ONTARIO

Power of Attorney for Personal Care and Advance Care Directive

A. NOTES

A1 **“Power of Attorney for Personal Care” = Appoints an Attorney for Personal Care**

A2 **“Attorney for Personal Care” = Substitute Decision-Maker**

A3 **“Advance Care Directive” = A written statement of your wishes regarding future health care**

A4 **To appoint an Attorney for Personal Care and make any decisions that are communicated in your Advance Care Directive, you (the “Grantor”) must:**

- Be **16** years of age or older
- Be mentally capable

A5 **An Attorney for Personal Care must:**

- Be **16** years of age or older
- Agree to be your Attorney for Personal Care
- **NOT** provide paid health care, residential, social, training or support services, unless they are your spouse, partner, or relative

A6 **You must sign your Power of Attorney for Personal Care and Advance Care Directive in the presence of TWO witnesses.**

A7 **If you are not physically able to sign this Power of Attorney for Personal Care and Advance Care Directive yourself, you should seek the assistance of a lawyer who can sign the agreement on your behalf. This must be done in the presence of you and your TWO witnesses.**

A8 **The witnesses must:**

- Be **18** years of age or older
- **NOT** be your spouse, partner, or child (or someone that you treat as your child)
- **NOT** be the same person you chose as your Attorney for Personal Care, nor their spouse or partner
- **NOT** be under guardianship or have a guardian of the person (Meaning they do not have a Substitute Decision-Maker appointed by the courts to be responsible for their personal care because they were found mentally incapable)
- Sign this Power of Attorney for Personal Care and Advance Care Directive in your presence

A9 **Any changes made to the wishes in your Advance Care Directive require you to revoke the existing Power of Attorney for Personal Care – in writing, signed and dated with TWO witnesses – and create a new one.**

A10 **"Personal Care" (Section C) includes health care, nutrition, shelter, clothing, hygiene, and safety.**

A11 **Amendments to the *Substitute Decisions Act, 1992* allow for remote witnessing of Powers of Attorney using videoconferencing technology. There are important regulations in place for remote witnessing in Ontario, and failure to follow the regulations may invalidate your Power of Attorney for Personal Care and Advance Care Directive. You may consider seeking legal advice if you wish to proceed with this option. Learn more about the regulations at *www.ontario.ca/laws/statute/S21004#sched8s1s1*.**

A12 **If you feel you have special circumstances that the Dying With Dignity Canada forms do not address, we suggest that you consult with a lawyer.**

B. PERSONAL INFORMATION

B1 **I, ____ revoke (cancel) any previous Power of**
(NAME)
Attorney for Personal Care and/or Advance Care Directives made by me.

B2 **Legal first name:** ____

B3 **Legal last name:** ____

B4 **Preferred name** (If different from legal name)**:** ____________________________

B5 **Pronouns** (Optional)**:** ____

B6 **Date of birth:** ____

B7 **Address:** ____

B8 **Phone:** ____

B9 **Email:** ____

C. APPOINTING AN ATTORNEY FOR PERSONAL CARE

(RECOMMENDED, BUT OPTIONAL)

C1 I appoint (choose) the following people to be my Attorney for Personal Care under the ***Substitute Decisions Act, 1992***, and to make personal care decisions (including health care decisions) for me if I do not have the capacity to do so for myself:

ATTORNEY FOR PERSONAL CARE #1

C2 **First name:** ______________________________

C3 **Last name:** ______________________________

C4 **Relationship to me:** ______________________________

C5 **Address:** ______________________________

C6 **Phone:** ______________________________

C7 **Email:** ______________________________

ATTORNEY FOR PERSONAL CARE #2 (OPTIONAL)

C8 **First name:** ______________________________

C9 **Last name:** ______________________________

C10 **Relationship to me:** ______________________________

C11 **Address:** ______________________________

C12 **Phone:** ______________________________

C13 **Email:** ______________________________

NOTE: Only complete the next section if you choose more than one Attorney for Personal Care.

C14 **I want my Attorneys for Personal Care to act:**

__________ **Jointly** (They need to make decisions together)
(INITIAL)

__________ **Consecutively** (The second Attorney for Personal Care will only make decisions if the first is unavailable)
(INITIAL)

D. HEALTH CARE DIRECTIONS
(PLEASE READ EACH LINE CAREFULLY)

D1 ____________ (INITIAL) **If I am sedated and unable to communicate, I would like the sedation lifted so that I can decide for myself to accept or refuse a particular therapy.**

D2 **Initial only ONE of the following two options. If you choose Option 1, skip to page 6.**

____________ (INITIAL) **Option 1:** I direct that my life be prolonged, and that I be provided **all life-sustaining treatments** that apply to my medical condition.

OR

____________ (INITIAL) **Option 2:** I direct that I **only receive care that will keep me comfortable and pain free**, and that my life is not prolonged (initial the options that apply below).

____________ (INITIAL) **In any circumstance**

____________ (INITIAL) **If I experience a serious life-threatening illness that cannot be reversed**

____________ (INITIAL) **If I experience permanent, chronic, and debilitating suffering**

____________ (INITIAL) **If I have advanced dementia** (please describe what this would look like for you)

____

____

____

____

____________ (INITIAL) **OTHER** (please explain)

____

____

____

____

____

D3 **I specifically REFUSE (say no to) the following (initial where you refuse):**

______ (INITIAL) **Electrical, mechanical, or other artificial stimulation of my heart** (such as CPR)

______ (INITIAL) **Respirator or ventilator**

______ (INITIAL) **Artificial feeding such as through a stomach tube, or an intravenous line** (IV)

______ (INITIAL) **Being spoon fed, if I am no longer able to feed myself**

______ (INITIAL) **Artificial hydration** (fluids) **by intravenous line**

______ (INITIAL) **Antibiotics**

______ (INITIAL) **Transfer to an intensive care unit or similar facility**

D4 **I would prefer to be cared for (select one):**

______ (INITIAL) **At home**

______ (INITIAL) **In hospice**

______ (INITIAL) **In hospital**

D5 ______ (INITIAL) **If my health care provider will not follow the directions provided in this Power of Attorney for Personal Care and Advance Care Directive, I ask that my care be transferred to another health care provider who will respect my legal rights.**

D6 ______ (INITIAL) **If I should be a patient in a health care facility which will not follow the directions provided in this Power of Attorney for Personal Care and Advance Care Directive, I ask that I be transferred to another facility.**

ADDITIONAL DIRECTIONS:

____

____

____

____

____

____

MEDICAL ASSISTANCE IN DYING AND ADVANCE REQUESTS

D7 I understand that the current laws of Canada do not allow me to request medical assistance in dying (MAID) in advance. I understand that my Attorney for Personal Care cannot consent to MAID on my behalf. If the law changes, here are my directions regarding MAID. I wish for my Attorney for Personal Care and health care providers to act on my directions below.

E. SIGNATURES

MY SIGNATURE (THE "GRANTOR")

E1 **First name:** ______________________________

E2 **Last name:** ______________________________

E3 **Signature:** ______________________________

E4 **Date:** ______________________________

OR

SIGNATURE ON MY BEHALF (BY A LAWYER AND IN THE PRESENCE OF THE WITNESSES BELOW)

E5 **First name:** ______________________________

E6 **Last name:** ______________________________

E7 **Relationship to the "Grantor":** ______________________________

E8 **Signature:** ______________________________

E9 **Address:** ______________________________

E10 **Phone:** ______________________________

E11 **Email:** ______________________________

E12 **Date:** ______________________________

ATTORNEY FOR PERSONAL CARE #1

I agree to be the Attorney for Personal Care for the person who created this Power of Attorney for Personal Care and Advance Care Directive. I understand the responsibilities that come with this role under the ***Substitute Decisions Act, 1992***.

E13 **First name:** ______________________________

E14 **Last name:** ______________________________

E15 **Signature:** ______________________________

E16 **Date:** ______________________________

ATTORNEY FOR PERSONAL CARE #2 (OPTIONAL)

I agree to be the Attorney for Personal Care for the person who created this Power of Attorney for Personal Care and Advance Care Directive. I understand the responsibilities that come with this role under the ***Substitute Decisions Act, 1992***.

E17 **First name:** ______________________________

E18 **Last name:** ______________________________

E19 **Signature:** ______________________________

E20 **Date:** ______________________________

WITNESS #1

I certify that I witnessed the signing of this Power of Attorney for Personal Care and Advance Care Directive. I declare that I am not the spouse, partner, or child of the Grantor, the Attorney for Personal Care, nor the spouse of the Attorney for Personal Care.

E21 **First name:** ______________________________

E22 **Last name:** ______________________________

E23 **Signature:** ______________________________

E24 **Address:** ______________________________

E25 **Phone:** ______________________________

E26 **Email:** ______________________________

E27 **Date:** ______________________________

WITNESS #2

I certify that I witnessed the signing of this Power of Attorney for Personal Care and Advance Care Directive. I declare that I am not the spouse, partner, or child of the Grantor, the Attorney for Personal Care, nor the spouse of the Attorney for Personal Care.

E28 **First name:** ______________________________

E29 **Last name:** ______________________________

E30 **Signature:** ______________________________

E31 **Address:** ______________________________

E32 **Phone:** ______________________________

E33 **Email:** ______________________________

E34 **Date:** ______________________________

F. DISTRIBUTION

I have shared this Power of Attorney for Personal Care and Advance Care Directive with the following people. This is a reminder to me to keep these people informed of any changes. I am aware that outdated copies of my Power of Attorney for Personal Care and Advance Care Directive may create confusion.

F1 **Name:** ______________________________

F2 **Name:** ______________________________

F3 **Name:** ______________________________

F4 **Name:** ______________________________

F5 **Name:** ______________________________

F6 **Name:** ______________________________

G. REVIEW

G1 **You should review your Power of Attorney for Personal Care and Advance Care Directive:**

- At least every three years
- When your health situation changes
- When your Attorney(s) for Personal Care change(s)

__________ **Date of last review:** ______________________________
(INITIAL)

__________ **Date of last review:** ______________________________
(INITIAL)

__________ **Date of last review:** ______________________________
(INITIAL)

__________ **Date of last review:** ______________________________
(INITIAL)

H. NEXT STEPS

H1 **After completing your Power of Attorney for Personal Care and Advance Care Directive, re-read it to ensure your preferences are clear.** Then, review it with your Attorney(s) for Personal Care. If a health care provider does not know you, they may need the Power of Attorney for Personal Care and Advance Care Directive to understand your wishes for care.

H2 Keep a copy of your Power of Attorney for Personal Care and Advance Care Directive in an easy-to-find place in an emergency. Leave a note in a prominent place, such as on your fridge with a magnet. This will let emergency personnel know where to look and who to call in a crisis. You can also print a wallet card and fridge note from the Dying With Dignity Canada website at ***dyingwithdignity.ca/advance-care-planning***.

H3 **Do not store your Power of Attorney for Personal Care and Advance Care Directive in any locked box, drawer or safe.**

H4 Discuss your completed Power of Attorney for Personal Care and Advance Care Directive with your health care provider. Give them a copy to put in your medical file. However, do not assume that doing so will result in your Power of Attorney for Personal Care and Advance Care Directive being available in an emergency. You or your Attorney(s) for Personal Care must ensure health care providers are provided with a copy of your Power of Attorney for Personal Care and Advance Care Directive. That is why you should appoint an Attorney for Personal Care.

H5 If there are no changes to be made, then you can leave the Power of Attorney for Personal Care and Advance Care Directive as is. If you wish to change your Attorney(s) or your directions, you must create a new Power of Attorney for Personal Care and Advance Care Directive.

H6 Your medical condition may change. Or you may reconsider some of the directions you wrote down. Download a new Power of Attorney for Personal Care and Advance Care Directive at ***dyingwithdignity.ca/advance-care-planning*** or call Dying With Dignity Canada (DWDC) toll free at **1-800-495-6156** to receive a copy in the mail. Tell everyone involved in your care that you have updated your Power of Attorney for Personal Care and Advance Care Directive.