Honor Your Five Wishes
Please call your HealthCare Partners provider’s office to discuss your advance directive or for help filling out this document.

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Print Your Name
Birth Date

My Wish For:
1. The person I want to make care decisions for me when I can’t
2. The kind of medical treatment I want or don’t want
3. How comfortable I want to be
4. How I want people to treat me
5. What I want my loved ones to know
How do I change to Five Wishes?

You may already have a living will or a durable power of attorney for health care. If you want to use Five Wishes instead, all you need to do is fill out and sign a new Five Wishes as directed. As soon as you sign it, it takes away any advance directive you had before. To make sure the right form is used, please do the following:

• Destroy all copies of your old living will or durable power of attorney for health care. Or you can write “revoked” in large letters across the copy you have. Tell your lawyer if he or she helped prepare those old forms for you. **AND**

What is Five Wishes?

Five Wishes is the first living will that talks about your personal, emotional and spiritual needs as well as your medical wishes. It lets you choose the person you want to make health care decisions for you if you are not able to make them for yourself. Five Wishes lets you say exactly how you wish to be treated if you get seriously ill. It was written with the help of The American Bar Association’s Commission on Law and Aging, and the nation’s leading experts in end-of-life care. It’s also easy to use. All you have to do is check a box, circle a direction, or write a few sentences.

How Five Wishes began

For 12 years, Jim Towey worked closely with Mother Teresa, and, for one year, he lived in a hospice she ran in Washington, DC. Inspired by this first-hand experience, Mr. Towey sought a way for patients and their families to plan ahead and to cope with serious illness. The result is Five Wishes and the response to it has been overwhelming. It has been featured on CNN and NBC’s Today Show and in the pages of Time and Money magazines. Newspapers have called Five Wishes the first “living will with a heart and soul.” Today, Five Wishes is available in 27 languages.

Who should use Five Wishes

Five Wishes is for anyone 18 or older — married, single, parents, adult children and friends. More than 19 million people of all ages have already used it. Because it works so well, lawyers, doctors, hospitals and hospices, faith communities, employers and retiree groups are handing out this document.

### Five Wishes States

If you live in the District of Columbia or one of the 42 states listed below, you can use Five Wishes and have the peace of mind to know that it substantially meets your state’s requirements under the law:

- Alaska
- Arizona
- Arkansas
- California
- Colorado
- Connecticut
- Delaware
- Florida
- Georgia
- Hawaii
- Idaho
- Illinois
- Iowa
- Kentucky
- Louisiana
- Maine
- Maryland
- Massachusetts
- Michigan
- Minnesota
- Mississippi
- Missouri
- Montana
- Nebraska
- Nevada
- New Jersey
- New Mexico
- New York
- North Carolina
- North Dakota
- Ohio
- Oklahoma
- Pennsylvania
- Rhode Island
- South Carolina
- South Dakota
- Tennessee
- Vermont
- Virginia
- Washington
- West Virginia
- Wisconsin
- Wyoming

If your state is not one of the 42 states listed here, Five Wishes does not meet the technical requirements in the statutes of your state. So some providers in your state may be reluctant to honor Five Wishes. However, many people from states not on this list do complete Five Wishes along with their state’s legal form. They find that Five Wishes helps them express all that they want and provides a helpful guide to family members, friends, caregivers and doctors. Most doctors and health care professionals know they need to listen to your wishes no matter how you express them.

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- Tell your Health Care Agent, family members and provider that you have filled out a new Five Wishes. Make sure they know about your new wishes.

### How Five Wishes can help you and your family

- It lets you talk with your family, friends and provider about how you want to be treated if you become seriously ill.
- Your family members will not have to guess what you want. It protects them if you become seriously ill, because they won’t have to make hard choices without knowing your wishes.
- You can know what your mom, dad, spouse or friend wants. You can be there for them when they need you most. You will understand what they really want.

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- Maryland
- Massachusetts
- Michigan
- Minnesota
- Mississippi
- Missouri
- Montana
- Nebraska
- Nevada
- New Jersey
- New Mexico
- New York
- North Carolina
- North Dakota
- Ohio
- Oklahoma
- Pennsylvania
- Rhode Island
- South Carolina
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- West Virginia
- Wisconsin
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If I am no longer able to make my own health care decisions, this form names the person I choose to make these choices for me. This person will be my Health Care Agent (or other term that may be used in my state, such as proxy, representative or surrogate).

**Wish 1  The person I want to make health care decisions for me when I can't make them for myself**

This person will make my health care choices if both of these things happen:
1. My attending or treating provider finds I am no longer able to make health care choices, **AND**
2. Another health care professional agrees that this is true.

If my state has a different way of finding that I am no longer able to make health care choices, then my state’s way should be followed.

**The person I choose as my health care agent is:**

<table>
<thead>
<tr>
<th>First Choice Name</th>
<th>Phone</th>
</tr>
</thead>
<tbody>
<tr>
<td>Address</td>
<td></td>
</tr>
</tbody>
</table>

If this person is not able or willing to make these choices for me, OR is divorced or legally separated from me, OR this person has died, then these people are my next choices:

<table>
<thead>
<tr>
<th>Second Choice Name</th>
<th>Third Choice Name</th>
<th>Phone</th>
</tr>
</thead>
<tbody>
<tr>
<td>Address</td>
<td>Address</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>City/State/ZIP</th>
<th></th>
</tr>
</thead>
</table>

**Picking the right person to be your health care agent**

Choose someone who knows you very well, cares about you, and who can make difficult decisions. A spouse or family member may not be the best choice because they are too emotionally involved. Sometimes they are the best choice. You know best. Choose someone who is able to stand up for you so that your wishes are followed. Also, choose someone who is likely to be nearby so that they can help when you need them. Whether you choose a spouse, family member, or friend as your Health Care Agent, make sure you talk about these wishes and be sure that this person agrees to respect and follow your wishes.

Your Health Care Agent should be at least 18 years or older (in Colorado, 21 years or older) and should **not be**:
- Your health care provider, including the owner or operator of a health or residential or community care facility serving you.
- An employee or spouse of an employee of your health care provider.
- Serving as an agent or proxy for 10 or more people unless he or she is your spouse or close relative.

**If I change my mind about having a health care agent, I will do one of the following**

a. Destroy all copies of this part of the Five Wishes form. OR
b. Tell someone, such as my provider or family, that I want to cancel or change my Health Care Agent. OR
c. Write the word “Revoked” in large letters across the name of each agent whose authority I want to cancel. Sign my name on that page.

I understand that my Health Care Agent can make health care decisions for me. I want my Agent to be able to do the following:

(Please cross out anything you don’t want your Agent to do that is listed below.)

- Make choices for me about my medical care or services, like tests, medicine, or surgery. This care or service could be to find out what my health problem is, or how to treat it. It can also include care to keep me alive. If the treatment or care has already started, my Health Care Agent can keep it going or have it stopped.
- Interpret any instructions I have given in this form or given in other discussions, according to my Health Care Agent’s understanding of my wishes and values.
- Consent to admission to an assisted living facility, hospital, hospice, or nursing home for me. My Health Care Agent can hire any kind of health care worker I may need to help me or take care of me. My Agent may also fire a health care worker, if needed.
- Make the decision to request, take away, or not give medical treatments, including artificially-provided food and water, and any other treatments to keep me alive.
- See and approve release of my medical records and personal files. If I need to sign my name to get any of these files, my Health Care Agent can sign it for me.
- Move me to another state to get the care I need or to carry out my wishes.
- Authorize or refuse to authorize any medication or procedure needed to help with pain.
- Take any legal action needed to carry out my wishes.
- Donate useable organs or tissues of mine as allowed by law.
- Apply for Medicare, Medicaid, or other programs or insurance benefits for me. My Health Care Agent can see my personal files, like bank records, to find out what is needed to fill out these forms.
- Listed below are any changes, additions, or limitations on my Health Care Agent’s powers.
Wish 2 My wish for the kind of medical treatment I want or don’t want

What you should keep in mind as my caregiver
- I do not want to be in pain. I want my provider to give me enough medicine to relieve my pain, even if that means that I will be drowsy or sleep more than I would otherwise.
- I want to be offered food and fluids by mouth, and kept clean and warm.
- I do not want anything done or omitted by my doctors or nurses with the intention of taking my life.

What “Life-Support Treatment” means to me
Life-support treatment means any medical procedure, device, or medication to keep me alive. Life-support treatment includes: medical devices put in me to help me breathe; food and water supplied by medical device (tube feeding); cardiopulmonary resuscitation (CPR); major surgery; blood transfusions; dialysis; antibiotics; and anything else meant to keep me alive. If I wish to limit the meaning of life-support treatment because of my religious or personal beliefs, I write this limitation in the space below. I do this to make very clear what I want and under what conditions.

In case of an emergency
If you have a medical emergency and ambulance personnel arrive, they may look to see if you have a Do Not Resuscitate form or bracelet. Many states require a person to have a Do Not Resuscitate form filled out and signed by a doctor. This form lets ambulance personnel know that you don’t want them to use life-support treatment when you are dying. Please check with your provider to see if you need to have a Do Not Resuscitate form filled out.

Here is the kind of medical treatment that I want or don’t want in the four situations listed below. I want my Health Care Agent, my family, my provider and other health care providers, my friends, and all others to know these directions.

Close to death:
If my doctor and another health care professional both decide that I am likely to die within a short period of time, and life-support treatment would only delay the moment of my death.
(Choose one of the following):
□ I want to have life-support treatment.
□ I do not want life-support treatment.
□ I want to have life-support treatment if my doctor believes it could help. But I want my doctor to stop giving me life-support treatment if it is not helping my health condition or symptoms.

In a coma and not expected to wake up or recover:
If my doctor and another health care professional both decide that I am in a coma from which I am not expected to wake up or recover, and I have brain damage, and life-support treatment would only delay the moment of my death.
(Choose one of the following):
□ I want to have life-support treatment.
□ I do not want life-support treatment.
□ I want to have life-support treatment if my doctor believes it could help. But I want my doctor to stop giving me life-support treatment if it is not helping my health condition or symptoms.

Permanent and severe brain damage and not expected to recover:
If my doctor and another health care professional both decide that I have permanent and severe brain damage, (for example, I can open my eyes, but I can not speak or understand) and I am not expected to get better, and life-support treatment would only delay the moment of my death.
(Choose one of the following):
□ I want to have life-support treatment.
□ I do not want life-support treatment.
□ I want to have life-support treatment if my doctor believes it could help. But I want my doctor to stop giving me life-support treatment if it is not helping my health condition or symptoms.

In another condition under which I do not wish to be kept alive:
If there is another condition under which I do not wish to have life-support treatment, I describe it below. In this condition, I believe that the costs and burdens of life-support treatment are too much and not worth the benefits to me. Therefore, in this condition, I do not want life-support treatment. (For example, you may write “end-stage condition.” That means that your health has gotten worse. You are not able to take care of yourself in any way, mentally or physically. Life-support treatment will not help you recover. Please leave the space blank if you have no other condition to describe.)
I wish to have warm baths often. I wish my lips and mouth kept moist to stop dryness. I wish to have a cool moist cloth put on my head if I have a fever. I wish to have pictures of my loved ones in my room, near my bed. I wish to have my hand held and to be talked to when possible, even if I don't seem to respond to the voice or touch of others. I wish to have others by my side praying for me when possible. I wish to have the members of my faith community told that I am sick and asked to pray for me and visit me. I wish to be massaged with warm oils as often as I can be. I wish to have my favorite music played when possible until my time of death. I wish to have personal care like shaving, nail clipping, hair brushing and teeth brushing, as long as they do not cause me pain or discomfort. I wish to have religious readings and well-loved poems read aloud when I am near death. I wish to know about options for hospice care to provide medical, emotional and spiritual care for me and my loved ones. I wish to be massaged with warm oils as often as I can be. I wish to have personal care like shaving, nail clipping, hair brushing and teeth brushing, as long as they do not cause me pain or discomfort. I wish to have religious readings and well-loved poems read aloud when I am near death. I wish to know about options for hospice care to provide medical, emotional and spiritual care for me and my loved ones.

Wish 3  My wish for how comfortable I want to be
(Please cross out anything that you don't agree with.)

Wish 4  My wish for how I want people to treat me
(Please cross out anything that you don't agree with.)

Wish 5  My wish for what I want my loved ones to know
(Please cross out anything that you don't agree with.)

If there is to be a memorial service for me, I wish for this service to include the following (list music, songs, readings, or other specific requests that you have):

(please use the space below for any other wishes. For example, you may want to donate any or all parts of your body when you die or urge others to make a memorial contribution to a charity you choose. please attach a separate sheet of paper if you need more space.)
**Signing the Five Wishes Form** (Please sign your Five Wishes form in the presence of the two witnesses.)

I, ____________________, ask that my family, my doctors, and other health care providers, my friends, and all others, follow my wishes as communicated by my Health Care Agent (if I have one and he or she is available), or as otherwise expressed in this form. This form becomes valid when I am unable to make decisions or speak for myself. If any part of this form cannot be legally followed, I ask that all other parts of this form be followed. I also revoke any health care advance directives I have made before.

Signature

Phone

**Witness Statement** (2 witnesses needed):

I, the witness, declare that the person who signed or acknowledged this form (hereafter “person”) is personally known to me, that he/she signed or acknowledged this [Health Care Agent and/or Living Will form(s)] in my presence, and that he/she appears to be of sound mind and under no duress, fraud, or undue influence.

I also declare that I am over 18 years of age and am NOT:

- Financially responsible for the person’s health care,
- An employee of a life or health insurance provider for the person,
- Related to the person by blood, marriage, or adoption, and,
- To the best of my knowledge, a creditor of the person, or entitled to any part of his/her estate under a will or codicil, by operation of law.

(Some states may have fewer rules about who may be a witness. Unless you know your state’s rules, please follow the above.)

Signature of Witness #1

Printed Name of Witness

Address

Phone

Signature of Witness #2

Printed Name of Witness

Address

Phone

**Notarization** (Only required for residents of Missouri, North Carolina, South Carolina and West Virginia)

If you live in Missouri, only your signature should be notarized.

If you live in North Carolina, South Carolina or West Virginia, you should have your signature, and the signatures of your witnesses, notarized.

STATE OF: ________________  COUNTY OF: ________________

On this _____ day of ____________, 20_____, the said __________________, and __________________, known to me (or satisfactorily proven) to be the person named in the foregoing instrument and witnesses, respectively, personally appeared before me, a Notary Public, within and for the State and County aforesaid, and acknowledged that they freely and voluntarily executed the same for the purposes stated therein.

Notary Public

My Commission Expires

**What To Do After You Complete Five Wishes**

- Make sure you sign and witness the form just the way it says in the directions. Then your Five Wishes will be legal and valid.
- Talk about your wishes with your health care agent, family members and others who care about you. Give them copies of your completed Five Wishes.
- Keep the original copy you signed in a special place in your home. Do NOT put it in a safe deposit box. Keep it nearby so that someone can find it when you need it.
- Fill out the wallet card below. Carry it with you. That way people will know where you keep your Five Wishes.

**Residents of Wisconsin must attach the Wisconsin notice statement to Five Wishes.**

More information and the notice statement are available at [agingwithdignity.org](http://agingwithdignity.org) or 888.594.7437.

**Residents of Institutions in California, Connecticut, Delaware, Georgia, New York, North Dakota, South Carolina and Vermont Must Follow Special Witnessing Rules.**

If you live in certain institutions (a nursing home, other licensed long-term care facility, a home for the mentally retarded or developmentally disabled, or a mental health institution) in one of the states listed above, you may have to follow special “witnessing requirements” for your Five Wishes to be valid. For further information, please contact a social worker or patient advocate at your institution.

Five Wishes is meant to help you plan for the future. It is not meant to give you legal advice. It does not try to answer all questions about anything that could come up. Every person is different, and every situation is different. Laws change from time to time. If you have a specific question or problem, talk to a medical or legal professional for advice.

**Five Wishes Wallet Card** (Cut out card, fold, and laminate for safekeeping.)

I have a Five Wishes Advance Directive.

Signature

Please consult this document and/or my health care agent in an emergency. My agent is:

Name

Address

City/State/ZIP

Phone

My primary care physician is:

Name

Address

City/State/ZIP

Phone

My document is located at:

...