~ Lifecare Directives ~

Standard Advance Directive

For

Massachusetts Residents

Statute-Compliant Advance Directive for Health Care Choices

Standard Advance Directive For Massachusetts Residents

_____ _____

Print Full Name *Date of Birth*

Your right *(when age 18 or older): To Document Your Personal Wishes, and to have these wishes followed ~~*

The Massachusetts legislature has sanctioned the use of a Health Care Proxy by which to name an agent to make health care choices if you are ever unable to do so. However, it has not provided a statutory Living Will for use by the public. Even so, many state and federal courts facing treatment choice dilemmas have urged the completion of a living will, and have noted that there is a constitutional right to control medical care by the use of such documents. In response to such findings, Lifecare staff have produced a "standard" (content limited) living will to assist in securing these important rights. An abbreviated Health Care Proxy form has also been provided. Together, these documents are referred to as an "advance directive."

Each has an introduction that summarizes the scope and purpose of the documents, as well as providing directions for completion. Read them carefully to ensure that your Advance Directives are fully and properly filled out.

***Understanding Your Directive*:**

To make the *best* choices for your medical care, your physician needs to know *your* wishes. In fact, the law requires doctors to seek your permission before giving you *any* treatment. However, if you are ever unable to speak due to severe illness or injury, this may not be possible. Completing an Advance Directive will help your family and physicians know who should speak for you, and understand what you want, if you cannot speak for yourself.

You can **revoke** (cancel) this directive at ***any*** time in any manner "evidencing a specific intent to revoke"(§7). Lifecare staff recommend revocation by: **1**) writing "revoked" across the front of the directive, followed by your signature and date, and the signature of at least one witness aged 18 years or older ; or **2**) by completing a Notice of Revocation; or **3**) by *telling* an adult witness that you want it revoked (who must then sign and date a statement, which becomes effective only when given to your doctor or health care provider); or **4**) *by simply completing a new directive* in which you state that any prior directive is no longer valid.

If you are **unable to write**, you may tell your directive witnesses what you want to have excluded, limited, or added to this directive. They must then sign, date, witness and/or notarize the statement of the limitations and exclusions as you have described them. Remember, unless you direct otherwise, this directive will **only** be used to guide your family and doctors if you are unable to make and communicate medical treatment decisions for yourself.

Instructions for Completing the Directive:

This directive is written in two parts. Neither document *must* be notarized to be valid, but both must be witnessed by two qualified adults. However, Lifecare staff recommend that you both notarize and witness your directives, to more fully ensure that others will honor your wishes. While it is best if you fill out the whole document, you may choose to complete only ***Section I***, leaving just a Declaration of your values and wishes. Or you may complete only ***Section II***, just naming someone to speak for you. However, this may leave your family and others without any evidence to support your wishes in the future, or leave them unsure who is to make decisions and speak for you. Thus, omitting either section may cause your loved ones difficulty if they must eventually make medical choices in your behalf. So, you are strongly encouraged to complete the entire directive.

To complete the document, you should ***initial*** in the underlined spaces provided beside all the questions that are asked, and fill in any blank lines as directed. Feel free to write "No," "None," or "Does Not Apply" in areas that would otherwise be left blank.

If there is anything in this Directive you do not understand, you should read the Guidebook, ask your physician or a health care professional, or call an attorney for help.

SECTION I:
MASSACHUSETTS LIVING WILL
and Personal Instructions

(Pursuant to the Patient Self-Determination Act, 1990)

1. INTRODUCTION: *This living will is established upon both common law and the 1990 Supreme Court ruling which acknowledges that all competent persons have a right to control their medical care through specific prior statements, whether expressed orally or in writing, and that such wishes remain valid even after loss of competence. Generally, clear evidence is needed of a person's treatment wishes, and many state courts have suggested that the "ideal situation" is one in which a person's wishes were expressed in some form of writing, such as a "living will" (see case* In re: Westchester County Medical Center, *72 N.Y.2d 517 (1988)). This living will has been designed to secure this right.*

However, this document has not been designed to support euthanasia (also known as"assisted suicide,""mercy killing,""physician-aid-in-dying," etc), which involves active steps to end a life (such as by medication overdose). Current research suggests that this should not be needed if individuals clearly document their wishes (including statements needed to secure comfort care), whereby the natural processes of dying are left unimpeded if they so desire. Please complete your Instruction as fully as possible to secure every right available to govern your future medical treatment.

LIVING WILL DECLARATION

2. I have chosen *not* to complete a Living Will at this time, but I *do* want to complete a comprehensive Health Care Power of Attorney (*sign here and skip to page 3*):
   Signature: _____ Date: _____

OR:

3. I, _____, being of sound mind, do herein direct that the instructions provided in this section of my Advance Health Care Directive be recognized as my Living Will and evidence of my health care treatment wishes. These instructions reflect my firm and settled commitments, and are provided to guide to any health care agent, proxy, surrogate, professional, family member, guardian, conservator, court, or other persons or entities providing, overseeing, or making medical decisions regarding my care, in the event I am unable to make my wishes otherwise known.

4. *Specific Health Care Directives*: I have specific wishes regarding the delivery of medical care in certain health care conditions. Therefore, in the following conditions, I wish to direct my medical treatment as follows: (Please Initial)

   _____ If I am ever diagnosed with a **terminal** illness, disease, or injury, and generally given six months or less to live:
   - I do [_____], or I do not [_____] want life-sustaining medical treatment used in any attempt to try and prolong my life.

   _____ If I am ever diagnosed as being **permanently unconscious** (in a coma, or a persistent vegetative condition):
   - I do [_____], or I do not [_____] want life-sustaining medical treatment used in any attempt to try and prolong my life.

   _____ If I am ever diagnosed as being in a "**minimally conscious**" condition, where I will remain permanently unable to make decisions or express my wishes:
   - I do [_____], or I do not [_____] want life-sustaining medical treatment used in any attempt to try and prolong my life.

   _____ If I am ever diagnosed as being in "**untreatable and severe pain**," where no medical, surgical or other relief can be obtained:
   - I do [_____], or I do not [_____] want life-sustaining medical treatment used in any attempt to try and prolong my life.

5. *Clarifying "life-sustaining medical treatment*." In the situations described above, I wish to leave the following directions about the treatments and procedures which may be used, withdrawn, or withheld: (Please Initial)

- I do [_____], or I do not [_____] want **cardiac resuscitation (CPR)** used in any attempt to try and prolong my life.

- I do [_____], or I do not [_____] want **breathing machines** used to replace or support my natural breathing (i.e., "respirators, "ventilators" or other such devices) in any attempt to try and prolong my life.

- I do [_____], or I do not [_____] want food and water to be given me through **tubes, IV lines, or other medical devices** in any attempt to try and prolong my life.

- I do [_____], or I do not [_____] want **antibiotics** used in any attempt to try and prolong my life.

6. *Comfort Care and Pain Relief*. In the specific medical situations I have outlined, I provide the following directions about comfort care and pain relief: (Please Initial)

- I do [_____], or I do not [_____] want maximum pain relief, if it may ***unintentionally*** **hasten my death**.

- I do [____], or I do not [____] want maximum pain relief, if it may result in ***temporary*** **addiction**, if I survived an extended hospital stay.

7. *Other Directions*. I wish to provide the following additional directions: _____

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

8. ***Signature of Principal and Witnesses***:

These directions express my legal right to include a statement of "desires on care, custody, and medical treatment," and to accept or refuse treatment under the laws of Michigan. I intend the instructions in this Statement to be carried out, unless I have rescinded them in a new writing or by clearly indicating that I have changed my mind.

By signing below, I indicate that I am fully aware of the contents of this Document, and understand its full purpose, effect, and import. Further, I am of legal age, and I am emotionally and mentally competent to complete this document. I am acting voluntarily and without fraud, duress or undue influence.

9. Signed: _____

Date: _____

Address: _____

Statement of Witnesses

10. I am at least 18 years of age. I know the Principal personally or have been provided convincing evidence of identity, and believe him or her to be of sound mind, under no duress, fraud, or undue influence. The Principal has affixed his/her signature or mark in my presence. I have not signed the Principal's signature (above) for or at the direction of the Principal. I declare under penalty of perjury that I am not related to the Principal by blood, marriage, or adoption, nor am I directly responsible for his or her medical care or costs. Further, I am not the attending physician, nor an employee of the physician or other health care provider or current care facility, nor a party to any parent organization thereof. I am also not the employee of a life or health insurance provider for the Principal, nor am I involved in directly physically caring for the individual. To the best of my knowledge I have no claim against the Principal's estate, nor am I entitled to any part of the individual's estate upon his or her death under a will now existing nor by any other operation of law.

11. Witness: _____

Printed Name:_____

Address: _____

12. Witness: _____

Printed Name:_____

Address: _____

SECTION II:
MASSACHUSETTS HEALTH CARE PROXY
For the Designation of a Health Care Agent

(Pursuant to Mass. Gen. Laws, Ch.201D: §1 to §17)

13. INTRODUCTION: *This section lets you name a person to make health care decisions for you, if you cannot make them for yourself. The person you name must be at least 18 years of age. Unless you indicate otherwise, the powers which you may grant through this document include the authority to make health care decisions, including life-sustaining treatment decisions, as well as other authorities regarding related affairs. If you have questions, you should seek further counsel and advice.*

14. ***Be it known that I***:

Full Legal Name: _____

Date of Birth: _____

Street Address: _____

City: _____ County: _____

State: _____ Zip Code: _____

~~ Intend by this document to create a Health Care Proxy designation (or "health care agent" appointment) under the laws of the State of Massachusetts. The authority of this document shall not be affected by my future disability, incompetency, or incapacity (as the "principal" herein). I am of sound mind, and state that my execution of this document is voluntary and done without fraud, undue influence, or duress. Creation of this Health Care Proxy is for the purpose of designating a Health Care Agent (or attorney-in-fact) to make medical and other related decisions for me, if I become unable to make them for myself . This designation becomes effective when my attending physician determines that I am no longer able make personal medical treatment decisions. By creating this document I revoke any prior Health Care Proxy document.

15. I understand that I am not required to choose an agent, but recognize that by doing so I may more fully ensure that my wishes are represented and carried out. Therefore:

(*Initial Only One*)

_____ I do not want to choose a health care agent at this time (or I have no one appropriate to the task). However, I instruct that Section I of this document be recognized by statutory law, case law, common law and/or federal law as a declaration of my wishes within this Advance Health Care Directive (*proceed now to sign on page 5*);

OR,

_____ I do wish to appoint a health care agent. I recognize that, by Massachusetts law, this person may *not* be my health care provider nor an employee of my health care provider, unless related to me by blood, marriage or adoption. The person I have chosen to act as my agent and to whom I give **full** authority to make all medical and health care decisions for me at any time during which I am unable to make them for myself, is:

16. **Name of Agent**: _____
Address: _____
Telephone: Home:_____ Work:_____
Cell Phone or Pager: _____ E-mail: _____

17. If for any reason I revoke the authority of my agent, or this individual is unavailable, unable, unwilling, or otherwise ineligible to make decisions for me, the following individuals (*to act alone and successively, in order of priority as listed*) are authorized to serve as alternate agents:

18. **Name of Alternate #1:**_____
Address: _____
Telephone: Home:_____ Work:_____
Cell Phone or Pager: _____ E-mail: _____

19. **Name of Alternate #2:** _____
Address: _____
Telephone: Home:_____ Work:_____
Cell Phone or Pager: _____ E-mail: _____

20. Each alternate successor designated shall be vested with the same power and duties as if originally named as my health care agent. These persons, *in priority of the order presented*, are to have binding authority over any and all other persons to make my personal and health care decisions. In making decisions in my behalf, *if my wishes are not otherwise clear*, I direct my agent to act in his/her best understanding of what my wishes would have been. Where my agent is not reasonably sure of what I would have wanted, he/she should decide according to his/her belief in my best interests as determined from a knowledge of my personal and family affairs, and other goals and values in life. The authority of my agent shall not be terminated <u>*unless*</u> it appears that he or she is clearly and obviously not acting in accordance with my known wishes, or is overwhelmingly ignoring my best interests if my wishes are not otherwise known.

21. **Additional statement of Desires, Special Provisions, and Limitations**.
Noted below are any added limitations or other provisions which my health care agent must follow in acting in his or her representative capacity:

22. *Living Will Declaration Incorporation (if completed) and Agent Instructions (if appointed)*: I intend for my agent to follow, incorporate and enforce as medical and attorney-in-fact directives, any and all wishes as outlined in the Living Will Declaration contained in this advance directive document.

23. *Other Wishes*: _____
_____
_____

STATEMENT AND SIGNATURE OF PRINCIPAL/GRANTOR:

24. This document is governed by Massachusetts law, although I request that it be honored in any state in which I may be found.

Severability: If any word, part, or provision of this declaration or its application to any person or circumstance is found to be invalid for any reason, that provision shall be severed without affecting any other power, authority, or application of this document which can be given effect without the invalid part, whether its directives are exercised by case law, common law, federal law, or statutory law.

By signing below, I indicate that I am fully aware of the contents of this document, and understand its purpose, effect, consequences, and full import. Further, I am of legal age, and I am emotionally and mentally competent to complete this document. I am acting voluntarily and without fraud, duress or undue influence.

25. Signed:_____ Date: _____

At: (City) _____ (State) _____

QUALIFIED WITNESSES

26. This Advance Directive for Health Care may not be upheld unless it is signed by two qualified adult witnesses who are personally present when you sign. Notarization is not required. However, *Lifecare* staff recommend you both witness and notarize your document to ensure your wishes are honored should either witness become unavailable in the future.

Statement of Witnesses

27. I am at least 18 years of age. I know the principal personally, and believe him or her to be at least 18 years of age and of sound mind, and that this document is being executed willingly, without constraint, and free from fraud, undue influence, or duress. The principal has had an opportunity to read the above form and has signed the form (or directed another to sign the form) in my presence. However, I have not signed the principal's signature for or at the direction of the principal. I declare under penalty of perjury that I am not related to the principal by blood, marriage, or adoption, nor am I directly responsible for his or her medical care or costs. Further, I am not an agent named herein, nor the attending physician, nor an employee of the physician or other health care provider. Nor am I the operator, administrator or employee of a health care facility in which the principal resides or has applied for admission, nor a party to any parent organization thereof. To the best of my knowledge I am not entitled to any part of the individual's estate upon his or her death under a will now existing nor by any other operation of law.

28. 1st Witness: _____
(Signature)

_____ _____
(Name Printed) (Date)

_____
(Residence Address)

29. 2nd Witness: _____
(Signature)

_____ _____
(Name Printed) (Date)

_____
(Residence Address)

CERTIFICATE OF ACKNOWLEDGMENT OF NOTARY PUBLIC: *(Notarization is not required if the document is properly witnessed, but it is still recommended to ensure full evidence of your intent and wishes*).

30. State of Massachusetts,

County of_____ }

Place: _____

On this_____day of _____, in the year_____, before me (insert officer name/title): _____, personally appeared (insert name of Principal on line here):_____, personally known to me (or proved to me on the basis of satisfactory evidence (describe:_____)) to be the person(s) whose name is subscribed to this/these instrument(s) and acknowledged to me that he/she executed the same in his/her authorized capacity, and that by his/her signature on the instrument(s), executed the instrument(s). I declare that he/she appears of sound mind and not under or subject to duress, fraud, or undue influence, that he/she acknowledges the execution of the same to be his/her voluntary act and deed, and that I am not the advocate (attorney-in-fact), proxy, surrogate, or a successor of any such, as designated within this document, nor do I hold any interest in his/her estate through a Will or by other operation of law.

WITNESS my hand and official seal:

31. _____ **Notary Seal:**
Signature of Notary Public

_____
Date Commission Expires

PHOTOCOPIES AND FACSIMILES:

32. A photocopy (photostatic copy) or electronic facsimile ("fax") of this document shall be deemed as valid as the original. I understand I should keep the original copy, and give copies of the original to 1) my advocate and alternate advocates, 2) my physician(s), 3) members of my family and others who might be called in the event of a medical emergency, and 4) any hospital or other health care facility where I receive treatment. My advocate(s) any my family or friends should be directed to give a copy of this directive to my health care provider(s) or physician(s) upon request.

For additional copies of this directive, or other related materials, please contact Lifecare Directives, LLC, at:

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