

ADVANCE HEALTH CARE DIRECTIVE WORKSHEET

This Worksheet is intended to provide guidance to clients of Rudman Winchell and the Maine Elder Law Firm, a Practice of Rudman Winchell, who are considering preparing an Advance Health Care Directive. If you would like us to prepare a Directive for you, please complete this Worksheet.

YOUR NAME: _____ **DATE:** _____

PART 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 have the option of naming two or more Agents to serve simultaneously. If you do so, it is important that they be able to work together. It is also important that you decide whether they will be Co-Agents who are required to act together or whether the concurrent Agents may act independently from one another when making decisions for you.

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 shall 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.

1st NAME: _____ Relationship: _____
ADDRESS: _____
TEL: Home: _____ Work: _____ Cell: _____

2nd NAME: _____ Relationship: _____
ADDRESS: _____
TEL: Home: _____ Work: _____ Cell: _____

3rd NAME: _____ Relationship: _____
ADDRESS: _____
TEL: Home: _____ Work: _____ Cell: _____

2. Specifying Individuals Who May Not Make Decisions

There may be a person in your life who should not be involved in any decisions regarding your health care. If you want to make it clear in your Directive that one or more individuals shall not make health care decisions for you, include them here.

Name: _____ Relationship: _____
Name: _____ Relationship: _____
Name: _____ Relationship: _____

3. Release to Agents

Please check here if you would like to authorize Rudman Winchell and/or Maine Elder Law Firm to release a copy of your signed Advance Health Care Directive to your Health Care Agent(s).

4. 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 (a), (b), or (c):

(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.

(c) My initial health care agent may exercise the authority in this Advance Health Care Directive immediately, but no successor agent may exercise the authority granted under this Advance Health Care Directive unless my primary doctor or a judge decides that I am not able to make my own health care decisions.

5. I would like my Agent to also have the following authorities (check all that apply)

My agent may consent to admission to an assisted living facility, hospital, hospice, or nursing home for me.

My agent can hire any kind of health care worker or provider I may need to help me or take care of me. My agent may also fire a health care worker or provider, if needed.

My agent may move me to another state to get the care I need or to carry out my wishes.

I give my agent the authority to apply for Medicare, Medicaid (MaineCare), or other programs or insurance benefits for me. To the extent this provision is consistent with any Financial Power of Attorney I may have executed, I further direct that my agent shall have access to my personal financial records, including but not limited to bank records, for the purpose of gathering the information needed to apply for said programs and benefits.

I desire to drive as long as it is safe for me to do so. When it is no longer reasonable for me to drive, I would like my agent to tell me I should no longer drive. I wish for my agent to assist by consulting with my physician or a driving rehabilitation specialist about my ability to drive safely. If I am unwilling or unable to surrender my driver's license after a professional concurs that I am unable to drive safely, my agent may advise the state department of motor vehicles of this issue, contact my physician to request she or he advise the state department of motor vehicles of this issue, take possession of my car keys or my car, and sell my car and use the proceeds to pay for alternative transportation. I trust my agent to take the necessary steps to prohibit my driving to ensure my safety and the safety of others while also protecting my dignity.

PART 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.

6. End-of-Life Decisions

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

Check (a) or (b). If you check (a), you may identify the conditions when you do not want life prolonged:

(a) Choice Not to Be Kept Alive: I do not want my life to be prolonged by the use of any medical procedures or interventions that serve only to prolong the process of dying. By way of example, I do not want treatment to keep me alive if any of the following are true:

If you choose (a), check any that apply:

(i) I have a terminal illness that will not get better, cannot be cured, and will result in my death quite soon. ("Terminal illness" means an incurable and irreversible condition that, without the use of life-sustaining treatments, is reasonably expected to result in my death within six (6) months regardless of the treatment received);

(ii) I am no longer conscious because I am in an irreversible coma (defined as a permanent loss of consciousness from which there is no reasonable possibility for a return to a cognitive life) or a vegetative state (defined as a state in which there is no higher cortical and cognitive function, but vegetative brain stem processes are maintained, with no realistic

possibility of recovery, as diagnosed in accordance with acceptable medical standards) and it is very likely that I will never be conscious again;

(iii) My doctor, after talking with others involved with my health care, determines that 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.

7. 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 would be 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. If you want to state a preference, complete the following:

Check (a), (b), or (c). If you check (a), you may identify a length of time.

(a) I do not want treatment to keep me alive if, after consultation with other immediate family members and my doctor, my agent determines that due to serious disease or damage to my brain:

(i) I can no longer recognize my loved ones and

(ii) I have not been able to communicate and understand for a period of at least _____ months, and the treatment is not expected to cure or improve my mental condition.

(b) I do not want treatment to keep me alive if the following is true:

(c) I want treatment to keep me alive that is generally given for my medical condition even if I can no longer recognize my loved ones or communicate and understand.

8. Preferences for Assisted Feeding

If you are experiencing one of the conditions described in Section 7, the question of assisted feedings may arise. Please check here if you want to include the following preferences for assisted feeding:

1. As long as I appear receptive to and cooperate in eating and drinking by showing signs of enjoyment or positive anticipation of eating and drinking, I want to receive assisted oral feedings.
2. I want to be fed only those foods I appear to enjoy, in any texture I prefer, and in whatever amount I readily accept.
3. I want all attempts to provide assisted oral feedings stopped when I no longer seem to enjoy or appear willing to eat or drink, or if I begin to cough, choke, or aspirate oral feedings into my lungs.
4. I do not want to receive assisted feedings once I am no longer willing to open my mouth, appear indifferent to being fed, or spit out food or fluids.
5. I do not want to be coerced, cajoled, or in any way forced to eat or drink.

9. Artificial Nutrition and Hydration in General

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

- (a) Artificial nutrition and hydration, including but not limited to intravenous feeding, hydration, tube feeding, and misting, must be given, not given, or stopped based on the instruction I gave in Part 2 about keeping me alive.
- (b) Artificial nutrition and hydration, including but not limited to intravenous feeding, hydration, tube feeding, and misting, must be given regardless of my condition and regardless of the instructions I gave in Part 2 about keeping me alive.

10. Relief from Pain

Check (a) or (b) below to state your preference for pain relief. In (b) you may state limitations for the purposes or methods of pain relief:

(a) If I am dying, I direct that at all times I be given treatment for the alleviation of pain or discomfort, even if it hastens my death.

(b) Except as I state in the following space, if I am dying I direct that at all times I be given treatment for the alleviation of pain or discomfort, even if it hastens my death:

11. If I am Pregnant

If I become pregnant, I direct my Agent to continue to follow the preferences and health care decisions that I have expressed in this Advance Health Care Directive.

If I become pregnant, I **do not want** my Agent to necessarily continue to follow the preferences and health care decisions that I have expressed in this Advance Health Care Directive, but rather to take into account the health and safety of my unborn child.

12. 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, Muslim, etc.): _____ **and be certain to also choose (a) or (b), below:**

(a) When consistent with my other wishes expressed in this Advance Health Care Directive Worksheet, I request that health care decisions be made for me consistent with my religious faith and traditions.

(b) Regardless of my other wishes stated in this Advance Health Care Directive Worksheet, I want health care decisions made for me consistent with my religious faith and traditions.

13. Special Instructions for Comfort and Care

If you want to provide special instructions to the people who may be attending to your treatment or care, such as family, friends, volunteers, and medical staffs, list those instructions in the space below. These may include things such as requesting that your favorite music is played, that others read from your favorite passages, that fresh air be introduced to the room, or that pets are allowed to visit even if you are unresponsive, etc.

14. 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:

**PART 3
AFTER DEATH INSTRUCTIONS**

15. Donation of Organs

If you want to donate any or all of your organs at the time of your death, you can do so by 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 my whole body. **(Please see below for more information)**
- (d) I give the following organs, tissues, or parts only: _____

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

- Transplant Research Therapy Education All purposes

If you have chosen option (c) above (making a gift of the whole body), identify the recipient
(for example, name of hospital, medical school, research facility, etc.)

16. Custody of Remains

You may identify an individual or a series of individuals to have custody of your remains after your death. Making this designation would minimize the chance of conflict between family members. The designation may be particularly useful if you are in a second or third marriage and have adult children from prior relationships.

I now choose my _____ (e.g., son, John Doe; mother, Jane Doe; husband, James Doe) to have custody and control of my body after my death with the right to decide everything about my funeral and burial.

You may also state your wishes regarding any funeral and memorial service or cremation, burial, etc.:

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