STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: South Carolina

REQUIREMENTS FOR ADVANCE DIRECTIVES UNDER STATE PLANS FOR MEDICAL ASSISTANCE

The following is a written description of the law of the State (whether statutory or as recognized by the courts of the State) concerning advance directives. If applicable, State should include definitions of living will, durable power of attorney for health care, durable power of attorney, witness requirements, special State limitations on living will declarations, proxy designation, process information and State forms, and identify whether State law allows for a health care provider or agent of the provider to object to the implementation of advance directives on the basis of conscience.

SEE ATTACHMENT

YOUR RIGHT TO MAKE DECISIONS ABOUT YOUR HEALTH CARE

You Have the Right to Make Health Care Decisions that Affect you

You have the right to make all decisions about the health care you receive. If you do not want certain treatments, you can tell your doctor, either in person or in writing, that you do not want them. If you want to refuse treatment but you do not have someone to name as your agent, you can sign a living will.

Most patients can express their wishes to their doctor, but some who are badly injured, unconscious, or very ill cannot. People need to know your wishes about health care in case you become unable to speak effectively for yourself. You can express your wishes in a health care power of attorney or a living will.

In a living will you can tell your doctor that you do not want to receive certain treatment. In a health care power of attorney you name an agent who will tell the doctor what treatment should or should not be provided.

The decision to sign a health care power of attorney or living will is very personal and very important. This pamphlet answers some frequently asked questions about health care powers of attorney and living wills.

These documents will be followed only if you are unable, due to illness or injury, to make decisions for yourself. While you are pregnant, however, these documents will not cause life support to be withheld.

If you do not have a living will or health care power of attorney that tells what you want done, you do not know what decisions will be made or who will make them. Decisions may be made by certain relatives designated by South Carolina law, by a person appointed by the court, or by the court itself. The best way to make sure your wishes are followed is to state your wishes in a health care power of attorney, or sometimes, a living will. If you want to refuse treatment but you do not have someone to name as your agent, you can sign a living will.

If you have questions about signing a health care power of attorney or living will, you should talk to your doctor; your minister, priest, rabbi, or other religious counselor; or your attorney. Finally, it is very important that you discuss your feelings about life support with your family. A health care power of attorney also should be discussed with the people you intend to name as your agent and alternate agents to make sure that they are willing to serve. It is also important to make sure that your agents know your wishes.

Are there forms for living wills and health care powers of attorney in South Carolina?

Yes. The South Carolina legislature has approved forms for both a living will and a health care power of attorney. The living will form that the

Legislature approved is called a "Declaration of a Desire for a Natural Death." You may be able to get these forms from the person who gave you this brochure. If not, you may call:

Your local Council on Aging	1 (800) 868-9095
South Carolina Commission on Aging	(803) 734-2995
Joint Legislative Committee on Aging	(803) 734-0457

How are a Health Care Power of Attorney and a Living Will different?

- The agent named in a health care power of attorney can make all of the decisions about your health care that need to be made. A living will affects only life support.

- A living will affects life support only in certain circumstances. A living will only tells the doctor what to do if you are permanently unconscious or if you are terminally ill and close to death. A health care power of attorney is not limited to these situations.

  "Permanently unconscious" means that you are in a persistent vegetative state in which your body functions but your mind does not. This is different from a coma, because a person in a coma usually wakes up, but a permanently unconscious person does not.

- A living will can only say what treatment you don't want. In a health care power of attorney you can say what treatment you do want as well as what you do not want.

- With a living will, you must decide what should be done in the future, without knowing exactly what the circumstances will be when the decision is put into effect. With a health care power of attorney, the agent can make decisions when the need arises, and will know what the circumstances are.

- An Ombudsman from the Governor's Office must be a witness if you sign a living will when you are in a hospital or nursing home. An Ombudsman does not have to be a witness if you sign a health care power of attorney in a hospital or nursing home.

I want to be allowed to die a natural death and not be kept alive by medical treatment, heroic measures, or artificial means. How can I make sure this happens?

The best way to be sure you are allowed to die a natural death is to sign a health care power of attorney that states the circumstances in which you would not want treatment. In the South Carolina form, you should specify your wishes in Items 6 and 7.

You may not have a person that you can trust to carry out your desire for a natural death. If not, a living will can ensure that you are allowed to die a natural death. However, it will only do so if you are permanently unconscious or terminally ill and close to death.

Which document should I sign if I want to be treated with all available life-sustaining procedures?

You should sign a Health Care Power Of Attorney, and not a living will. The South Carolina Health Care Power of Attorney form allows you to say either that you do or that you do not want life-sustaining treatment. A living will only allows you to say that you do not want life-sustaining procedures.

What if I have an old health care power of attorney or living will, or signed one in another state?

If you previously signed a living will or health care power of attorney, even in another state, it is probably valid. However, it may be a good idea to sign the most current forms. For example, the current South Carolina living will form covers artificial nutrition and hydration whereas older forms did not.

How is a health care power of attorney different from a durable power of attorney?

A health care power of attorney is a specific type of durable power of attorney that names an agent only to make health care decisions.

A durable power of attorney may or may not allow the agent to make health care decisions. It depends on what the document says. The agent may only be able to make decisions about property and financial matters.

What are the requirements for signing a living will?

You must be eighteen years old to sign a living will. Two persons must witness your signing the living will form. A notary public must also sign the living will. If you sign a living will while you are a patient in a hospital or a resident in a nursing home, a representative from the Governor's Office (the Ombudsman) must witness your signing.

There are certain people who cannot witness your living will. The living will form says who cannot be a witness. You should read the living will form carefully to be sure your witnesses are qualified.

What are the requirements for signing a health care power of attorney?

You must have two witnesses sign the document. The form tells you who cannot be witnesses. (These are the same people who cannot witness a living will.) Unlike a living will, the health care power of attorney may be signed in a hospital or

in a nursing home without having someone from the Ombudsman's Office present. It is not necessary to have a notary sign your health care power of attorney.

Whom should I appoint as my agent? What if my agent cannot serve?

You should appoint a person you trust and who knows how you feel about health care. You also should name at least one alternate, who will make decisions if your agent is unable or unwilling to make these decisions. You should talk to the people you choose as your agent and alternate agents to be sure they are willing to serve. Also, they should know how you feel about health care.

Is there anything I need to know about completing the living will or health care power of attorney form?

Each form contains spaces for you to state your wishes about things like whether you want life support and tube feeding. If you do not put your initials in either blank, tube feeding may be provided, depending upon your condition. Be sure to read the forms carefully and follow the instructions.

Where should I keep my health care power of attorney or living will?

Keep the original in a safe place where your family members can get it. You also should give a copy to as many of the following people as you are comfortable with: your family members, your doctor, your lawyer, your minister or priest, or your agent. Do not put your only copy of these documents in your safe deposit box.

What if I change my mind after I have signed a living will or health care power of attorney?

You may revoke (cancel) your living will or health care power of attorney any time. The forms contain instructions for doing so. You must tell your doctor and anyone else who has a copy that you have changed your mind and you want to revoke your living will or health care power of attorney.

Your patients may ask you for a sample form of the advance directives like the Durable Power of Attorney for Health Care and the Declaration of a Desire for a Natural Death. Attached to this Medicaid Bulletin are copies of the statutory forms. If you decide to provide your patients with forms for advance directives, it is suggested that providers use copies of these specific forms. Doctors and other health care providers recognize these forms and do not have to question the validity of other forms which may or may not comply with state law. There are also certain statutory protections which are provided to health care providers and hospitals by the statute. Use of the statutory form Durable Power Of Attorney for Health Care and Declaration of Desire for Natural Death will insure that these protections are available to the health care provider.

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EFFECTIVE DATE: 1/01/93
RO APPROVAL: 3/22/93
SUPERSEDES: MA 91-19

HEALTH CARE POWER OF ATTORNEY
(South Carolina Statutory Form, Code of Laws Section 62-5-504)

1. DESIGNATION OF HEALTH CARE AGENT

I, _____, 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, treatment, surgical procedures, diagnostic procedures, medication, and the use of 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:_____

_____

_____

_____

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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 DISCREATION 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.

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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 successors to my agent, each to act alone and successively, in 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_____ 20____. My current home address is:_____

_____

Signature:_____

Print Name:_____

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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, 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:_____

_____

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DECLARATION OF A DESIRE FOR A NATURAL DEATH

STATE OF SOUTH CAROLINA

COUNTY OF_____

I,_____Declarant, being at least eighteen 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 _____20_____.

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 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 and 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.

_____ 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.

_____ 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:_____

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:_____

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REVOCATION PROCEDURES

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

(1) BY BEING DEFACED, TORN, OBLITERATED, OR OTHERWISE DESTROYED, TORN, OBLITERATED, OR OTHERWISE DESTROYED IN EXPRESSION OF YOUR INTENT TO EVOKE BY YOU OR BY 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 THIS DECLARATION. AN ORAL REVOCATION COMMUNICATED 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 BY 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 witness to the foregoing Declaration dated the** _____ **day of** _____ **20**____ **at least one of us being first duly sworn, declare to the undersigned authority, on the basis of our best information and belief, that the Declaration was on that date signed by the declarant as and his DECLARATION OF A DESIRE FOR A NATURAL DEATH in our presence and we, at this request and this 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 spouse, lineal ancestor, descendant of the parents or declarant, or spouse of any of them; not directly financially responsible for the declarant's medical care; not entitled to any portion of the declarant's estate upon his decease, whether 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 attendant's 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_____**, the declarant and subscribed and sworn before me by** _____**, the witness this** ___**day of** _____**,20**____**.**

Notary's Signature_____

Notary Public for _____

My Commission Expires_____

SEAL

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