

# FIVE WISHES<sup>®</sup>

## 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

Althea Halchuck

Print Your Name

04/23/1951

Birthdate

# FIVE WISHES<sup>®</sup>

*There are many things in life that are out of our hands. This Five Wishes document gives you a way to control something very important — how you are treated if you get seriously ill. It is an easy-to-complete form that lets you say exactly what you want. Once it is filled out and properly signed, it is valid under the laws of most states.*

## What Is Five Wishes?

Five Wishes is the first living will (also called an advance directive) 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 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 Can Help You And Your Family

- It lets you talk with your family, friends and doctor 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.

## 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 29 languages.

## Who Should Use Five Wishes

Five Wishes is for anyone 18 or older — married, single, parents, adult children, and friends. More than 35 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.

People who use Five Wishes find that it helps them express all that they want and provides a helpful guide to family members, friends, care givers and doctors. Most doctors and health care professionals know they need to listen to your wishes no matter how you express them.

## Five Wishes In My State

Five Wishes was created with help from the American Bar Association's Commission on Law and Aging. **If you live in the District of Columbia or most states you can use Five Wishes and have the peace of mind to know that it substantially meets your state's requirements under the law.** If you live in one of six states (**Indiana, Kansas, New Hampshire, Ohio, Oregon, or Texas**) you can still use Five Wishes but may need to take an extra step. Find out more at [FiveWishes.org/states](https://www.fivewishes.org/states).

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

## How Do I Start Using Five Wishes?



Let us help with some tips on how to start using Five Wishes and how to talk about it. Activate your Five Wishes to get these benefits at [FiveWishes.org/activate](https://www.fivewishes.org/activate).

# WISH 1

## The Person I Want To Make Health Care Decisions For Me When I Can't Make Them For Myself.

*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). This person will make my health care choices if both of these things happen:*

- *My attending or treating doctor finds I am no longer able to make health care choices, AND*
- *Another health care professional agrees that this is true.*

*If my state has a different way of finding that I am not able to make health care choices, then my state's way should be followed.*

### The Person I Choose As My Health Care Agent Is:

First Choice Name

Phone

Address

City/State/Zip

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:

Second Choice Name

Third Choice Name

Address

Address

City/State/Zip

City/State/Zip

Phone

Phone

### 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 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.

*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.

---

---

---

---

---

---

---

## **If I Change My Mind About Having A Health Care Agent, I Will**

- Destroy all copies of this part of the Five Wishes form. *OR*
- Tell someone, such as my doctor or family, that I want to cancel or change my Health Care Agent. *OR*
- 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.

# WISH 2

## My Wish For The Kind Of Medical Treatment I Want Or Don't Want.

*I believe that my life is precious and I deserve to be treated with dignity. When the time comes that I am very sick and am not able to speak for myself, I want the following wishes, and any other directions I have given to my Health Care Agent, to be respected and followed.*

### What You Should Keep In Mind As My Caregiver

- I do not want to be in pain. I want to be comfortable. Wish 3 says what can be done to make me comfortable.
- I want to be offered food and fluids by mouth if it is safe for me to eat and drink. I want to be 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 if you choose not to be

resuscitated. 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 doctor 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 doctors 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. If it has been started, I want it stopped.
- ☐ 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. If it has been started, I want it stopped.
- ☐ 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. If it has been started, I want it stopped.
- ☐ 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.)

---

---

---

---

---

---

---



*The next three wishes deal with my personal, spiritual, and emotional wishes. They are important to me. I want to be treated with dignity near the end of my life, so I would like people to do the things written in Wishes 3, 4, and 5 when they can be done. I understand that my family, my doctors and other health care providers, my friends, and others may not be able to do these things or are not required by law to do these things. I do not expect the following wishes to place new or added legal duties on my doctors or other health care providers. I also do not expect these wishes to excuse my doctor or other health care providers from giving me the proper care asked for by law.*

## WISH 3

### **My Wish For How Comfortable I Want To Be.**

(Please cross out anything that you don't agree with.)

- I do not want to be in pain. I want my doctor to give me enough medicine to relieve my pain, even if that means I will be drowsy or sleep more than I would otherwise.
- If I show signs of depression, nausea, shortness of breath, or hallucinations, I want my care givers to do whatever they can to help me.
- I wish to have a cool moist cloth put on my head if I have a fever.
- I want my lips and mouth kept moist to stop dryness.
- I wish to have warm baths often. I wish to be kept fresh and clean at all times.
- I wish to be massaged with warm oils as often as I can be.
- If I am not able to control my bowel or bladder functions, I wish for my clothes and bed linens to be kept clean, and for them to be changed as soon as they can be if they have been soiled.
- 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 or spiritual 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 4

### **My Wish For How I Want People To Treat Me.**

(Please cross out anything that you don't agree with.)

- I wish to have people with me when possible. I want someone to be with me when it seems that death may come at any time.
- 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 visited by a chaplain or clergy.
- I wish to be cared for with kindness and cheerfulness, and not sadness.
- I wish to have pictures of my loved ones in my room, near my bed.
- I wish to have my favorite music played when possible until my time of death.
- I want to die in my home, if that can be done.
- I wish to be called by my name.  
Please call me: \_\_\_\_\_



# WISH 5

## My Wish For What I Want My Loved Ones To Know.

(Please cross out anything that you don't agree with.)

- I wish to have my family and friends know that I love them.
- I wish to be forgiven for the times I have hurt my family, friends, and others.
- I wish to have my family, friends, and others know that I forgive them for when they may have hurt me in my life.
- I wish for my family and friends to know that I do not fear death. I think it is not the end, but a new beginning for me.
- I wish for all of my family members to make peace with each other before my death, if they can.
- I wish for my family and friends to think about what I was like before I became seriously ill. I want them to remember me in this way after my death.
- I wish for my family and friends and caregivers to respect my wishes even if they don't agree with them.
- I wish for my family and friends to look at my dying as a time of personal growth for everyone, including me. This will help me live a meaningful life in my final days.
- I wish for my family and friends to get counseling if they have trouble with my death. I want memories of my life to give them joy and not sorrow.
- After my death, I would like my body to be (circle one): buried *OR* cremated.
- My body or remains should be put in the following location: \_\_\_\_\_
- The following person knows my funeral wishes: \_\_\_\_\_

If anyone asks how I want to be remembered, please say the following about me:

---

---

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):

---

---

It is important for my health care providers to know what matters most to me. I wish for them to know the following:

---

---

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. You may also wish to designate a charity to receive memorial contributions. Or you may want to give instructions on what should be done with your social media or other electronic records. Please attach a separate sheet of paper if you need more space.

---

---

# Signing My Five Wishes

Please make sure you sign your Five Wishes in the presence of two witnesses.

I, Althea Halchuck, 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.

XXX SAMPLE ONLY NOT FOR USE XXXXXX

Signature

Address

Phone

Date

Address (cont.)

## 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 (19 in Alabama) and am NOT:

- The individual appointed as (agent/proxy/surrogate/patient advocate/representative) by this document or his/her successor,
- The person’s health care provider, including owner or operator of a health, long-term care, or other residential or community care facility serving the person,
- An employee of the person’s health care provider,
- 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,
- A beneficiary of any legal instrument, account, or benefit plan of the person, 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

Signature of Witness #2

Printed Name of Witness

Printed Name of Witness

Address

Address

Phone

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.

My Commission Expires: \_\_\_\_\_

\_\_\_\_\_  
Notary Public

## 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.
- Talk to your doctor during your next office visit. Give your doctor a copy of your Five Wishes. Make sure it is put in your medical record. Be sure your doctor understands your wishes and is willing to follow them. Ask him or her to tell other doctors who treat you to honor them.
- If you are admitted to a hospital or nursing home, take a copy of your Five Wishes with you. Ask that it be put in your medical record.
- I have given the following people copies of my completed Five Wishes:  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_



**Activate your Five Wishes benefits at [FiveWishes.org/activate](https://www.fivewishes.org/activate) to receive additional resources and updates.**

*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.*

### **Residents of MICHIGAN should complete the “Acceptance by Health Care Agent (Patient Advocate)” form**

It can be downloaded at [fivewishes.org/michigan](https://www.fivewishes.org/michigan)

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

More information and the notice statement are available at [fivewishes.org/wisconsin](https://www.fivewishes.org/wisconsin) or (888) 594-7437.

### **Residents of Institutions In CALIFORNIA, CONNECTICUT, DELAWARE, NEVADA, NEW YORK, 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 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 Wallet Card

Important Notice to Medical Personnel:  
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:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Cut Out Card, Fold and Laminate for Safekeeping

## Here's What People Are Saying About Five Wishes

"It will be a year since my mother passed on. We knew what she wanted because she had the Five Wishes living will. When it came down to the end, my brother and I had no questions on what we needed to do. We had peace of mind."

*Cheryl K.  
Longwood, Florida*

"I must say I love your Five Wishes. It's clear, easy to understand, and doesn't dwell on the concrete issues of medical care, but on the issues of real importance—human care. I used it for myself and my husband."

*Susan W.  
Flagstaff, Arizona*

"I don't want my children to have to make the decisions I am having to make for my mother. I never knew that there were so many medical options to be considered. Thank you for such a sensitive and caring form. I can simply fill it out and have it on file for my children."

*Diana W.  
Hanover, Illinois*



**Activate your Five Wishes benefits at [FiveWishes.org/activate](https://www.fivewishes.org/activate) to receive additional resources and updates.**

### To order or for any questions about Five Wishes:

(888) 5-WISHES or (888) 594-7437  
[www.FiveWishes.org](https://www.FiveWishes.org)

Five Wishes is a program of:



P.O. Box 1661  
Tallahassee, Florida 32302

Five Wishes is a trademark of Aging with Dignity. All rights reserved. The contents of this publication are copyrighted materials of Aging with Dignity. No part of this publication may be reproduced, transmitted, or sold in any form or by any means, electronic or mechanical, including photocopy and recording, without written permission from Aging with Dignity. While the contents of this document are copyrighted, you are permitted to photocopy them to provide a copy of your completed Five Wishes to your physician, care provider, Health Care Agent, family members, or other loved ones. Your completed Five Wishes may be stored and distributed electronically. All other reproductions or uses of Five Wishes require permission from Aging with Dignity. Aging with Dignity wishes to thank Oregon Health Decisions for contributing to the drafting of wish number two, and Kate Callahan, Charles Sabatino, and Tere Saenz for their help.

(12/19) © 2019 Aging with Dignity, PO Box 1661, Tallahassee, Florida 32302 • [www.agingwithdignity.org](https://www.agingwithdignity.org) • (888) 594-7437

Five Wishes is a trademark of Aging with Dignity. All rights reserved. The contents of this publication are copyrighted materials of Aging with Dignity. This copy of Five Wishes was created for the sole use of Althea Halchuck whose date of birth is 04/23/1951. No part of this publication may be modified for use by anyone other than the aforementioned individual. Copyright 2020 Aging with Dignity, Inc.