



## WORKSHEET: ADVANCE HEALTH CARE DIRECTIVE

With the information you provide in this Worksheet, Skelton Law Offices will prepare an Advance Health Care Directive for you.

YOUR NAME: \_\_\_\_\_ DATE: \_\_\_\_\_

### SECTION 1: NAMING A HEALTH CARE AGENT

In Maine, you may include a health care power of attorney in your Advance Health Care Directive. The person you choose to make your health care decisions is called your Health Care Agent. When you appoint a Health Care Agent, you are not giving up the right to make your own decisions while you are able to do so. And if you become incapacitated, the Health Care Agent must make decisions according to any instructions you have given and wishes you have made known while competent. (See Section 2, below.)

You are encouraged to name alternate Agents in the event that the first person you have nominated as Health Care Agent is unable or unwilling to serve. You also have the option of naming two or more Co-Agents, but, if you do so, it is important that they be able to work together. It is also important that you decide whether Co-Agents are required to act together or whether the Co-Agents may act independently from one another when making decisions for you.

#### 1.1. Nominations of Health Care Agents

Provide the following information for any person you nominate as a Health Care Agent. Unless you indicate otherwise, we assume that the first person is your first choice for Health Care Agent, the second person is your second choice for Health Care Agent, etc.

1<sup>st</sup> NAME: \_\_\_\_\_

ADDRESS: \_\_\_\_\_

TEL: Home: \_\_\_\_\_ Work: \_\_\_\_\_ Cell: \_\_\_\_\_

2<sup>nd</sup> NAME: \_\_\_\_\_

ADDRESS: \_\_\_\_\_

TEL: Home: \_\_\_\_\_ Work: \_\_\_\_\_ Cell: \_\_\_\_\_

3<sup>rd</sup> NAME: \_\_\_\_\_

ADDRESS: \_\_\_\_\_  
TEL: Home: \_\_\_\_\_ Work: \_\_\_\_\_ Cell: \_\_\_\_\_

**1.2. Effective Date of Health Care Agent's Authority**

You should indicate when the appointment of your Health Care Agent(s) will be effective. The nomination can be effective immediately or "spring" into effect only if a physician or judge has decided that you are unable to make your own decisions. Check the box which expresses your preference:

(a) My health care agent can make decisions for me only when my primary doctor or a judge decides that I am not able to make my own health care decisions.

(b) My health care agent can start making health care decisions for me right away. This does not mean I have given up the right to make my own decisions if I am still aware. When my health care agent makes a health care decision for me, I will be told, if possible, about that decision before it is carried out unless I say I do not want to know. If I disagree with that decision and am still aware, I can make a different decision. I can change my mind at any time as long as I am aware and either change or end my health care agent's right to make decisions for me and make decisions for myself. If I want to end my health care agent's right to make decisions for me, I will tell my primary doctor or I will put it in writing and sign it.

**1.3. Option: Request that Health Care Agent Keep Others Advised**

Do you want to require your Health Care Agent to keep others advised of your medical condition? If so, specify the individual(s) to be informed:

I hope my agent and alternate agents keep \_\_\_\_\_  
\_\_\_\_\_ (e.g., children, spouse, siblings, other family members, etc.) informed of my medical condition.

**1.4. Option: Specifying Individuals Who May Not Make Health Care Decisions**

There may be a spouse, child, parent or other close relative who should not be involved in any decisions regarding your health care. If so, you may want to specifically identify that individual in your Advance Health Care Directive with language like the following:

I hereby direct that I do not want my \_\_\_\_\_ (e.g., son, daughter, sister, father, estranged spouse, etc.) \_\_\_\_\_ (Name) to be involved with any health care decisions, or any other decisions, on my behalf.

## SECTION 2: INSTRUCTIONS FOR HEALTH CARE

If you are satisfied to allow your Health Care Agent to determine what is best for you, you do not need to fill out this Section. If you do not limit your Health Care Agent's authority, he or she can make any and all health care decisions for you including consenting to or withholding consent for any care and treatment; choosing your physician; placing you in an institution such as a nursing home; and deciding whether you should be kept alive by artificial means if you are terminally ill.

If you want to provide instructions to your Health Care Agent, you may use the language provided below. If you wish to provide additional instructions or write your own wishes, you are free to do so.

### 2.1. End-of-Life Decisions

In the next two sections, you have the opportunity to state your general philosophy about end-of-life treatment. You direct your health care providers and others involved in your care to provide, withhold or withdraw treatment in accordance with the choice you make.

#### 2.1.1. Prolonging Life.

Indicate your preference by checking either (a) or (b):

(a) Choice Not to Be Kept Alive: I do not want treatment to keep me alive if any of the following are true:

(i) I have an illness that will not get better, cannot be cured, and will result in my death quite soon; or

(ii) I am no longer aware (conscious) and it is very likely that I will never be conscious again; or

(iii) the likely risks and burdens of treatment would outweigh the expected benefits.

(b) Choice to Be Kept Alive: I want to be kept alive as long as possible within the limits of generally accepted health care standards.

**2.1.2. Artificial Nutrition and Hydration.**

Check (a) or (b) below to state your preference about tube feeding or having water and nutrition fed into your veins:

- (a) Artificial nutrition and hydration must be given, not given, or stopped based on the choice I made above about keeping me alive.
- (b) Artificial nutrition and hydration must be given regardless of my condition and regardless of the choice I made above about keeping me alive.

**2.2. Relief from Pain**

Do you want to direct that treatment for alleviation of pain or discomfort be provided at all times, even if it hastens your death?  Yes  No

If you have any special instructions regarding pain relief, indicate below:

---



---

**2.3. Option: Statement of Preference for Remaining at Home**

Do you want to include the following statement?  Yes  No

I want to remain at home, and I do not want to go to a facility like a nursing home unless it is not medically feasible to care for me at home.

**2.4. Option: Request for Consideration of Faith**

If you want your Health Care Agent to make all end-of-life decisions consistent with your religious faith and traditions, please identify your faith below (e.g. Catholic, Jewish, Seventh Day Adventist, Islam, etc.): \_\_\_\_\_

**2.5. Option: Identifying Specific Conditions that Are Worse than Death**

For some people, there are conditions that are worse than death and, if those conditions occur, they would not want to be kept alive. An example is that in the event of an advanced dementia from a condition like Alzheimer’s disease, an individual would choose to not be treated for pneumonia.

Check (a) if this is a statement of your preferences. Instead, if you choose (b), you can be more specific about the circumstances under which you would not want to receive treatment:

(a) I do not want treatment to keep me alive if my doctor decides that I can no longer recognize most people or communicate and understand due to serious disease or damage to my brain and treatment to keep me alive is not expected to cure or improve my mental condition.

(b) I do not wish to receive life saving treatment if my health care agent concludes that the following are true:

(i) I have suffered permanent cognitive or physical or combined physical and cognitive losses, so I am no longer aware of

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_ and

(ii) I am no longer able to \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_ and

(iii) Because of the above losses, I cannot give informed consent to treatment and to ending treatment and have lost the ability to direct my care or end treatment which might keep me alive in that state, and

(iv) The losses have lasted at least \_\_\_\_\_ months.

When I have been in this permanent impaired condition for the required time, even though I may not then be close to death because of the physical or cognitive impairment, I expect to receive basic care that provides for my comfort, including oral and body hygiene, reasonable efforts to offer food and fluids by mouth, positioning, warmth, appropriate lighting, the caring presence of others, and medications for comfort, but I want to let nature take its course should any further infection, illness, or progression of illness be life-threatening.

### SECTION 3: DONATION OF ORGANS AT DEATH

This section is optional. If you want to donate any or all of your organs at the time of your death, you can do so including an instruction in your Advance Health Care Directive. Check the appropriate boxes below:

- (a) I give no organs, tissues or parts.  
 (b) I give any needed organs, tissues or parts.  
 (c) I give the following organs, tissues or parts only:

\_\_\_\_\_

If I have made a gift, it is for the following purposes:

- |                          |                  |                          |           |
|--------------------------|------------------|--------------------------|-----------|
| <input type="checkbox"/> | Transplant       | <input type="checkbox"/> | Research  |
| <input type="checkbox"/> | Therapy          | <input type="checkbox"/> | Education |
| <input type="checkbox"/> | All of the above |                          |           |

#### SECTION 4: FUNERAL AND BURIAL ARRANGEMENTS

This section is optional. You may identify a person who will have the authority to make decisions about your bodily remains **and/or** you can record your preferences regarding disposition of your bodily remains and any ceremonies following your death.

I now choose my \_\_\_\_\_ (e.g., son, daughter, sister, father, spouse, etc.) \_\_\_\_\_ (Name) to have custody and control of my body after my death with the right to decide everything about my funeral and burial.

These are my wishes regarding possible burial, cremation, funeral and memorial service:

---

---

---

#### SECTION 5: REVOCATIONS OF PRE-EXISTING HEALTH DIRECTIVES

Have you previously created any Living Wills or Advance Health Care Directives?  Yes  No

If so, do you want to revoke those pre-existing documents and replace them with the new document to be prepared from this Worksheet?  Yes  No

#### SECTION 6: OTHER WISHES OR INSTRUCTIONS

You should not feel limited by this form. You can elaborate on the preferences and wishes stated above, and you can use your own words to provide instructions to health care providers and family members and to make your wishes known. If there are other wishes that you would like to include in your Advance Health Care Directive, provide them here:

---

---

---

---

---

---

---

---

---

P:\SYSTEM - Estate Planning System\EP-2.2. AHCD Worksheet 5-12-05.DOC