ARKANSAS
Advance Directive
Planning for Important Healthcare Decisions

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

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

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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, please read all the instructions.
    - Your state-specific advance directive forms, which are the pages with the gray instruction bar on the left side.

ACTION STEPS

3. You may want to photocopy these forms before you start so you will have a clean copy if you need to start over.

4. When you begin to fill out the forms, refer to the gray instruction bars - they will guide you through the process.

5. 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.

6. Once the form is completed and signed, photocopy the form and give it to the person you have appointed to make decisions on your behalf, your family, friends, healthcare providers and/or faith leaders so that the form is available in the event of an emergency.

Introduction to Your Arkansas Advance Directive

This packet contains two legal documents that protect 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.

1. The **Arkansas Declaration** is your state's living will. It allows you to state your wishes about medical care in the event that you either: (1) develop a terminal condition and are unable to make your own medical decisions; or (2) you are in a permanently unconscious state. The Declaration becomes effective when you are in either of these states, your doctor and one other doctor has determined you are in such a state, and the Declaration has been communicated to your doctor.

The Declaration lets you name a Health Care Proxy to make decisions about your medical care—including decisions about life support — if you can no longer make your own decisions about healthcare. Your proxy can only make decisions for you if you become terminally ill or permanently unconscious.

2. The **Arkansas Durable Power of Attorney for Healthcare** lets you name someone to make decisions about your medical care any time you lose the ability to make medical decisions yourself.

Note: These documents will be legally binding only if the person completing them is a competent adult (at least 18 years old).

Instructions for Completing Your Arkansas Declaration

How do I make my Arkansas Declaration legal?

The law requires that you sign your Declaration in the presence of two witnesses, who must also sign to show that you voluntarily signed the documents.

Whom should I appoint as my Healthcare Proxy?

In your Declaration, you may designate a Health Care Proxy. Your Health Care Proxy is the person you appoint to make decisions about your medical care if you become permanently unconscious or are both terminally ill and unable to make decisions for yourself. Your Healthcare Proxy can be a family member or a close friend whom you trust to make serious decisions.

The person you name as your Healthcare Proxy must be 18 years old or older, clearly understand your wishes and be willing to accept the responsibility of making medical decisions for you. (A proxy may also be called an "agent" or "attorney-in-fact.")

Can I add personal instructions to my Declarations?

Yes. You can add personal instructions in the section called "Other directions."

What if I change my mind?

You may revoke a Declaration at any time and in any manner, regardless of your mental or physical condition. Your revocation becomes effective when you (or a witness to your revocation) notify your doctor or other healthcare provider, who must then make the revocation a part of your medical record.

What other important facts should I know?

Due to restrictions in the state law, a pregnant patient's Arkansas Declaration will not be honored if it is possible that the fetus could develop to the point of live birth with continued application of life-sustaining treatment.

Instructions for Completing Your Arkansas Declaration (continued)

What facts about organ donation should I know?

Who may receive your anatomical gift
Under Arkansas law, you may make a gift of all or part of your body for transplantation, therapy, research, or education to any of the following entities: a tissue or eye bank or any other organ procurement organization; hospital; accredited medical school, dental school, college, or university; or any individual designated as the recipient by you.

How you can make a gift
You can use the Arkansas Declaration form to make a donation. You can also donate your organs in any of these other ways: (1) by authorizing a statement indicating your intent to donate in your driver's license application; (2) by signing a donor card; (3) by indicating in a will; or (4) by making any statement to at least two adults, at least one of whom is a disinterested witness (i.e. not a family member nor potential recipient of the gift).

How others can make a gift for you
Unless you explicitly prohibit such gifts in your Declaration or other signed document, your attorney for health care (or, if you did not designate such a person, a family member) has the authority to make anatomical gifts on your behalf.

How to refuse to make a gift
You can refuse to make an anatomical gift by making such a statement in your Declaration.

You can also refuse to make a gift in any of these other ways: (1) any writing signed by you refusing to make such donations; (2) in your will; or (3) during a terminal illness or injury, you communicate such refusal to at least two adults, at least one of whom is a disinterested witness (i.e. not a family member nor potential recipient of your donation.)

Revocation suspension, expiration or cancellation of a driver's license on which you noted consent to make a gift does not invalidate your gift.

How to revoke or amend a gift
You can revoke or amend an anatomical gift by: (1) any writing signed by you revoking or amending such gift that is witnessed by at least two adults, at least one of whom is a disinterested witness (i.e. not a family member nor potential recipient of your donation); (2) 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. If the gift was not made in a will, you may revoke or amend it by any form of communication during a terminal illness or injury addressed to at least two adults, at least one of whom is a disinterested witness.

Completing Your Arkansas Durable Power of Attorney for Healthcare

Whom should I appoint as my Healthcare Power of Attorney?

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

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

How do I make my Arkansas Durable Power of Attorney for Healthcare legal?

The law requires that you sign your Durable Power of Attorney for Healthcare in the presence of two witnesses who are at least eighteen (18) years of age.

Should I add personal instructions to my Arkansas Durable Power of Attorney for Healthcare?

One of the strongest reasons for naming a healthcare power of attorney is to have someone who can respond flexibly as your medical situation changes and deal with situations that you did not foresee. If you add instructions to this document, you might unintentionally restrict your healthcare power of attorney's power to act in your best interest.

Talk with your healthcare power of attorney about your future medical care and describe what you consider to be an acceptable "quality of life". If you want to record your wishes about specific treatments or conditions, you should use your Arkansas Declaration (the living will).

What if I change my mind?

Although state law does not specifically list ways by which you may revoke your Durable Power of Attorney for Healthcare, you may revoke your Durable Power of Attorney for Healthcare at any time by executing a new Durable Power of Attorney for Healthcare or by otherwise specifying in writing that you wish to revoke it.

INSTRUCTIONS

INITIAL THE OPTION(S) THAT REFLECT YOUR WISHES

ADD PERSONAL INSTRUCTIONS (IF ANY)

PRINT THE NAME OF YOUR PROXY

SIGN AND DATE THE DOCUMENT AND PRINT YOUR ADDRESS

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ARKANSAS DECLARATION - PAGE 1 OF 2

If I should either (1) have an incurable or irreversible condition that will cause my death within a relatively short time, and I am no longer able to make decisions regarding my medical treatment; or (2) if I should become permanently unconscious, I direct my attending physician, pursuant to the Arkansas Rights of the Terminally Ill or Permanently Unconscious Act, to withhold or withdraw treatments that only prolong the process of dying and are not necessary to my comfort or to alleviate pain.

In addition, the following specific directives apply (initial the option(s) that apply):

a. It is my specific directive that nutrition may be withheld after consultation with my attending physician.
b. It is my specific directive that hydration may be withheld after consultation with my attending physician.
c. It is my specific directive that nutrition may not be withheld.
d. It is my specific directive that hydration may not be withheld.

Other Directions:

I direct my attending physician, pursuant to the Arkansas Rights of the Terminally Ill or Permanently Unconscious Act, to follow the instructions of

____
(name of proxy)

whom I appoint as my Health Care Proxy to make medical treatment decisions on my behalf, including whether life-sustaining treatment should be withheld or withdrawn.

Signed this ______________ day of __________________, __________.
(day) (month) (year)

Signature ____

Address____

____

ORGAN DONATION (OPTIONAL)

INITIAL THE OPTION THAT REFLECTS YOUR WISHES

ADD NAME OR INSTITUTION (IF ANY)

PRINT YOUR NAME, SIGN, AND DATE THE DOCUMENT

WITNESSING PROCEDURE

YOUR WITNESSES MUST SIGN AND PRINT THEIR ADDRESSES

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ORGAN DONATION (OPTIONAL)

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 attorney for health care or other agent, or your family, may have the authority to make a gift of all or part of your body under Arkansas 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 Arkansas law, I hereby give, effective on my death:

_____ Any needed organ or parts.

_____ The following part or organs listed below:

For (initial one):

_____ Any legally authorized purpose.

_____ Transplant or therapeutic purposes only.

Declarant name: ____

Declarant signature: _________________________, Date: ____________

The declarant voluntarily signed or directed another person to sign this writing in my presence.

Witness ____

Address ____

____

Witness ____

Address ____

____

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INSTRUCTIONS	ARKANSAS DURABLE POWER OF ATTORNEY FOR HEALTH CARE - PAGE 1 OF 2
PRINT YOUR NAME	I, ______________________________, hereby (your name) appoint:
PRINT NAME, HOME ADDRESS, AND TELEPHONE NUMBER OF YOUR AGENT	______________________________ (name, home address and telephone number of agent) ______________________________
	as my health care agent to make any and all health care decisions for me, except to the extent that I state otherwise. This Durable Power of Attorney for Health Care shall take effect in the event I become unable to make my own health care decisions. My health care agent and any alternate health care agent as appointed below shall have the authority to make all health care decisions regarding any care, treatment, service, or procedure to maintain, diagnose, treat, or provide for my physical or mental health or personal care. If I should either (1) have an incurable or irreversible condition that will cause my death within a relatively short time and I am no longer able to make decisions regarding my medical treatment; or (2) if I should become permanently unconscious, my health care agent and any alternate health care agent shall also have the authority to make decisions regarding the providing, withholding or withdrawing of life sustaining treatment pursuant to the Arkansas Rights of the Terminally Ill or Permanently Unconscious Act.
ADD PERSONAL INSTRUCTIONS (IF ANY)	Optional Instructions:
PRINT NAME, HOME ADDRESS, AND TELEPHONE NUMBER OF YOUR ALTERNATE AGENT	If the health care agent I appoint is unable, unwilling or unavailable to act as my health care agent, then I appoint: ______________________________ (name, home address and telephone number of alternate agent) ______________________________ as my alternate health care agent.

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ARKANSAS DURABLE POWER OF ATTORNEY FOR HEALTH CARE - PAGE 2 OF 2

SIGN AND DATE THE DOCUMENT AND PRINT YOUR ADDRESS

Signed this __________ day of ______________________, ______________.
(day) (month) (year)

Signature____

Address ____

____

WITNESSING PROCEDURE

Statement by Witnesses (must be 18 or older):
I declare that the person who signed this document appeared to execute the durable power of attorney for health care willingly and free from duress. He or she signed (or asked another to sign for him or her) this document in my presence.

YOUR WITNESSES MUST SIGN AND PRINT THEIR NAMES AND ADDRESSES

Witness ____
(Sign and Print name)

Address ____

____

Witness ____
(Sign and Print name)

Address ____

____

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You Have Filled Out Your Advance Directive, Now What?

1. Your Arkansas Declaration and Durable Power of Attorney for healthcare are important legal documents. Keep the original signed documents in a secure but accessible place. Do not put the original documents in a safe deposit box or any other security box that would keep others from having access to them.

2. Give photocopies of the signed originals to your agent, alternate agent, 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 documents placed in your medical records.

3. Be sure to talk to your proxy, agent, doctor(s), clergy, and 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 document after it has been signed and witnessed, you must complete new documents.

5. Remember, you can always revoke your Arkansas Declaration and Durable Power of Attorney for healthcare.

6. Be aware that your Arkansas documents will not be effective in the event of a medical emergency. Ambulance personnel are required to provide cardiopulmonary resuscitation (CPR) unless they are presented with either an Emergency Medical Services Do Not Resuscitate Order entered on a form approved by the Arkansas Department of Health or with a Do Not Resuscitate identification approved by the Arkansas Department of Health. The Emergency Medical Services Do Not Resuscitate Orders and Identification are designed for people whose poor health gives them little chance of benefiting from CPR. The Emergency Medical Services Do Not Resuscitate Order must be signed by your physician and instruct ambulance personnel not to attempt CPR if your heart or breathing should stop. Ambulance personnel may follow these orders only with respect to adult patients.

   Currently not all states have laws authorizing non-hospital do-not-resuscitate orders. We suggest you speak to your physician for more information. **Caring Connections does not distribute these forms.**