. The advance directives in this package will be legally binding only if the person completing them is a competent adult who is 18 years of age or older, or an emancipated minor.

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, scan, or take a photo of the form and give it to the person you have appointed to make decisions on your behalf, your family, friends, healthcare 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 your electronic healthcare record, or 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.
6. West Virginia maintains an Advance Directive Registry, the e-Directive Registry. By filing your advance directive with the registry, your healthcare provider and loved ones may be able to find a copy of your advance directive in the event you are unable to provide one. You can read more about the registry, including instructions on how to file your advance directive, at <https://wvendlife.org/wv-e-directive-registry/>.

INTRODUCTION TO YOUR WEST VIRGINIA ADVANCE HEALTH CARE DIRECTIVE

This packet contains a **West Virginia Combined Medical Power of Attorney and Living Will**, which protects 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.

The **Medical Power of Attorney**, lets you name an adult, called a “representative,” to make decisions about your health care—including decisions about life-prolonging intervention—if you can no longer speak for yourself. The **Living Will** lets you state your wishes about health care in the event you cannot speak for yourself and you develop a terminal condition or you are in a persistent vegetative state.

How do I make my West Virginia Advance Health Care Directive legal?

You must sign or, if you are unable to sign, direct someone to sign on your behalf and in your presence your **West Virginia Combined Medical Power of Attorney and Living Will** in the presence of two adult witnesses **AND** before a notary public.

Your witnesses **cannot** be:

- a person signing the document on your behalf;
- related to you;
- any person with knowledge that they are entitled to any portion of your estate;
- directly financially responsible for the cost of your health care;
- your attending physician; or
- your health care representative or successor representative.

Whom should I appoint as my representative?

Your agent is the person you appoint to make decisions about your healthcare 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 healthcare decisions for you.

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

- your treating health care provider;
- an employee of your treating health care provider, unless related to you;
- an operator of a health care facility in which you are a patient or in which you reside; or
- an employee of an operator of a health care facility in which you are a patient or in which you reside, unless related to you.

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

Should I add personal instructions to my advance directive?

Yes! One of the most important reasons to execute an advance directive is to have your voice heard. When you name an agent and clearly communicate to them what you want and don't want, they are in the strongest position to advocate for you. Because the future is unpredictable, be careful that you do not unintentionally restrict your agent's power to act in your best interest. Be especially careful with the words "always" and "never." In any event, be sure to talk with your agent and others about your future healthcare and describe what you consider to be an acceptable "quality of life."

When does my agent's authority become effective?

Your **Medical Power of Attorney** goes into effect when your doctor determines and records in your medical record that you are unable because of physical or mental impairment to appreciate the nature and implications of a health care decision, to make an informed choice regarding the alternatives presented and to communicate that choice in an unambiguous manner.

Your **Living Will** goes into effect when your doctor determines that you are no longer capable of making or communicating your health care decisions and documents in your record that you are in a terminal condition or a persistent vegetative state.

You retain the primary authority for your healthcare decisions as long as you are able to make your wishes known.

Agent Limitations

Your agent will be bound by the current laws of West Virginia as they regard pregnancy and termination of pregnancies.

What if I change my mind?

You may revoke your Advance Directive at any time by:

- physically destroying the document or having someone destroy on your behalf at your direction and in your presence;
- signing and dating a written revocation that is given to your doctor; or
- orally revoking your document in the presence of a witness at least eighteen years of age, who must sign and date a written confirmation of your revocation.
- You should be sure to notify your representative and attending physician in order to be sure that your revocation is effective.

Mental Health Issues

These forms do not *expressly* address mental illness, although you can state your wishes and grant authority to your agent regarding mental health issues. For additional information and forms for Mental Health Advance Directives please visit The West Virginia Center for End-of-Life Care's website (<https://wvendlife.org/meet-the-forms/advance-directives/mental-health-ad/>). If you would like to make more detailed advance care plans regarding mental illness, you could talk to your physician and an attorney about a durable power of attorney tailored to your needs.

What other important facts should I know?

Be aware that your advance directive will not be effective in the event of a medical emergency, except to identify your agent. Ambulance and hospital emergency department personnel are required to provide cardiopulmonary resuscitation (CPR) unless you have a separate physician's order, which are typically called "prehospital medical care directives" or "do not resuscitate orders." DNR forms may be obtained from your state health department or department of aging (<https://www.hhs.gov/aging/state-resources/index.html>). Another form of orders regarding CPR and other treatments are state-specific POLST (portable orders for life sustaining treatment) (<https://polst.org/form-patients/>). Both a POLST and a DNR form MUST be signed by a healthcare provider and MUST be presented to the emergency responders when they arrive.

These directives instruct ambulance and hospital emergency personnel not to attempt CPR (or to stop it if it has begun) if your heart or breathing should stop.

YOU CAN SUBMIT
FORMS TO THE E-
DIRECTIVE REGISTRY
BY FAXING YOUR
FORMS TO 844-616-
1415 OR MAILING
THEM TO PO BOX
9022, 64 MEDICAL
CENTER DRIVE,
MORGANTOWN, WV
26506

PRINT THE DATE

PRINT YOUR
NAME AND
ADDRESS

PRINT THE NAME,
ADDRESS AND
TELEPHONE
NUMBER OF YOUR
REPRESENTATIVE
AND SUCCESSOR
REPRESENTATIVE

PRINT YOUR NAME

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Home. 2025 Revised.

**WEST VIRGINIA
COMBINED MEDICAL POWER OF ATTORNEY
AND LIVING WILL - PAGE 1 OF 4**

STATE OF WEST VIRGINIA
COMBINED MEDICAL POWER OF ATTORNEY AND LIVING WILL

*The Person I Want to Make Health Care Decisions For Me When I Can't Make Them for
Myself AND The Kind of Medical Treatment I Want and Don't Want If I Have A Terminal
Condition*

Dated: _____, 20____

I, _____,
(Insert your name and address)

hereby appoint as my representative to act on my behalf to give, withhold, or withdraw
informed consent to health care decisions in the event that I am not able to do so myself.

The person I choose as my representative is (One person):

(Insert the name, address, area code, and telephone number of the person you wish to
designate as your representative. Please insert only one name.)

The person I choose as my successor representative is (One person):

If my representative is unable, unwilling, or disqualified to serve, then I appoint

(Insert the name, address, area code, and telephone number of the person you wish to
designate as your representative. Please insert only one name.)

Principal Name: _____
(Insert your name)

This appointment shall extend to, but not be limited to, health care decisions relating
to medical treatment, surgical treatment, nursing care, medication, hospitalization,
care and treatment in a nursing home or other facility, and home health care. The
representative appointed by this document is specifically authorized to be granted
access to my medical records and other health information and to act on my behalf to
consent to, refuse, or withdraw any and all medical treatment or diagnostic
procedures, or autopsy if my representative determines that I, if able to do so, would
consent to, refuse, or withdraw such treatment or procedures. Such authority shall
include, but not be limited to, decisions regarding the withholding or withdrawal of life-
prolonging interventions, subject to the special directives and limitations as stated
below:

**WEST VIRGINIA
COMBINED MEDICAL POWER OF ATTORNEY
AND LIVING WILL - PAGE 2 OF 4**

1. IN A TERMINAL CONDITION: If I am very sick and unable to communicate my wishes for myself and I am certified by one physician, who has personally examined me, to have a terminal condition, I direct that life-prolonging intervention that would serve solely to prolong the dying process be withheld or withdrawn. Thus, if a physician has determined that I am in a terminal condition, I understand that completing this form would mean that I refuse cardiopulmonary resuscitation (CPR). It also means that I refuse or request the removal of a breathing machine (ventilator), dialysis, and medically administered food and fluids, such as might be provided intravenously or by feeding tube. I want to be allowed to die naturally and only be given medications or other medical procedures necessary to keep me comfortable. I want to receive as much medication as is necessary to alleviate my pain. Nevertheless, oral food and fluids, such as may be provided by spoon or by straw, shall be offered as desired and can be tolerated.

2. OTHER LIVING WILL SPECIAL DIRECTIVES OR LIMITATIONS ON THIS POWER: Comments about mental health treatment, funeral arrangements, autopsy, and organ donation may be placed here. My failure to provide special directives or limitations does not mean that I want or refuse certain treatments.

In exercising the authority under this medical power of attorney, my representative shall act consistently with my special directives or limitations as stated in this advance directive.

3. NOT IN A TERMINAL CONDITION: MEDICAL POWER OF ATTORNEY SPECIAL DIRECTIVES OR LIMITATIONS ON THIS POWER: Comments about tube feedings, breathing machines, cardiopulmonary resuscitation, dialysis, mental health treatment, funeral arrangements, autopsy and organ donation may be placed here. My failure to provide special directives or limitations does not mean that I want or refuse certain treatments.

ADD OTHER
INSTRUCTIONS, 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

**WEST VIRGINIA
COMBINED MEDICAL POWER OF ATTORNEY
AND LIVING WILL - PAGE 3 OF 4**

I appoint this representative because I believe this person understands my wishes and values and will act to carry into effect the health care decisions that I would make if I were able to do so and because I also believe that this person will act in my best interest when my wishes are unknown. It is my intent that my family, my physician, and all legal authorities be bound by the decisions that are made by the representative appointed by this document and it is my intent that these decisions should not be the subject of review by any health care provider or administrative or judicial agency.

It is my intent that this document be legally binding and effective and that this document be taken as a formal statement of my desire concerning the method by which any health care decisions should be made on my behalf during any period when I am unable to make such decisions.

THIS MEDICAL POWER OF ATTORNEY SHALL BECOME EFFECTIVE ONLY UPON MY INCAPACITY TO GIVE, WITHHOLD, OR WITHDRAW INFORMED CONSENT TO MY OWN MEDICAL CARE.

Signature of the Principal (*Sign your name*)

Address of the Principal (*Write your full address*)

I did not sign the principal's signature above for or at the direction of the principal. I am at least 18 years of age and am not related to the principal by blood or marriage, nor entitled to any portion of the estate of the principal to the best of my knowledge under any will of principal or codicil thereto, nor directly financially responsible for principal's medical care. I am not the principal's attending physician or the principal's medical power of attorney representative or successor medical power of attorney representative under a medical power of attorney.

Witness _____ DATE _____

Witness _____ DATE _____

STATE OF _____ COUNTY OF _____

SIGN, DATE, AND
WRITE YOUR ADDRESS

TWO WITNESSES
MUST SIGN AND
DATE

**WEST VIRGINIA
COMBINED MEDICAL POWER OF ATTORNEY
AND LIVING WILL - PAGE 4 OF 4**

A NOTARY PUBLIC
MUST COMPLETE THIS
SECTION OF
YOUR DOCUMENT

I, _____, a Notary Public of said County, do
certify that _____, as principal, and _____ and
_____, as witnesses, whose names are signed to the writing
above bearing date on the _____ day of _____,
20_____, have this day acknowledged the same before me.

Given under my hand this _____ day of
_____, 20_____. My
commission expires: _____

Signature of Notary Public
Insert Notary Stamp Above

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www.caringinfo.org