

# **ALABAMA**

## **Advance Directive**

### **Planning for Important Healthcare Decisions**

*Caring Connections*  
1731 King St., Suite 100, Alexandria, VA 22314  
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800/658-8898

#### **CARING CONNECTIONS**

Caring Connections, a program of the National Hospice and Palliative Care Organization (NHPCO), is a national consumer engagement initiative to improve care at the end of life.

Caring Connections tracks and monitors all state and federal legislation and significant court cases related to end-of-life care to ensure that our advance directives are up to date.

#### **It's About How You LIVE**

*It's About How You LIVE* is a national community engagement campaign encouraging individuals to make informed decisions about end-of-life care and services. The campaign encourages people to:

- Learn about options for end-of-life services and care
- Implement plans to ensure wishes are honored
- Voice decisions to family, friends and healthcare providers
- Engage in personal or community efforts to improve end-of-life care

Visit [www.caringinfo.org](http://www.caringinfo.org) to learn more about the LIVE campaign, obtain free resources, or join the effort to improve community, state and national end-of-life care.

If you would like to make a contribution to help support our work, please visit [www.nationalhospicefoundation.org/donate](http://www.nationalhospicefoundation.org/donate). Contributions to national hospice programs can also be made through the Combined Health Charities or the Combined Federal Campaign by choosing #11241.

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## **Your Advance Care Planning Packet**

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## Using these materials

### BEFORE YOU BEGIN

1. Check to be sure that you have the materials for each state in which you may receive healthcare.
2. These materials include:
  - Instructions for preparing your advance directive.
  - Your state-specific advance directive forms, which are the pages with the gray instruction bar on the left side.

### PREPARING TO COMPLETE YOUR ADVANCE DIRECTIVE

3. Read the HIPAA Privacy Rule Summary on page 4.
4. Read all the instructions, on pages 7 through 8, as they will give you specific information about the requirements in your state.
5. Refer to the Glossary located in Appendix A if any of the terms are unclear.

### ACTION STEPS

6. You may want to photocopy these forms before you start so you will have a clean copy if you need to start over.
7. When you begin to fill out the form, refer to the gray instruction bars - they will guide you through the process.
8. Talk with your family, friends, and physicians about your advance directive. Be sure the person you appoint to make decisions on your behalf understands your wishes.
9. Once the form is completed and signed, photocopy the form and give it to your proxy and alternate proxy, family, friends, healthcare providers and/or faith leaders so that the form is available in the event of an emergency.

If you have questions or need guidance in preparing your advance directive or about what you should do with it after you have completed it, please refer to the state-specific contacts for Legal & End-of-Life Care Resources Pertaining to Healthcare Advance Directives, located in Appendix B.

## Summary of the HIPAA Privacy Rule

HIPAA is a federal law that gives you rights over your health information and sets rules and limits on who can look at and receive your health information.

### Your Rights

You have the right to:

- Ask to see and get a copy of your health records.
- Have corrections added to your health information.
- Receive a notice that tells you how your health information may be used and shared.
- Decide if you want to give your permission before your health information can be used or shared for certain purposes, such as marketing.
- Get a report on when and why your health information was shared for certain purposes.
- If you believe your rights are being denied or your health information isn't being protected, you can:
  - File a complaint with your provider or health insurer, or
  - File a complaint with the U.S. Government.

You also have the right to ask your provider or health insurer questions about your rights. You also can learn more about your rights, including how to file a complaint from the Web site at [www.hhs.gov/ocr/hipaa/](http://www.hhs.gov/ocr/hipaa/) or by calling 1-866-627-7748.

### Who Must Follow this Law?

- Doctors, nurses, pharmacies, hospitals, clinics, nursing homes, and many other healthcare providers.
- Health insurance companies, HMOs, most employer group health plans.
- Certain government programs that pay for healthcare, such as Medicare and Medicaid.

### What Information is Protected?

- Information your doctors, nurses, and other healthcare providers put in your medical record.
- Conversations your doctor has had about your care or treatment with nurses and other healthcare professionals.
- Information about you in your health insurer's computer system.
- Billing information about you from your clinic/healthcare provider.
- Most other health information about you, held by those who must follow this law.

## Summary of the HIPAA Privacy Rule (continued)

Providers and health insurers who are required to follow this law must keep your information private by:

- Teaching the people who work for them how your information may and may not be used and shared,
- Taking appropriate and reasonable steps to keep your health information secure.

To make sure that your information is protected in a way that does not interfere with your healthcare, your information can be used and shared:

- For your treatment and care coordination,
- To pay doctors and hospitals for your healthcare,
- With your family, relatives, friends or others you identify who are involved with your healthcare or your healthcare bills, unless you object,
- To protect the public's health, such as reporting when the flu is in your area, or
- To make required reports to the police, such as reporting gunshot wounds.

Your health information cannot be used or shared without your written permission unless this law allows it. For example, without your authorization, your provider generally cannot:

- Give your information to your employer.
- Use or share your information for marketing or advertising purposes, or
- Share private notes about your mental health counseling sessions.

## **Introduction to Your Alabama Advance Directive**

This packet contains the *Alabama Advance Directive for Healthcare* which protects your right to refuse medical treatment you do not want or to request treatment you do want in the event you lose the ability to make decisions yourself.

The first part of this document is your state's *Living Will*. It lets you discuss your wishes about medical care in the event that you develop a terminal condition or are permanently unconscious and can no longer make your own medical decisions. The Living Will becomes effective when your doctor and one other physician document in your medical record that you are in a terminal condition or permanently unconscious.

The second part of this document permits the appointment of a *Healthcare Proxy*. This section lets you name someone to make decisions about your medical care, including decisions about life-sustaining treatment, if you can no longer speak for yourself. It goes into effect when your doctor determines that you are unable to communicate your healthcare decisions.

Caring Connections recommends that you complete sections one, two and three of this document to best ensure that you receive the medical care you want when you can no longer speak for yourself.

*Note: This document will be legally binding only if the person completing the document is a competent adult.*

## **Instructions for Completing Your Alabama Advance Directive for Healthcare**

### **How do I make my *Alabama Advance Directive for Healthcare* legal?**

The law requires that you sign your document, or direct another to sign it, in the presence of two witnesses who must be at least 19 years of age. These witnesses must also sign the document to show that they personally know you, believe you to be of sound mind, that they did not sign the document on your behalf and that they do not fall into any of the categories of people who cannot be witnesses. The law also requires that your appointed healthcare proxy and alternate healthcare proxy sign and date the document.

*Note: You do not need to notarize your Alabama Advance Directive.*

Your witnesses **cannot** be:

- your appointed healthcare proxy,
- related to you by blood, adoption or marriage,
- entitled to any portion of your estate upon your death, either through your will or under the laws of interstate succession, or
- directly financially responsible for your medical care.

### **Can I add personal instructions to my *Living Will*?**

Yes. You can add personal instructions to your living will. For example, if there are any specific forms of treatment that you wish to refuse that are not already listed in the document, you may list them here.

You may also want to emphasize pain control by adding specific instructions such as, "I want to receive as much pain medication as necessary to ensure my comfort." It is important to learn about the kinds of life-sustaining treatment you might receive. Consult your physician for more information.

### **Whom should I appoint as my proxy?**

A proxy is the person you appoint to make decisions about your medical care if you become unable to make those decisions yourself. (A proxy may also be called an "agent.") Your proxy may be a family member or a close friend whom you trust to make serious decisions. The person you name as your proxy should clearly understand your wishes and be willing to accept the responsibility of making medical decisions for you.

You can appoint a second person as your alternate proxy. The alternate will step in if the first person you name as your proxy is unable, unwilling, or unavailable to act for you.

## **Instructions for Completing Your Alabama Directive for Healthcare (continued)**

### **Instructions for my healthcare proxy.**

One of the strongest reasons for naming a proxy is to have someone who can respond flexibly as your medical situation changes and deal with situations that you did not foresee.

We urge you to talk with your proxy about your future medical care and describe what you consider to be an acceptable “quality of life.”

### **What if I change my mind?**

You may revoke your Advance Directive for Healthcare at any time by:

- obliterating, burning, tearing or otherwise destroying or defacing the document,
- executing, or directing another person to execute, a dated written revocation (formal statement that you have changed your mind), or
- orally expressing your intent to revoke the Advance Directive for Healthcare in the presence of a witness, 19 years of age or older, who must sign and date a written confirmation that you made an oral revocation. An oral revocation becomes effective once the signed and dated confirmation is given to your doctor or healthcare provider, who will then make it a part of your medical record.

### **What other important facts should I know?**

The directions of a pregnant patient’s Alabama Advance Directive for Healthcare authorizing the providing, withdrawal or withholding of life-sustaining treatments and artificially provided nutrition and hydration will not be honored due to restrictions in the state law.

INSTRUCTIONS

**Alabama Advance Directive for Health Care  
(Living Will and Health Care Proxy) Page 1 OF 7**

This form may be used in the State of Alabama to make your wishes known about what medical treatment or other care you would or would not want if you become too sick to speak for yourself. You are not required to have an advance directive. If you do have an advance directive, be sure that your doctor, family, and friends know you have one and know where it is located.

Section 1. LIVING WILL

I, \_\_\_\_\_, being of sound mind and at least 19 years old, would like to make the following wishes known. I direct that my family, my doctors and health care workers, and all others follow the directions I am writing down. I know that at any time I can change my mind about these directions by tearing up this form and writing a new one. I can also do away with these directions by tearing them up and by telling someone at least 19 years of age of my wishes and asking him or her to write them down.

I understand that these directions will only be used if I am not able to speak for myself.

IF I BECOME TERMINALLY ILL OR INJURED:

Terminally ill or injured is when my doctor and another doctor decide that I have a condition that cannot be cured and where death will result in the near future without the use of artificial life sustaining procedures.

Life-Sustaining Treatment:

Life-Sustaining Treatment includes drugs, machines, or medical procedures that would keep me alive but would not cure me. I know that even if I choose not to have life-sustaining treatment, I will still get medicines and treatments that ease my pain and keep me comfortable.

Place your initials by either Yes or No:

I want to have life-sustaining treatment if I am terminally ill or injured.

Yes \_\_\_\_\_ No \_\_\_\_\_

Artificially provided food and hydration (Food and water through a tube or an IV)

I understand that if I am terminally ill or injured I may need to be given food and water through a tube or an IV to keep me alive if I can no longer chew or swallow on my own or with someone helping me.

Place your initials by either Yes or No:

I want to have food and water provided through a tube or an IV if I am terminally ill or injured. Yes \_\_\_\_\_ No \_\_\_\_\_

PRINT YOUR  
NAME

PLACE YOUR  
INITIALS BY EITHER  
YES OR NO

PLACE YOUR  
INITIALS BY  
EITHER YES OR NO

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IF I BECOME PERMANENTLY UNCONSCIOUS:

Permanent unconsciousness is when my doctor and another doctor agree that within a reasonable degree of medical certainty I can no longer think, feel anything, knowingly move, or be aware of being alive. They believe this condition will last indefinitely without hope for improvement and have watched me long enough to make that decision. I understand that at least one of these doctors must be qualified to make such a diagnosis.

Life-Sustaining Treatment:

Life-sustaining treatment includes drugs, machines, or other medical procedures that would keep me alive but would not cure me. I know that even if I choose not to have life-sustaining treatment, I will still get medicine and treatments that ease my pain and keep me comfortable.

Place your initials by either Yes or No:

I want to have life-sustaining treatment if I am permanently unconscious.

Yes\_\_\_\_\_ No\_\_\_\_\_

Artificially provided food and hydration (Food and water through a tube or an IV) I understand that if I become permanently unconscious, I may need to be given food and water through a tube or an IV to keep me alive if I can no longer chew or swallow on my own or with someone helping me.

Place your initials by either Yes or No:

I want to have food and water provided through a tube or an IV if I am permanently unconscious. Yes\_\_\_\_\_ No\_\_\_\_\_

OTHER DIRECTIONS:

Please list any other things that you want done or not done. In addition to the directions I have listed on this form, I also direct the following:

If you do not have other directions, place your initials here:

\_\_\_\_\_ No, I do not have other directions.

PLACE YOUR INITIALS BY EITHER YES OR NO

PLACE YOUR INITIALS BY EITHER YES OR NO

ADD PERSONAL INSTRUCTIONS (IF ANY)

IF YOU DO NOT HAVE OTHER DIRECTIONS, PLACE YOUR INITIALS HERE

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Section 2. HEALTH CARE PROXY

This form can be used in the State of Alabama to name a person you would like to make medical or other decisions for you if you become too sick to speak for yourself. This person is called a health care proxy. You do not have to name a health care proxy. The directions in this form will be followed even if you do not name a health care proxy.

Place your initials by only one answer:

\_\_\_\_\_ I do not want to name a health care proxy.  
(If you check this answer go to section 3.)

\_\_\_\_\_ I do want the person listed below to be my health care proxy.  
I have talked with this person about my wishes.

First choice for proxy: \_\_\_\_\_

Relationship to me: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Day-time phone number: \_\_\_\_\_

Night-time phone number: \_\_\_\_\_

If this person is not able, not willing, or not available to be my health care proxy, this is my next choice:

Second choice for proxy: \_\_\_\_\_

Relationship to me: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Day-time phone number: \_\_\_\_\_

Night-time phone number: \_\_\_\_\_

PLACE YOUR  
INITIALS BY ONLY  
ONE ANSWER

PRINT THE NAME,  
RELATIONSHIP AND  
ADDRESS OF YOUR  
PROXY

PRINT THE  
NAME,  
RELATIONSHIP  
AND ADDRESS  
OF YOUR  
ALTERNATE  
PROXY

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Instructions for Proxy

Place your initials by either yes or no:

I want my health care proxy to make decisions about whether to give me food and water through a tube or an IV.

Yes\_\_\_\_\_ No\_\_\_\_\_

Place your initials by only one of the following:

\_\_\_\_\_ I want my health care proxy to follow only the directions as listed on this form.

\_\_\_\_\_ I want my health care proxy to follow my directions as listed on this form and to make any decisions about things I have not covered in the form.

\_\_\_\_\_ I want my health care proxy to make the final decision, even though it could mean doing something different from what I have listed on this form.

Section 3.

The things listed on this form are what I want.

I understand the following:

If my doctor or hospital does not want to follow the directions I have listed, they must see that I get to a doctor or hospital who will follow my directions. If I am pregnant, or if I become pregnant, the choices I have made on this form will not be followed until after the birth of the baby.

If the time comes for me to stop receiving life-sustaining treatment or food and water through a tube or an IV, I direct that my doctor talk about the good and bad points of doing this, along with my wishes, with my health care proxy, if I have one, and with the following people:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

INITIAL  
YES OR NO

PLACE YOUR  
INITIALS BEFORE  
ONE OF THE THREE  
OPTIONS

LIST THE PEOPLE  
YOU WOULD WANT  
YOUR DOCTOR TO  
TALK WITH

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## Section 4.

## ORGAN DONATION (OPTIONAL)

Under Alabama law, you may make a gift of all or part of your body to a bank or storage facility or a hospital, physician or medical or dental school for transplantation, therapy, medical or dental education or research or for the advancement of medical or dental science or therapy; or to any specified individual for therapy or transplantation needed by him/her. The holder of a driver's license or identification card may also make a gift by authorizing a statement or symbol indicating that the donor has made an anatomical gift to be imprinted on the donor's driver's license or identification card. Revocation, suspension expiration, or cancellation of a driver's license or identification card upon which an anatomical gift is indicated does not invalidate the gift. You may also authorize your agent to do so or a member of your family may make a gift unless you give them notice **that** you do not want a gift made. An individual may refuse to make an anatomical gift by (1) a writing signed in the same manner as a document of gift, (2) a statement attached to or imprinted on a donor's motor vehicle operator's license, or (3) any other writing used to identify the individual as refusing to make an anatomical gift. During a terminal illness or injury, the refusal may be by any form of communication addressed to at least two adults, at one of whom is a disinterested witness.

You, or someone else authorized to do so, may amend or revoke your gift by signing a record or by a later-executed document of gift that either expressly amends or revokes the previous gift or does so by inconsistency. If the record is not signed by you, it must be witnessed by at least two adults, at least one of whom is a disinterested witness, and state that it has been signed and witnessed.

You may also revoke your gift by the destruction or cancellation of the document of gift, or the portion of the document of gift used to make the gift, with the intent to revoke the gift.

In the space below you may make a gift yourself or state that you do not want to make a gift. If you do not complete this section, your agent will have the authority to make a gift of a part of your body pursuant to law. **The donation elections you make below survive your death.**

ORGAN DONATION  
(OPTIONAL)

CHECK THE  
OPTION THAT  
REFLECTS YOUR  
WISHES

Initial the line next to the statement below that best reflects your wishes. You do not have to initial any of the statements. **If you do not initial any of the statements, your agent and your family will have the authority to make a gift of all or part of your body under Alabama law.**

I do not want to make an organ or tissue donation and I do not want my agent or family to do so.

I have already signed a written agreement or donor card regarding organ and tissue donation with the following individual or institution:

Name of individual / institution: \_\_\_\_\_

Pursuant to Alabama law, I hereby give, effective on my death: (Select one)

Any needed organ or parts.

The following part or organs listed below:

For the following purpose: (Select one)

Any legally authorized purpose.

Transplant or therapeutic purposes only.

CHECK THE  
OPTION THAT  
REFLECTS YOUR  
WISHES. ADD  
PERSONAL  
INSTRUCTIONS, IF  
ANY

Section 5. My signature

Your Name \_\_\_\_\_

The Month, Day, and Year of your birth: \_\_\_\_\_

Your signature: \_\_\_\_\_

Date signed: \_\_\_\_\_

Section 6. Witnesses (need two witnesses to sign)

I am witnessing this form because I believe this person to be of sound mind. I did not sign the person's signature and I am not the health care proxy. I am not related to the person by blood, adoption, or marriage and not entitled to any part of his or her estate. I am at least 19 years of age and am not directly responsible for paying for his or her medical care.

Name of first witness: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Name of second witness: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Section 7. Signature of Proxy

I, \_\_\_\_\_, am willing to serve as the health care proxy.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Signature of second choice for proxy:

I, \_\_\_\_\_, am willing to serve as the health care proxy if the first choice cannot serve.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

PRINT YOUR NAME, THE MONTH, DAY AND YEAR OF YOUR BIRTH

SIGN AND DATE YOUR DOCUMENT

WITNESSING PROCEDURE

WITNESSES MUST SIGN THEIR NAMES

WITNESS #1

WITNESS #2

THE PROXY AND ANY ALTERNATE PROXY MUST PRINT THEIR NAMES AND SIGN AND DATE THE DOCUMENT

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Courtesy of Caring Connections 1731 King St., Suite 100, Alexandria, VA 22314 www.caringinfo.org, 800/658-8898

## You Have Filled Out Your Advance Directive, Now What?

1. Your *Alabama Advance Directive for Healthcare* is an important legal document. Keep the original signed document in a secure but accessible place. Do not put the original document in a safe deposit box or any other security box that would keep others from having access to it.
2. Give photocopies of the signed original to your proxy and alternate proxy, doctor(s), family, close friends, clergy and anyone else who might become involved in your healthcare. If you enter a nursing home or hospital, have photocopies of your document placed in your medical records there. You may also file your advance directive and have it recorded in the office of the judge of probate in the county where you reside for a fee of \$5.00. An advance directive so recorded will not be open to the public, but will be available at the request of emergency medical and hospital personnel, treating physicians, members of immediate family, your healthcare proxy, and any other person you authorize.
3. Be sure to talk to your proxy(s), doctor(s), clergy, family and friends about your wishes concerning medical treatment. Discuss your wishes with them often, particularly if your medical condition changes.
4. If you want to make changes to your documents after they have been signed and witnessed, you must complete a new document.
5. Remember, you can always revoke your Alabama Advance Directive.
6. Be aware that your Alabama document will not be effective in the event of a medical emergency. Ambulance personnel are required to provide cardiopulmonary resuscitation (CPR) unless they are given a separate order that states otherwise. These orders, commonly called "non-hospital do-not-resuscitate orders," are designed for people whose poor health gives them little chance of benefiting from CPR. These orders must be signed by your physician and instruct ambulance personnel not to attempt CPR if your heart or breathing should stop.

Currently not all states have laws authorizing non-hospital do-not-resuscitate orders. We suggest you speak to your physician if you are interested in obtaining this form.

**Caring Connections does not distribute these forms.**

## Appendix A

### Glossary

***Advance directive*** - A general term that describes two kinds of legal documents, living wills and medical powers of attorney. These documents allow a person to give instructions about future medical care should he or she be unable to participate in medical decisions due to serious illness or incapacity. Each state regulates the use of advance directives differently.

***Artificial nutrition and hydration*** – Artificial nutrition and hydration supplements or replaces ordinary eating and drinking by giving a chemically balanced mix of nutrients and fluids through a tube placed directly into the stomach, the upper intestine or a vein.

***Brain death*** – The irreversible loss of all brain function. Most states legally define death to include brain death.

***Capacity*** - In relation to end-of-life decision-making, a patient has medical decision making capacity if he or she has the ability to understand the medical problem and the risks and benefits of the available treatment options. The patient's ability to understand other unrelated concepts is not relevant. The term is frequently used interchangeably with competency but is not the same. Competency is a legal status imposed by the court.

***Cardiopulmonary resuscitation*** - Cardiopulmonary resuscitation (CPR) is a group of treatments used when someone's heart and/or breathing stops. CPR is used in an attempt to restart the heart and breathing. It may consist only of mouth-to-mouth breathing or it can include pressing on the chest to mimic the heart's function and cause blood to circulate. Electric shock and drugs also are used frequently to stimulate the heart.

***Do-Not-Resuscitate (DNR) order*** - A DNR order is a physician's written order instructing healthcare providers not to attempt cardiopulmonary resuscitation (CPR) in case of cardiac or respiratory arrest. A person with a valid DNR order will not be given CPR under these circumstances. Although the DNR order is written at the request of a person or his or her family, it must be signed by a physician to be valid. A non-hospital DNR order is written for individuals who are at home and do not want to receive CPR.

***Emergency Medical Services (EMS)***: A group of governmental and private agencies that provide emergency care, usually to persons outside of healthcare facilities; EMS personnel generally include paramedics, first responders and other ambulance crew.

***Healthcare agent***: The person named in an advance directive or as permitted under state law to make healthcare decisions on behalf of a person who is no longer able to make medical decisions.

**Hospice** - Considered to be the model for quality, compassionate care for people facing a life-limiting illness or injury, hospice and palliative care involve a team-oriented approach to expert medical care, pain management, and emotional and spiritual support expressly tailored to the person's needs and wishes. Support is provided to the persons loved ones as well.

**Intubation**- Refers to "endotracheal intubation" the insertion of a tube through the mouth or nose into the trachea (windpipe) to create and maintain an open airway to assist breathing.

**Life-sustaining treatment** - Treatments (medical procedures) that replace or support an essential bodily function (may also be called life support treatments). Life-sustaining treatments include cardiopulmonary resuscitation, mechanical ventilation, artificial nutrition and hydration, dialysis, and other treatments.

**Living will** - A type of advance directive in which an individual documents his or her wishes about medical treatment should he or she be at the end of life and unable to communicate. It may also be called a "directive to physicians", "healthcare declaration," or "medical directive."

**Mechanical ventilation** - Mechanical ventilation is used to support or replace the function of the lungs. A machine called a ventilator (or respirator) forces air into the lungs. The ventilator is attached to a tube inserted in the nose or mouth and down into the windpipe (or trachea).

**Medical power of attorney** - A document that allows an individual to appoint someone else to make decisions about his or her medical care if he or she is unable to communicate. This type of advance directive may also be called a healthcare proxy, durable power of attorney for healthcare or appointment of a healthcare agent. The person appointed may be called a healthcare agent, surrogate, attorney-in-fact or proxy.

**Palliative care** - A comprehensive approach to treating serious illness that focuses on the physical, psychological, spiritual, and existential needs of the patient. Its goal is to achieve the best quality of life available to the patient by relieving suffering, and controlling pain and symptoms.

**Power of attorney** – A legal document allowing one person to act in a legal matter on another's behalf regarding to financial or real estate transactions.

**Respiratory arrest**: The cessation of breathing - an event in which an individual stops breathing. If breathing is not restored, an individual's heart eventually will stop beating, resulting in cardiac arrest.

***Surrogate decision-making*** - Surrogate decision-making laws allow an individual or group of individuals (usually family members) to make decisions about medical treatments for a patient who has lost decision-making capacity and did not prepare an advance directive. A majority of states have passed statutes that permit surrogate decision making for patients without advance directives.

***Ventilator*** – A ventilator, also known as a respirator, is a machine that pushes air into the lungs through a tube placed in the trachea (breathing tube). Ventilators are used when a person cannot breathe on his or her own or cannot breathe effectively enough to provide adequate oxygen to the cells of the body or rid the body of carbon dioxide.

***Withholding or withdrawing treatment*** - Forgoing life-sustaining measures or discontinuing them after they have been used for a certain period of time.

## Appendix B

### Legal & End-of-Life Care Resources Pertaining to Healthcare Advance Directives

#### LEGAL SERVICES

The Southern Alabama Regional Council on Aging (SARCOA) Area Agency on Aging (AAA) contracts with Davis and Neal, Attorneys at Law to provide services to persons 60 or older.

The services are free for persons with low to moderate incomes.

Individuals over 60 can get legal information and advice about most issues, including:

- *Healthcare*
- *Civil Matters*
- *Nursing Home Abuse*
- *Living Wills / Advance Directives*
- *Legal Assistance and much more*

- You must be 60 or older to receive assistance
- Services are free, however a donation is encouraged but not mandatory

#### To find out more information about the services contact:

Clayton Davis, Attorney at Law  
(334) 671-3990 or (888) 671-5246  
3355 N. Oates Street, Dothan, Alabama, 36303

#### END-OF-LIFE SERVICES

Older Alabamians can get in contact with the Area Agency on Aging to find out about other services including, but not limited to:

- Home delivered meals
- Transportation
- Home Healthcare
- Adult Daycare
- Legal Assistance
- Housing and other services offered

**For more information on other services and to locate an agency in your region call:**  
1-800-243-5463

**OR**

**Click on the following link:** <http://www.adss.state.al.us/aaa.cfm>