The Rest Of Your Life www.theroyl.com

Advance Directive And Durable Power Of Attorney

Declaration of a Desire for a Natural Death and Health Care Power of Attorney

State of South Carolina

The Rest of Your Life recommends that you review completed documents with an attorney, especially if there are mitigating circumstances surrounding your Advance Directive or Durable Power of Attorney.

Advance Directives Electronic Forms

The ROYL is a leader in offering electronic Advance Directive documents for digital signatures. Electronic Advance Directive Forms are secure and accessible anytime from any device that allows for Internet access.

Why do an Advance Directive?

Anyone 18 years of age or older should have an Advance Directive. This document allows for the care you have designated to be respected and followed through in the event you cannot speak for yourself. It allows for you to name someone to speak on your behalf, but most importantly it removes the stress, anxiety and guilt from decisions that your loved ones would otherwise have to make on your behalf.

An Advance Directive is not just for aging people. The cases of Teri Shivo and Karen Ann Quinlan serve as examples of how any adult, regardless of age, can benefit from having one. Both young adults, Shivo and Quinlan were kept alive by machines for years because they did not tell or write down what they wanted in the event of a tragic accident. The court battles that ensued took not only an emotional toll, but required government involvement because of disagreements between spouses and family members.

Description:

An Advance Directive, sometimes referred to as a Living Will or an Advance Health Care Directive, allows you to make your wishes known if you are unable to speak for yourself. An Advance Directive provides you and your loved ones with peace of mind that your care is compatible with your wishes. This is truly a gift to those you love as it helps them clearly know what to do in this stressful situation.

Advance Directive requirements vary from state to state. You can download the appropriate state form here at no cost prior to completing the form online so that you have the required information prepared in advance.

Security:

Your documents are processed using DocuSign, the leader in global electronic signature and document security.

When you complete your Advance Directive with The ROYL, you can download it as a PDF file to your computer's hard drive. DocuSign will email a final copy to the designees in your Advance Directive. We recommend you print a hard copy and send it via email or mail to others you want to have copies.

Contact us if you have questions in preparing the forms selected.

NOTICE: You must have the required information available prior to initiating the document (designees, contact information, wishes for care).

APPENDIX 1

DECLARATION OF A DESIRE FOR A NATURAL DEATH

STATE OF SOUTH CAROLINA COUNTY OF_____

I, EXAMPLE _____(____ / ____/ ____),Declarant, being at least eighteen
Social Security Number

years of age and a resident of and domiciled in the City of _____, County of _____, State of South Carolina, make this Declaration this ____day of _____, 19____.

I willfully and voluntarily make known my desire that no life-sustaining procedures be used to prolong my dying if my condition is terminal or if I am in a state of permanent unconsciousness, and I declare:

If at any time I have a condition certified to be a terminal condition by two physicians who have personally examined me, one of whom is my attending physician, and the physicians have determined that my death could occur within a reasonably short period of time without the use of life-sustaining procedures or if the physicians certify that I am in a state of permanent unconsciousness and where the application of life-sustaining procedures would serve only to prolong the dying process, I direct that the procedures be withheld or withdrawn, and that I be permitted to die naturally with only the administration of medication or the performance of any medical procedure necessary to Provide me with comfort care.

INSTRUCTIONS CONCERNING ARTIFICIAL NUTRITION AND HYDRATION

INITIAL ONE OF THE FOLLOWING STATEMENTS

If my condition is **TERMINAL** and could result in death within a reasonably short time,

____I direct that nutrition and hydration **BE PROVIDED** through any medically indicated means, including medically or surgically implanted tubes.

OR

I direct that nutrition and hydration **NOT BE PROVIDED** through any medically indicated means, including medically or surgically implanted tubes.

INITIAL ONE OF THE FOLLOWING STATEMENTS

If I am in a **PERSISTENT VEGETATIVE STATE** or other condition of permanent unconsciousness,

____I direct that nutrition and hydration **BE PROVIDED** through any medically indicated means, including medically or surgically implanted tubes.

OR

____I direct that nutrition and hydration **NOT BE PROVIDED** through any medically indicated means, including medically or surgically implanted tubes.

In the absence of my ability to give directions regarding the use of life-sustaining procedures, it is my intention that this Declaration be honored by my family and physicians and any health facility in which I may be a patient as the final expression of my legal right to refuse medical or surgical treatment, and I accept the consequences from the refusal.

I am aware that this Declaration authorizes a physician to withhold or withdraw life-sustaining procedures. I am emotionally and mentally competent to make this Declaration.

APPOINTMENT OF AN AGENT (OPTIONAL)

1. You may give another person authority to **REVOKE** this declaration on your behalf. If you wish to do so, please enter that person's name in the space below.

Name of Agent with Power to Revoke: EXAMPLE
Address: _____
Telephone Number: _____

2. You may give another person authority to ENFORCE this declaration on your behalf. If you wish to do so, please enter that person's name in the space below.

Name of Agent with Power to Enforce: _____
Address: _____
Telephone Number: _____

REVOCATION PROCEDURES

THIS DECLARATION MAY BE REVOKED BY ANY ONE OF THE FOLLOWING METHODS. HOWEVER, A REVOCATION IS NOT EFFECTIVE UNTIL IT IS COMMUNICATED TO THE ATTENDING PHYSICIAN:

(1) BY BEING DEFACED. TORN, OBLITERATED, OR OTHERWISE DESTROYED, IN EXPRESSION OF YOUR INTENT TO REVOKE, BY YOU OR 13Y SOME PERSON IN YOUR PRESENCE AND BY YOUR DIRECTION. REVOCATION BY DESTRUCTION OF ONE OR MORE OF MULTIPLE ORIGINAL DECLARATIONS REVOKES ALL OF THE ORIGINAL DECLARATIONS:

(2) BY A WRITTEN REVOCATION SIGNED AND DATED BY YOU EXPRESSING YOUR INTENT TO REVOKE;

(3) BY YOUR ORAL EXPRESSION OF YOUR INTENT TO REVOKE THE DECLARATION, AN ORAL REVOCATION TO THE ATTENDING PHYSICIAN BY A PERSON OTHER THAN YOU IS EFFECTIVE ONLY IF:
   (A) THE PERSON WAS PRESENT WHEN THE ORAL REVOCATION WAS MADE;
   (B) THE REVOCATION WAS COMMUNICATED TO THE PHYSICIAN WITHIN A *REASONABLE TIME;*
   (C) YOUR PHYSICAL OR MENTAL CONDITION MAKES IT IMPOSSIBLE FOR THE PHYSICIAN TO CONFIRM THROUGH SUBSEQUENT CONVERSATION WITH YOU THAT THE REVOCATION HAS OCCURRED. TO BE EFFECTIVE AS A REVOCATION, THE ORAL EXPRESSION CLEARLY MUST INDICATE YOUR DESIRE THAT THE

DECLARATION NOT BE GIVEN EFFECT OR THAT LIFE-SUSTAINING PROCEDURES BE ADMINISTERED;

(4) IF YOU, IN THE SPACE ABOVE, HAVE AUTHORIZED AN AGENT TO REVOKE THE DECLARATION, THE AGENT MAY REVOKE ORALLY OR 13Y A WRITTEN, SIGNED, AND DATED INSTRUMENT. AN AGENT MAY REVOKE ONLY IF YOU ARE INCOMPETENT TO DO SO. AN AGENT MAY REVOKE THE DECLARATION PERMANENTLY OR TEMPORARILY;

(5) By YOUR EXECUTING ANOTHER DECLARATION AT A LATER TIME.

_____
Signature of Declarant

AFFIDAVIT

STATE OF_____ COUNTY OF _____

We, _____and _____the undersigned witnesses to the foregoing Declaration, dated the _____ day of _____ , 19 ___ at least one of us being first duly sworn, declare to the undersigned authority, on the basis of our beat information and belief, that the Declaration was on that date signed by the declarant as and for his DECLARATION OF A DESIRE FOR A NATURAL DEATH in our presence and we, at his request and in his presence, and in the presence of each other, subscribe our names as witnesses on that date. The declarant is personally known to us, and we believe him to be of sound mind. Each of us affirms that he is qualified as a witness* to this Declaration under the provisions of the South Carolina Death with Dignity Act in that he is not related to the declarant by blood, marriage, or adoption either as a spouse, lineal ancestor, descendant of the parents of the declarant, or spouse of any of them; nor directly financially responsible for the declarant's medical care; nor entitled to any portion of the declarant's estate upon his decease, whether under any will or as an heir by intestate succession; nor the beneficiary of a life insurance policy of the declarant; nor the declarant's attending physician; nor an employee of the attending physician; nor a person who has a claim against the declarant's decedent's estate as of this time. No more than one of us is an employee of a health facility in which the declarant is a patient, If the declarant is a resident in a hospital or nursing care facility at the date of execution of this Declaration, at least one of us is an ombudsman designated by the State Ombudsman, Office of the Governor.

_____ _____
Witness Witness*

Subscribed before me by EXAMPLE, the declarant, and subscribed and sworn to before me by _____
the witness(es), this _____ day of _____, 19_____.

_____
Signature of Notary Public

(SEAL)

Notary Public for _____

My commission expires, _____

*If qualified as a witness, the Notary Public may serve as a witness. SC Code of Laws Sec. 44-77-10 (Rev. 6191)

APPENDIX 2

HEALTH CARE POWER OF ATTORNEY

(South Carolina Statutory Form, Code of Laws Section 62-5-504)

INFORMATION ABOUT THIS DOCUMENT

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

1 . This document gives the person you name as your agent the power to make health care decisions for you if you cannot make the decisions for yourself. This power includes the power to make decisions about life-sustaining treatment. Unless you state otherwise, your agent will have the same authority to make decisions about your health care as you would have.

2. This power is subject to any limitations or statements of your desires that you include in this document. You may state in this document any treatment you do not desire or treatment you want to be sure you receive. Your agent will be obligated to follow your instructions when making decisions on your behalf. You may attach additional pages if you need more space to complete the statement.

3. After you have signed this document, you have the right to make health care decisions for yourself if you are mentally competent to do so. After you have signed this document, no treatment may be given to you or stopped over your objection if you are mentally competent to make that decision.

4. You have the right to revoke this document, and terminate your agent's authority, by informing either your agent or your health care provider orally or in writing.

5. If there is anything in this document that you do not understand, you should ask a social worker, lawyer, or other person to explain it to you.

6. This power of attorney will not be valid unless two persons sign as witnesses. Each of these persons must either witness your signing of the power of attorney or witness your acknowledgement that the signature on the power of attorney is yours.

   The following persons may not act as witnesses:

   A. Your spouse: Your children, grandchildren, and other linear descendants: your parents. grandparents. and other linear ancestors: your siblings and their linear descendants: or a spouse of any of these persons.

   B. A person who is directly financially responsible for your medical care.

   C. A person who is named in your will, or, if You have no will, who would inherit your property by intestate succession.

   D. A beneficiary of a life insurance policy on your life.

   E. The persons named in the health Care Power of Attorney as your agent or successor agent.

F. Your physician or an employee of your physician.

G. Any person who would have a claim against any portion of your estate (persons to whom you owe money).

If you are patient in a health facility, no more than one witness may be an employee of that facility.

7. Your agent must be a person who is 18 years old or older and of sound mind. It may not be your doctor or any other health care provider that is now providing, you with treatment: or an employee of your doctor or provider: or spouse of the doctor, provider, or employee; unless the person is a relative of yours.

8. You should inform the person that you want him or her to be your health care agent. You should discuss this document with your agent and your physician and give each a signed copy. If you are in a health care facility or a nursing care facility, a copy of this document should be included in your medical record.

HEALTH CARE POWER OF ATTORNEY

(South Carolina Statutory Form, Code of Laws Section 62-5-504)

1. DESIGNATION OF HEALTH CARE AGENT

I, EXAMPLE _____, hereby appoint
(Principal)

_____
(Agent)

_____
(Address)

_____

Home Telephone: _____ Work Telephone: _____as my agent to make health care decisions for me as authorized in this document.

2. EFFECTIVE DATE AND DURABILITY

By this document I intend to create a durable power of attorney effective upon. and only during, any period of mental incompetence.

3. AGENT'S POWERS

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

Accordingly, unless specifically limited by Section E. below, my agent is authorized as follows:

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

B. To authorize, or refuse to authorize, any medication or procedure intended to relieve pain,

even though such use may lead to physical damage, addiction, or hasten the moment of, but not intentionally cause, my death;

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

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

E. The powers granted above do not include the following powers or are subject to the following rules or limitations: _____
_____
_____
_____

4. ORGAN DONATION (INITIAL ONLY ONE)
My agent may _____; may not _____ consent to the donation of all or any of my tissue or organs for purposes of transplantation.

5. EFFECT ON DECLARATION OF A DESIRE FOR A NATURAL DEATH (LIVING WILL)

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

6. STATEMENT OF DESIRES AND SPECIAL PROVISIONS
With respect to any Life-Sustaining Treatment, I direct the following: (INITIAL ONLY ONE OF THE FOLLOWING 4 PARAGRAPHS)

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

OR

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

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

OR

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

OR

(4) _____ DIRECTIVE IN MY OWN WORDS: _____
_____

_____
_____
_____

7. STATEMENT OF DESIRES REGARDING TUBE FEEDING

With respect to Nutrition and Hydration provided by means of a nasogastric tube or tube into the stomach. intestines, or veins, I wish to make clear that: (INITIAL ONLY ONE)

_____ I do not want to receive these forms of artificial nutrition and hydration, and they may be withheld or withdrawn under the conditions given above.

OR

_____I do want to receive these forms of artificial nutrition and hydration.

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

8. SUCCESSORS

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

A. First Alternate Agent: _____
Address: _____
_____ Telephone: _____

B. Second Alternate Agent:_____
Address: _____
_____ Telephone: _____

9. ADMINISTRATIVE PROVISIONS

a. I revoke any prior Health Care Power of Attorney and any provisions relating to health- care of any other prior power of attorney.
b. This power of attorney is intended to be valid in any jurisdiction in which it is presented.

10. UNAVAILABILITY OF AGENT

If at any relevant time the Agent or Successor Agents named herein are unable or unwilling to make decisions concerning my health care, and those decisions are to be made by a guardian, by the Probate Court, or by a surrogate pursuant to the Adult Health Care Consent Act, it is my intention that the guardian, Probate Court, or surrogate make those decisions in accordance with my directions as stated in this document.

BY SIGNING HERE I INDICATE THAT I UNDERSTAND THE CONTENTS OF THIS DOCUMENT AND THE EFFECT OF THIS GRANT OF POWERS TO MY AGENT.
I sign my name to this Health Care Power of Attorney on this _____ day of _____ 19 .
My current home address is: _____

_____
Signature: EXAMPLE
Print Name: _____

WITNESS STATEMENT

I declare, on the basis of information and belief, that the person who signed or acknowledged this document (the principal) is personally known to me, that he/she signed or acknowledged this Health Care Power of Attorney in my . presence. and that he/she appears to be of sound mind and under no duress, fraud, or undue influence.

I am not related to the principal by blood. marriage, or adoption, either as a spouse. a lineal ancestor,

descendant of the parents of the principal, or spouse of any of them. I am not directly Financially responsible for the principal's medical care. I am not entitled to any portion of the principal's estate upon his/her decease, whether under any will or as an heir by intestate succession, nor am I the beneficiary of an insurance policy on the principal's life. nor do I have a claim against the principal's estate as of this time. I am not the principal's attending physician, nor an employee of the attending physician. No more than one witness is an employee of a health facility in which the principal is a patient. I am not appointed as Health Care Agent or Successor Health Care Agent by this document.

Witness No. 1:

Signature: _____Date: _____

Print Name: _____ Telephone _____

Residence Address: _____

_____

Witness No. 2:

Signature: _____ Date: _____

Print Name: _____ Telephone _____

Residence Address: _____

_____

APPENDIX 3

STATEMENT OF DESIRES REGARDING MENTAL HEALTH TREATMENT AND CARE

ADDENDUM TO THE SOUTH CAROLINA HEALTH CARE POWER OF ATTORNEY FORM

OF EXAMPLE

(Name of Principal)

This statement is effective for **THREE YEARS** from the date signed, unless sooner revoked or replaced.

I have experienced past mental health treatment.

(Optional) I am aware that I have a mental illness that has been diagnosed as _____

_____

_____

_____

(Optional) The name of my doctor or other mental health practitioner is: _____

_____

My doctor's telephone number is: _____

With respect to the following forms of mental health treatment or care, I wish to make clear my desires as follows:

1. Regarding admission to a hospital:

   If I become unable to give or withhold informed consent for mental health treatment, my

wishes regarding admission to a hospital for mental health treatment are as follows: **[Instruction: Choose section A.** or **B.** or **C.** or **D.]**

A.____ I leave the decision of my admission to a hospital for mental health treatment to my health care agent named in my Health Care Power of Attorney.

B.____ I consent to being admitted to a hospital for mental health treatment.

C.____ I do not consent to being admitted to a hospital for mental health treatment.

D.____ I consent to being admitted to a hospital for mental health treatment, except that I do not consent to admission to: _____

_____

2. Regarding Psychotropic Medications:

If I become unable to give or withhold informed consent for mental health treatment, MY wishes regarding receiving psychotropic medication are as follows: **[Instruction: Choose section A.** or **B.** or **C.** or **D. and complete ONLY that section. Filling out section E. is optional-]**

A.____ I leave the decision of the administration of psychotropic medications to my health care agent named in my Health Care Power of Attorney.

B.____ I consent to the administration of any psychotropic medication prescribed by my treating physician.

C.____ I do not consent to the administration of any psychotropic medication.

Optional) My reasons for refusing all psychotropic medications are:

_____

_____

D.____ I consent to the administration of psychotropic medications except I expressly do not consent to the following medication(s) administered to me:

_____

(Optional) My understanding of the risks and benefits of these specific medications is:

_____

_____

(Optional) My reasons for refusing these specific medications are:

_____

_____

E.____ Other instructions and preferences regarding the administration of psychotropic medications: _____

_____

_____

3. Regarding electroconvulsive (shock) therapy:

If I become unable to give or withhold informed consent for mental health treatment my wishes regarding receiving electro-convulsive therapy are as follows: **[Instruction: Choose either Section A.** or **B.** or **C.** or **D. and complete ONLY that section.]**

A. ____ I leave the decision regarding the administration of electroconvulsive therapy to my health care agent named in my Health Care Power of Attorney.

B. ____ I consent to the administration of electroconvulsive therapy prescribed by my treating physician.

C. ____I do not consent to the administration of electroconvulsive therapy.

(Optional) My reasons for refusing electroconvulsive therapy are: _____

_____

_____

D.____ I consent to the administration of electroconvulsive therapy under the following conditions (Circle 1. or 2., below and **fill** in the blanks):

1. for the following number of treatments only:

2. with the number of treatments to be determined by

Dr. _____

Address: _____

_____

4. Regarding seclusion or restraint:

If while hospitalized my behavior becomes threatening to myself or others, my preference regarding staff's response to my behavior is as follows: **[Instruction: Choose either Section A. or B. Filling out Section C. is optional.]**

A. ____That I be placed in a seclusion room until I have regained self-control and the threatening behavior appears at an end.

B.____ That I be placed in mechanical restraints until I have regained self-control and the threatening behavior appears at an end.

C.____ Other instructions or preferences regarding the use of seclusion or restraint:

_____

_____

5. Additional instructions and statements of desires regarding my mental health treatment:

_____

_____

_____

_____

6. I may attach a statement of instructions or requests concerning personal matters or issues which I would like followed in the event I become unable to manage my affairs or clearly communicate my wishes.

THIS ADDENDUM IS EFFECTIVE FOR THREE YEARS FROM THE DATE SIGNED, UNLESS SOONER REVOKED OR REPLACED. THE EXPIRATION OR REVOCATION OF THIS ADDENDUM SHALL NOT REVOKE MY SOUTH CAROLINA HEALTH CARE POWER OF ATTORNEY FORM.

BY SIGNING THIS ADDENDUM BELOW I INDICATE THAT I UNDERSTAND THE CONTENTS

OF THIS DOCUMENT AND THE EFFECT OF THIS GRANT OF POWERS TO MY AGENT:

I sign my name to this Addendum to Health Care Power of Attorney on this _____day of _____, 19____. My current home address is: _____

_____

Signature: EXAMPLE _____

Print Name:_____

WITNESS STATEMENT

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

Witness No. 1:

Signature: _____ Date: _____

Print Name: _____Telephone: _____

Residence Address: _____

_____

Witness No. 2:

Signature: _____ Date: _____

Print Name: _____Telephone: _____

Residence Address: _____

_____

(Optional) PHYSICIAN'S REVIEW:

I reviewed the foregoing Statement of Desires Regarding Mental Health Treatment and Care with _____and
(Name of Principal)
am aware of its provisions.

_____ _____

Physician Date

Additional Pages: