

Health Care Advance Directive

FORM AND INSTRUCTIONS

CAUTION: This Health Care Advance Directive is a general form provided for your convenience. While it meets the legal requirements of most states, it may or may not fit the requirements of your particular state. Many states have special forms or special procedures for creating Health Care Advance Directives. Even if your state's law does not clearly recognize this document, it may still provide an effective statement of your wishes if you cannot speak for yourself.

Section 1- HEALTH CARE AGENT

Print your full name here as the "principal" or creator of the health care advance directive.

Print the full name, address and telephone number of the person (age 18 or older) you appoint as your health care agent. Appoint only a person with whom you have talked and whom you trust to understand and carry out your values and wishes.

Many states limit the persons who can serve as your agent. If you want to meet all existing state restrictions do not name any of the following as your agent, since some states will not let them act in that role:

- your health care providers, including physicians;
- staff of health care facilities or nursing care facilities providing your care;
- guardians of your finances (also called conservators);
- employees of government agencies financially responsible for your care;
- any person serving as agent for 10 or more persons.

Section 2 - ALTERNATE AGENTS

It is a good idea to name alternate agents in case your first agent is not available. Of course, only appoint alternates if you fully trust them to act faithfully as your agent and you have talked to them about serving as your agent. Print the appropriate information in this paragraph. You can name as many alternate agents as you wish, but place them in the order you wish them to serve.

Section 3 - EFFECTIVE DATE AND DURABILITY

This sample document is effective if and when you cannot make health care decisions. Your agent and your doctor determine if you are in this condition. Some state laws include specific procedures for determining your decision-making ability. If you wish, you can include other effective dates or other criteria for determining that you cannot make health care decisions (such as requiring two physicians to evaluate your decision-making ability). You also can state that the power will end at some later date or event before death.

In any case, you have the right to revoke or take away the agent's authority at any time. To revoke, notify your agent or health care provider orally or in writing. If you revoke, it is best to notify in writing both your agent and physician and anyone else who has a copy of the directive. Also destroy the health care advance directive document itself.

Health Care Advance Directive Part I

Appointment of Health Care Agent

1. HEALTH CARE AGENT

I, _____ hereby appoint:

PRINCIPLE

_____ *Agent's Name*

_____ *Address*

_____ Home Phone# _____ Work Phone#

as my agent to make health and personal care decisions for me as authorized in this document.

2. ALTERNATE AGENTS

IF

- I revoke my Agent's authority; or
- my Agent becomes unwilling or unavailable to act; or
- if my agent is my spouse and I become legally separated or divorced,

I name the following (each to act alone and successively, in the order named) as alternates to my Agent:

A. First Alternate Agent

Name _____

Address _____

Telephone _____

B. Second Alternate Agent

Name _____

Address _____

Telephone _____

3. EFFECTIVE DATE AND DURABILITY

By this document I intend to create a health care advance directive. It is effective upon, and only during, any period in which I cannot make or communicate a choice regarding a particular health care decision. My agent, attending physician and any other necessary experts should determine that I am unable to make choices about health care.

Section 4 - AGENT'S POWERS

This grant of power is intended to be as broad as possible. Unless you set limits, your agent will have authority to make any decision you could make to obtain or stop any type of health care.

Even under this broad grant of authority, your agent still must follow your wishes and directions, communicated by you in any manner now or in the future. To specifically limit or direct your agent's power, you must complete Section 6 in Part II of the advance directive.

4. AGENT'S POWERS

I give my Agent full authority to make health care decisions for me. My Agent shall follow my wishes as known to my Agent either through this document or through other means. When my agent interprets my wishes, I intend my Agent's authority to be as broad as possible, except for any limitations I state in this form. In making any decision, my Agent shall try 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, then my Agent shall make a choice for me based upon what my Agent believes to be in my best interests. Unless specifically limited by Section 6, below, my Agent is authorized as follows:

- A. To consent, refuse, or withdraw consent to any and all types of health care. Health care means any care, treatment, service or procedure to maintain, diagnose or otherwise affect an individual's physical or mental condition. It includes, but is not limited to, artificial respiration, nutritional support and hydration, medication and cardiopulmonary resuscitation;
- B. To have access to medical records and information to the same extent that I am entitled, including the right to disclose the contents to others as appropriate for my health care;
- C. To authorize my admission to or discharge (even against medical advice) from any hospital, nursing home, residential care, assisted living or similar facility or service;
- D. To contract on my behalf for any health care related service or facility on my behalf, without my Agent incurring personal financial liability for such contracts;
- E. To hire and fire medical, social service, and other support personnel responsible for my care;
- F. 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;
- G. To make anatomical gifts of part or all of my body for medical purposes, authorize an autopsy, and direct the disposition of my remains, to the extent permitted by law;
- H. To take any other action necessary to do what I authorize here, including (but not limited to) granting any waiver or release from liability required by any hospital, physician, 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 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.

Section 5 - MY INSTRUCTIONS ABOUT END-OF-LIFE TREATMENT

The subject of end-of-life treatment is particularly important to many people. In this paragraph, you can give general or specific instructions on the subject. The different paragraphs are options choose only one, or write your desires or instructions in your own words (in the last option). If you are satisfied with your agent's knowledge of your values and wishes and you do not want to include instructions in the form, initial the first option and do not give instructions in the form.

Any instructions you give here will guide your agent. If you do not appoint an agent, they will guide any health care providers or surrogate decision-makers who must make a decision for you if you cannot do so yourself. The instruction choices in the form describe different treatment goals you may prefer, depending on your condition.

Directive In Your Own Words. If you would like to state your wishes about end-of-life treatment in your own words instead of choosing one of the options provided, you can do so in this section. Since people sometimes have different opinions on whether nutrition and hydration should be refused or stopped under certain circumstances, be

sure to address this issue clearly in your directive. Nutrition and hydration means food and fluids given through a nasogastric tube or tube into your stomach, intestines, or veins, and does not include non-intrusive methods such as spoon feeding or moistening of lips and mouth.

Some states allow the stopping of nutrition and hydration only if you expressly authorize it. If you are creating your own directive, and you do not want nutrition and hydration, state so clearly.

Health Care Advance Directive

Part II

Instructions About Health Care

5. MY INSTRUCTIONS ABOUT END-OF-LIFE TREATMENT

(Initial only ONE of the following statements)

_____ NO SPECIFIC INSTRUCTIONS. My agent knows my values and wishes, so I do not wish to include any specific instructions here.

_____ DIRECTIVE TO WITHHOLD OR WITHDRAW TREATMENT. Although I greatly value life, I also believe that at some point, life has such diminished value that medical treatment should be stopped, and I should be allowed to die. Therefore, I do not want to receive treatment, including nutrition and hydration, when the treatment will not give me a meaningful quality of life. I do not want my life prolonged...

... if the treatment will leave me in a condition of permanent unconsciousness, such as with an irreversible coma or a persistent vegetative state.

... if the treatment will leave me with no more than some consciousness and in an irreversible condition of complete, or nearly complete, loss of ability to think or communicate with others.

... if the treatment will leave me with no more than some ability to think or communicate with others, and the likely risks and burdens of treatment outweigh the expected benefits. Risks, burdens and benefits include consideration of length of life, quality of life, financial costs, and my personal dignity and privacy.

_____ DIRECTIVE TO RECEIVE TREATMENT. I want my life to be prolonged as long as possible, no matter what my quality of life.

_____ DIRECTIVE ABOUT END-OF-LIFE TREATMENT IN MY OWN WORDS:

SECTION 6 -ANY OTHER HEALTH CARE INSTRUCTIONS OR LIMITATIONS OR MODIFICATIONS OF MY AGENT’S POWERS

In this section, you can provide instructions about other health care issues that are not end-of-life treatment or nutrition and hydration. For example, you might want to include your wishes about issues like non-emergency surgery, elective medical treatments or admission to a nursing home. Again, be careful in these instructions not to place limitations on your agent that you do not intend. For example, while you may not want to be admitted to a nursing home, placing such a restriction may make things impossible for your agent if other options are not available.

You also may limit your agent's powers in any way you wish. For example, you can instruct your agent to refuse any specific types of treatment that are against your religious beliefs or unacceptable to you for any other reasons. These might include blood transfusions, electro-convulsive therapy, sterilization, abortion, amputation, psychosurgery, or admission to a mental institution, etc. Some states limit your agent’s authority to consent to or refuse some of these procedures, regardless of your health care advance directive.

Be very careful about stating limitations, because the specific circumstances surrounding future health care decisions are impossible to predict. If you do not want any limitations, simply write in “No limitations.”

SECTION 7 - PROTECTION OF THIRD PARTIES WHO RELY ON MY AGENT

In most states, health care providers cannot be forced to follow the directions of your agent if they object. However most states also require providers to help transfer you to another provider who is willing to honor your instructions. To encourage compliance with the health care advance directive, this paragraph states that providers who rely in good faith on the agent’s statements and decisions will not be held civilly liable for their actions.

SECTION 8 - DONATION OF ORGANS AT DEATH

In this section you can state your intention to donate bodily organs and tissues at death. If you do not wish to be an organ donor, initial the first option. The second option is a donation of any or all organs or parts. The third option allows you to donate only those organs or tissues you specify. Consider mentioning the heart, liver, lung, kidney, pancreas, intestine, cornea, bone, skin, heart valves, tendons, ligaments, and saphenous vein in the leg. Finally, you may limit the use of your organs by crossing out any of the four purposes listed that you do not want (transplant, therapy, research or education). If you do not cross out any of these options, your organs may be used for any of these purposes.

6. ANY OTHER HEALTH CARE INSTRUCTIONS OR LIMITATIONS OR MODIFICATIONS OF MY AGENTS POWERS

7. PROTECTION OF THIRD PARTIES WHO RELY ON MY AGENT

No person who relies in good faith upon any representations by my Agent or Alternate Agent(s) shall be liable to me, my estate, my heirs or assigns, for recognizing the Agent's authority.

Upon my death: (Initial one)

_____ I do not wish to donate any organs or tissue, OR

_____ I give any needed organs, tissues, or parts, OR

_____ I give only the following organs, tissues, or parts:

(please specify)

My gift (if any) is for the following purposes: (Cross out any of the following you do not want)

- Transplant

- Research

- Therapy

- Education

SECTION 9 - NOMINATION OF GUARDIAN

Appointing a health care agent helps to avoid a court-appointed guardian for health care decision-making. However, if a court becomes involved for any reason, this paragraph expressly names your agent to serve as guardian. A court does not have to follow your nomination, but normally it will honor your wishes unless there is good reason to override your choice.

SECTION 10 - ADMINISTRATIVE PROVISIONS

These items address miscellaneous matters that could affect the implementation of your health care advance directive.

SIGNING THE DOCUMENT

Required state procedures for signing this kind of document vary. Some require only a signature, while others have very detailed witnessing requirements. Some states simply require notarization.

The procedure in this booklet is likely to be far more complex than your state law requires because it combines the formal requirements from virtually every state. Follow it if you do not know your state's requirements and you want to meet the signature requirements of virtually every state.

First, sign and date the document in the presence of two witnesses and a notary.

9. NOMINATION OF GUARDIAN

If a guardian of my person should for any reason need to be appointed, I nominate my Agent (or his or her alternate then authorized to act), named above.

10. ADMINISTRATIVE PROVISIONS

(All apply)

- I revoke any prior health care advance directive.
- This health care advance directive is intended to be valid in any jurisdiction in which it is presented.
- A copy of this advance directive is intended to have the same effect as the original.

SIGNING THE 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 Advance Directive on this

_____ day of _____, 20____.

My Signature

My Name

My current home address is

Your witnesses should know your identity personally and be able to declare that you appear to be of sound mind and under no duress or undue influence.

In order to meet the different witnessing requirements of most states, do not have the following people witness your signature:

- Anyone you have chosen to make health care decisions on your behalf (agent or alternate agents).
- Your treating physician, health care provider, health facility operator, or an employee of any of these.
- Insurers or employees of your life/health insurance provider.
- Anyone financially responsible for your health care costs.
- Anyone related to you by blood, marriage, or adoption.
- Anyone entitled to any part of your estate under an existing will or by operation of law, or anyone who will benefit financially from your death. Your creditors should not serve as witnesses.

If you are in a nursing home or other institution, a few states have additional witnessing requirements. This form does not include witnessing language for this situation. Contact a patient advocate or an ombudsman to find out about the state's requirements in these cases.

Second, have your signature notarized. Some states permit notarization as an alternative to witnessing. Doing both witnessing and notarization is more than most states require, but doing both will meet the execution requirements of most states.

This form includes a typical notary statement, but it is wise to check state law in case it requires a special form of notary acknowledgment.

WITNESS STATEMENT

I declare that the person who signed or acknowledged this document is personally known to me, that he/she signed or acknowledged this health care advance directive in my presence, and that he/she appears to be of sound mind and under no duress, fraud, or undue influence.

I am not:

- the person appointed as agent by this document,
- the principal's health care provider,
- an employee of the principal's health care provider,
- financially responsible for the principal's health care,
- related to the principal by blood, marriage, or adoption, and,
- to the best of my knowledge, a creditor of the principal/or entitled to any part of his/her estate under a will now existing or by operation of law.

Witness # 1:

Signature _____ date _____

Print Name _____

Telephone _____

Residence Address _____

Witness #2:

Signature _____ date _____

Print Name _____

Telephone _____

Residence Address _____

NOTARIZATION

STATE OF _____

COUNTY OF _____

On this _____ day of _____, 20_____.

the said _____, known to me (or satisfactorily proven) to be the person named in the foregoing instrument, personally appeared before me, a Notary Public, within and for the State and County aforesaid, and acknowledged that he or she freely and voluntarily executed thesame for the purposes stated therein.

My Commission Expires:

NOTARY PUBLIC