

ADVANCE HEALTH-CARE DIRECTIVE OF XXX

ABOUT THIS FORM

This form is a legal document that lets you name another individual or individuals as your “agent(s)” to make health-care decisions for you if you become incapable of making your own decisions (**Part 1**). It also allows you to communicate your wishes -- ahead of time -- regarding your care near the end of life (**Part 2**). If desired, you may also make choices about being an organ donor (**Part 3**).

IMPORTANT: Your agent will not be asked to make any decisions as long as you are capable and can communicate for yourself. You always have the right to give instructions about your own health care if you are able. However, if you do not write down your wishes about your health care in advance, and if you later become unable to understand, make, or communicate those wishes, they may not be honored because they may remain unknown to others.

USING THIS FORM

Part 1 of this form is a power of attorney for health care. You can name one person as your agent for health-care decisions and several alternates, if the primary person you designate is unable to serve or is not available.

Part 2 of this form provides you with the ability to give specific instructions regarding whether or not you wish to receive life-sustaining medical measures if you are ever declared “terminally ill” or “permanently unconscious” or to have a “serious illness or frailty.” There is also additional space in Part 2 for you to write out any additional instructions regarding your medical care.

Part 3 of this form lets you express an intention to donate your body, organs and/or tissues following your death, if you so choose.

HOW TO SIGN THIS FORM CORRECTLY SO THAT IT IS VALID

After you have finished filling this form out, sign and date it in front of two (2) qualified witnesses. It does not need to be notarized to be effective. You will find the signature page following Part 3. Your witnesses will also have to sign this form on the last page, following your signature.

ABOUT THE WITNESSES:

- They cannot be related to you in any way (blood, marriage, or adoption).
- They cannot be a beneficiary of your estate.
- They cannot have a claim (actual or potential) against your estate.
- They cannot have direct financial responsibility for your medical care.
- If you are a resident in a long-term-care facility when you are signing, the witnesses cannot be owners, operators, or employees of the facility, and one of the witnesses must be a person designated by the Delaware Division of Services for Aging and Adults with Physical Disabilities or the Delaware Public Guardian.
- They must be over 18 years old.

***IF YOU HAVE QUESTIONS ABOUT THIS FORM,
YOU SHOULD SEEK LEGAL ADVICE BEFORE COMPLETING AND SIGNING IT.***

ADVANCE HEALTH-CARE DIRECTIVE

I, XXX, of _____ County, Delaware, declare this to be my Advance Health-Care Directive and revoke all previous Advance Health- Care Directives made by me.

PART 1: POWER OF ATTORNEY FOR HEALTH CARE

(1) DESIGNATION OF AGENT: I designate the following individual as my Agent to make health-care decisions for me:

Name: _____

Address: _____
(Street) (City) (State) (Zip Code)

Telephone: _____

OPTIONAL: I hereby designate additional or successor Agent(s):

Name: _____

Address: _____
(Street) (City) (State) (Zip Code)

Telephone: _____

Name: _____

Address: _____
(Street) (City) (State) (Zip Code)

Telephone: _____

If more than one Agent has been designated above, I intend for these Agents to (**initial only one**):

- _____ Act in succession (if one is not available, the next shall serve)
- _____ Act independently (any available Agent may serve solely and independently)
- _____ Act jointly (all Agents must act together, not independently)

(2) AUTHORITY OF AGENT(S): My Agent(s) is authorized to (**initial all that apply**):

- _____ Provide for my admission to, or discharge from, a medical, nursing, residential, mental health or similar facility
- _____ Enter into agreements for my care at home or in a facility
- _____ Employ and discharge medical personnel, including physicians, psychiatrists, dentists, nurses, and therapists

- _____ Approve medical and surgical procedures, including administration of drugs
- _____ Consent to and arrange for the administration of pain-relieving drugs
- _____ Consent to psychiatric treatment
- _____ Sign medical releases for medical personnel who provide treatment to me pursuant to instructions given by my Agent

(3) **WHEN AGENT’S AUTHORITY BECOMES EFFECTIVE:** My Agent’s authority becomes effective when my primary care physician or my currently treating physician determines I lack the capacity to make my own health-care decisions.

(4) **AGENT’S OBLIGATION:** My Agent shall make health-care decisions for me in accordance with this power of attorney for health care, any instructions I give in Part 2 of this form, and my other wishes, to the extent they are known to my Agent. To the extent that my wishes are unknown, my Agent shall make health-care decisions for me in accordance with what my Agent determines to be in my best interest. In determining my best interest, my Agent shall consider my personal values to the extent known to my Agent.

(5) **AUTHORIZATION TO RELEASE MEDICAL INFORMATION:** Effective immediately and continuously until my death or revocation by a writing signed by me or someone authorized to make health-care decisions for me, I authorize and request any physician, health-care professional, health-care provider, and medical care facility (collectively, “health-care providers”) to provide to my Agent information, oral or written, relating to my physical and mental condition and the diagnosis, prognosis, care, and treatment thereof upon the request of my Agent I have appointed under this instrument, including, but not limited to, health information as defined and described in the Health Insurance Portability and Accountability Act of 1996 (Public Law 104-191, 110 Stat. 2024, generally referred to as “HIPAA”), the regulations promulgated thereunder and any other state or local laws and rules. Information disclosed by a health-care provider may be redisclosed and may no longer be subject to the privacy rules provided by Section 164 of Title 45 of the Code of Federal Regulations. It is my intent by this authorization for my Agent to be considered a personal representative under privacy regulations related to protected health information and for my Agent to be entitled to all health information in the same manner as if I personally were making the request. This authorization and request shall also be considered a consent to the release of such information under current laws, rules, and regulations as well as under future laws, rules, and regulations and amendments to such laws, rules, and regulations to include but not be limited to the express grant of authority to personal representatives as provided by Regulation Section 164.502(g) of Title 45 of the Code of Federal Regulations and the medical information privacy laws and regulations.

PART 2: END – OF – LIFE DECISIONS

This form offers you three treatment options to guide end-of-life decisions if you are diagnosed with a “Qualifying Condition.”

"Qualifying condition" means the existence of 1 or more of the following conditions in the patient, certified in writing in the patient's medical record by the attending physician and by at least 1 other physician who, when the condition in question is "permanently unconscious" shall be a board-certified neurologist and/or neurosurgeon:

- (1) "Permanently unconscious" or "permanent unconsciousness" means a medical condition that has existed for at least 4 weeks and that has been diagnosed in accordance with currently accepted medical standards and with reasonable medical certainty as total and irreversible loss of consciousness and capacity for interaction with the environment. The term includes, without limitation, a persistent vegetative state or irreversible coma.
- (2) "Terminal condition" means any disease, illness or condition sustained by any human being for which there is no reasonable medical expectation of recovery and which, as a medical probability, will result in the death of such human being regardless of the use or discontinuance of medical treatment implemented for the purpose of sustaining life or the life processes.
- (3) "Serious illness or frailty" means a condition based on which the health-care practitioner would not be surprised if the patient died within the next year.

It is important to read each option fully before you choose your desired option. Please note that you are able to choose only one option, although you will have the opportunity to write-in any other medical instructions.

After you have read all three options, write your initials on the line next to the option you have selected that represents your choice for treatment instructions. You may only select one option. Some options include additional choices. If there are additional choices you wish to make within an option, **write your initials** next to those choices.

_____ OPTION 1

In the event I become terminally ill or permanently unconscious or have a serious illness or frailty and am unable to understand, make or communicate my wishes, I direct my Agent to make all decisions regarding what medical treatments I should or should not have.

_____ **OPTION 2**

- a. In the event I become **terminally ill** and I am unable to understand, make or communicate my wishes, I direct that my life be prolonged as long as possible using all possible treatments within the limits of generally accepted health-care standards, with the following exceptions (initial those treatments -- if any -- you do not want, even if they could prolong your life):

_____ heart-lung resuscitation (CPR)
_____ ventilator (breathing machine)
_____ dialysis (kidney machine)
_____ surgery
_____ blood transfusions
_____ chemotherapy or radiation treatment
_____ artificial nutrition or hydration through a conduit (tube feeding)
_____ antibiotics

- b. In the event I become **permanently unconscious** and am unable to understand, make or communicate my wishes, I direct that my life be prolonged as long as possible using all possible treatments within the limits of generally accepted health-care standards, with the following exceptions (initial those treatments -- if any -- you do not want, even if they could prolong your life):

_____ heart-lung resuscitation (CPR)
_____ ventilator (breathing machine)
_____ dialysis (kidney machine)
_____ surgery
_____ blood transfusions
_____ chemotherapy or radiation treatment
_____ artificial nutrition or hydration through a conduit (tube feeding)
_____ antibiotics

- c. In the event I have a "**serious illness or frailty**" and I am unable to understand, make or communicate my wishes, I direct that my life be prolonged as long as possible using all possible treatments within the limits of generally accepted health-care standards, with the following exceptions (initial those treatments -- if any -- you do not want, even if they could prolong your life):

_____ heart-lung resuscitation (CPR)
_____ ventilator (breathing machine)
_____ dialysis (kidney machine)
_____ surgery
_____ blood transfusions
_____ chemotherapy or radiation treatment
_____ artificial nutrition or hydration through a conduit (tube feeding)
_____ antibiotic

_____ **OPTION 3**

- a. In the event I become terminally ill and am unable to understand, make or communicate my wishes, I direct that no life sustaining measures be taken, with the following exceptions (initial those treatments -- if any -- you do want, even if they could sustain your life):

_____ heart-lung resuscitation (CPR)
_____ ventilator (breathing machine)
_____ dialysis (kidney machine)
_____ surgery
_____ blood transfusions
_____ chemotherapy or radiation treatment
_____ artificial nutrition or hydration through a conduit (tube feeding)
_____ antibiotics

- b. In the event I become permanently unconscious and am unable to understand, make or communicate my wishes, I direct that no life sustaining measures be taken, with the following exceptions (initial those treatments -- if any -- you do want, even if they could sustain your life):

_____ heart-lung resuscitation (CPR)
_____ ventilator (breathing machine)
_____ dialysis (kidney machine)
_____ surgery
_____ blood transfusions
_____ chemotherapy or radiation treatment
_____ artificial nutrition or hydration through a conduit (tube feeding)
_____ antibiotics

- c. In the event I have a “**serious illness or frailty**” and I am unable to understand, make or communicate my wishes,, I direct that no life sustaining measures be taken, with the following exceptions (initial those treatments -- if any -- you do want, even if they could sustain your life):

_____ heart-lung resuscitation (CPR)
_____ ventilator (breathing machine)
_____ dialysis (kidney machine)
_____ surgery
_____ blood transfusions
_____ chemotherapy or radiation treatment
_____ artificial nutrition or hydration through a conduit (tube feeding)
_____ antibiotics

COMFORT CARE

Regardless of the option I chose above regarding end of life decisions.

to **(initial only one)**

- the physician in attendance at my death
 - the hospital in which I die
 - the following named physician, hospital, storage bank or other medical institution:
-

for the following purpose(s) **(initial all that apply)**

- any purpose authorized by law
- transplantation
- therapy
- research
- medical education

NOTE: For your advance health-care directive to be effective, you and your witnesses must sign this form on the following two pages.

ADMINISTRATIVE PROVISIONS

REVOCATION, REMOVAL, AMENDMENT, OR RESIGNATION: I understand that upon my written notification to my health-care Agent(s), I can:

amend this document; or

revoke this document; or

remove one or more of the persons named in this document as health-care Agent.

Also, upon written notification to me or to anyone who is caring for me or has custody of me, one or more of my health-care Agents may resign.

EFFECT OF COPY: A copy of this form has the same effect as the original.

SIGNATURE

Having carefully read this document, I understand its purpose and effect, and hereby sign and date below:

(Date)

(Sign your name)

XXX

(Street)

(City, State, Zip Code)

STATEMENT OF WITNESSES

SIGNED AND DECLARED by the above-named declarant as and for his/her written declaration under 16 Del. C. §§ 2502,2503, in our presence, who in his/her presence at his/her request, and in the presence of each other, have hereunto subscribed our names as witnesses, and state:

- A. The Declarant is mentally competent.
- B. That neither of us is prohibited by § 2503 of Title 16 of the Delaware Code from being a witness. Neither of us:
 - 1. Is related to the declarant by blood, marriage, or adoption;
 - 2. Is entitled to any portion of the estate of the declarant under any will of the declarant or codicil thereto then existing nor, at the time of the executing of the advance health-care directive, is so entitled by operation of law then existing;
 - 3. Has, at the time of the execution of the advance health-care directive, a present or inchoate claim against any portion of the estate of the declarant;
 - 4. Has a direct financial responsibility for the declarant's medical care;
 - 5. Has a controlling interest in or is an operator or an employee of a health-care institution in which the declarant is a patient or resident; or
 - 6. Is under eighteen years of age.
- C. That if the declarant is a resident of a sanitarium, rest home, nursing home, boarding home or related institution, one of the witnesses, _____, is at the time of the execution of the advance health-care directive, a patient advocate or ombudsman designated by the Division of Services for Aging and Adults with Physical Disabilities or the Public Guardian.

Witness

Witness

(Print name)

(Print name)

(Address)

(Address)

(City, State, Zip Code)

(City, State, Zip Code)

(Signature of Witness)

(Date)

(Signature of Witness)

(Date)

You do not need to have this form notarized, but notarization may enhance its effectiveness in other states.

(Optional Notarization)

Sworn and subscribed to me this _____ day of _____, 20__.

My term expires: _____

(Notary)