NEW JERSEY
Advance Directive
Planning for Important Health Care Decisions

CaringInfo
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CARINGINFO

CaringInfo, 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.

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 health care providers
Engage in personal or community efforts to improve end-of-life care

Note: The following is not a substitute for legal advice. While CaringInfo updates the following information and form to keep them up-to-date, changes in the underlying law can affect how the form will operate in the event you lose the ability to make decisions for yourself. If you have any questions about how the form will help ensure your wishes are carried out, or if your wishes do not seem to fit with the form, you may wish to talk to your health care provider or an attorney with experience in drafting advance directives.

Using these Materials

BEFORE YOU BEGIN

1. Check to be sure that you have the materials for each state in which you may receive health care.

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

1. You may want to photocopy or print a second set of these forms before you start so you will have a clean copy if you need to start over.

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

3. 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.

4. 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, health care providers and/or faith leaders so that the form is available in the event of an emergency.

5. You may also want to save a copy of your form in an online personal health records application, program, or service that allows you to share your medical documents with your physicians, family, and others who you want to take an active role in your advance care planning.

Introduction to Your New Jersey Advance Directive

This packet contains a legal document, a **New Jersey Advance Directive**, that 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. You may fill out Part I, Part II, or both, depending on your advance planning needs. You must complete Part III.

Part I is the **New Jersey Proxy Declaration.** This part lets you name an adult, called your health care representative, or representative, to make decisions about your health care—including decisions about life-sustaining treatments—if you can no longer speak for yourself.

Part II is a **New Jersey Instruction Declaration**, which is your state's living will. Part II lets you state your wishes regarding health care decisions in the event that you can no longer make your own.

Part III contains the signature and witnessing provisions so that your document will be effective.

Your advance directive goes into effect when your doctor and one other doctor determine in writing that you are no longer able to understand and appreciate the nature and consequences of your health care decisions and you are no longer able to reach an informed health care decision.

This form does not expressly address mental illness. If you would like to make advance care plans regarding mental illness, you should talk to your physician and an attorney about a durable power of attorney tailored to your needs.

Note: These documents will be legally binding only if the person completing them is a competent adult who is at least 18 years of age.

Instructions Completing Your Advance Directive for Health care

How do I make my *Advance Directive for Health Care* legal?

You must sign and date your document, or direct another to sign and date it:

1. in the presence of two witnesses who must be at least 18 years of age. These witnesses must also sign the document to show that they believe you to be of sound mind, that you voluntarily signed the document, and that they are not your appointed health care representative or alternate health care representative;

OR

2. before a notary public, an attorney at law, or another person authorized to administer oaths.

Can I add personal instructions to my Living Will?

One of the strongest reasons for naming a representative is to have someone who can respond flexibly as your health care situation changes and deal with situations that you did not foresee. If you add instructions to this document it may help your representative carry out your wishes, but be careful that you do not unintentionally restrict your representative's power to act in your best interest. In any event, be sure to talk with your representative about your future medical care and describe what you consider to be an acceptable "quality of life."

Whom should I appoint as my representative?

Your representative is the person you appoint to make decisions about your health care if you become unable to make those decisions yourself. Your representative may be a family member or a close friend whom you trust to make serious decisions. The person you name as your representative should clearly understand your wishes and be willing to accept the responsibility of making health care decisions for you.

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

You **cannot** appoint an operator, administrator, or employee of your treating health care institution, unless he or she is related to you by blood, marriage, domestic partnership, or adoption. However, you can appoint a physician so long as he or she is not serving as your attending physician at the same time.

What if I change my mind?

You may revoke your Advance Directive, or any part of it, at any time by:

- Announcing your revocation either orally or in writing to your health care representative, your doctor or other health care provider, or a reliable witness,
- Performing any other act that demonstrates your intent to revoke the document, or
- Executing a subsequent Advance Directive.

If you designate your spouse as your representative, his or her authority is automatically revoked upon divorce or legal separation, unless you specify otherwise in the "further instructions" section of the Advance Directive. If you designate your domestic partner, his or her authority is automatically revoked upon termination of your domestic partnership, unless otherwise specified in the "further instructions" section of the Advance Directive.

What other important facts should I know?

If you are female, you may include instructions specific to your pregnancy in the event that you are pregnant when your Advance Directive goes into effect.

PART I

PRINT YOUR NAME

PRINT THE NAME, ADDRESS AND HOME AND WORK TELEPHONE NUMBERS OF YOUR HEALTH CARE REPRESENTATIVE

PRINT THE NAME, ADDRESS, AND TELEPHONE NUMBER OF YOUR FIRST ALTERNATE HEALTH CARE REPRESENTATIVE

PART I: PROXY DIRECTIVE

I, _____, hereby appoint:
(your name)

_____
(name of health care representative)

_____
(address of health care representative)

_____

_____ (home phone number)

_____ (work phone number)

to be my health care representative to make any and all health care decisions for me, including decisions to accept or to refuse any treatment, service or procedure used to diagnose or treat my physical or mental condition, and decisions to provide, withhold or withdraw life-sustaining treatment. I direct my health care representative to make decisions on my behalf in accordance with my wishes as stated in this document, or as otherwise known to him or her. In the event my wishes are not clear or if a situation arises that I did not anticipate, my health care representative is authorized to make decisions in my best interests.
If the person I have designated above is unable, unwilling or unavailable to act as my health care representative, I hereby designate the following person(s) to act as my health care representative, in the following order of priority:

1. Name _____

Address _____

City _____ State _____

Telephone _____

PRINT THE NAME, ADDRESS AND TELEPHONE NUMBER OF YOUR SECOND ALTERNATE HEALTH CARE REPRESENTATIVE

2. Name _____

Address _____

City _____ State _____

Telephone _____

I direct that my health care representative comply with the following instructions and/or limitations (optional):

ADD ADDITIONAL INSTRUCTIONS, IF ANY

_____

_____

_____

_____

_____

_____

(use additional pages if necessary)

ADD INSTRUCTIONS, IF ANY, TO BE FOLLOWED IN THE EVENT YOU ARE PREGNANT

I direct that my health care representative comply with the following instructions in the event that I am pregnant when this Directive becomes effective (optional):

_____

_____

_____

_____

_____

(use additional pages if necessary)

PART II

PART II. INSTRUCTION DIRECTIVE

In Part II, you are asked to provide instructions concerning your future health care. This will require making important and perhaps difficult choices. Before completing your directive, you should discuss these matters with your health care representative, doctor and family members or others who may become responsible for your care.

In the sections below, you may state the circumstances in which various forms of medical treatment, including life-sustaining measures, should be provided, withheld or discontinued. If the options and choices below do not fully express your wishes, you should use the "Further Instructions" section below, and/or attach a statement to this document which would provide those responsible for your care with additional information you think would help them in making decisions about your medical treatment. **Please familiarize yourself with all sections of Part II before completing your directive.**

General Instructions.
To inform those responsible for my care of my specific wishes, I make the following statement of personal views regarding my health care.

Initial ONE of the following two statements with which you agree:

INITIAL ONLY ONE

1. _____I direct that all medically appropriate measures be provided to sustain my life regardless of my physical or mental condition.

IF YOU INITIAL STATEMENT 2, YOU MUST SPECIFY WHEN YOU WOULD LIKE TO FOREGO LIFE-SUSTAINING MEASURES ON THE FOLLOWING PAGES

2. _____ There are circumstances in which I would not want my life to be prolonged by further medical treatment. In these circumstances, life-sustaining measures should not be initiated and if they have been, they should be discontinued. I recognize that is likely to hasten my death. In the following, I specify the circumstances in which I would choose to forego life-sustaining measures.

If you have initialed statement 2, on the following page please initial each of the statements (a, b, c) with which you agree:

INITIAL EACH LETTERED STATEMENT (A, B, AND/OR C) THAT REPRESENTS WHEN YOU WOULD LIKE TO FOREGO LIFE-SUSTAINING MEASURES

IF YOU INITIALED STATEMENT A, INDICATE WHAT YOU CONSIDER TO BE A TERMINAL CONDITION THAT WILL JUSTIFY THE WITHHOLDING OR DISCONTINUING OF LIFE-SUSTAINING MEASURES

a. _____I realize that there may come a time when I am diagnosed as having an incurable and irreversible illness, disease, or condition. If this occurs, and my attending physician and at least one additional physician who has personally examined me determine that my condition is terminal, I direct that life-sustaining measures which would serve only to artificially prolong my dying be withheld or discontinued. I also direct that I be given all medically appropriate care necessary to make me comfortable and relieve pain. To me, terminal condition means that my physicians have determined that:

____ I will die within a few days, or
____ I will die within a few weeks, or
____ I have a life expectancy of approximately _____or less (enter 6 months or 1 year)

b. ____If there should come a time when I become permanently unconscious, and it is determined by my attending physician and at least one additional physician with appropriate expertise who has personally examined me, that I have totally and irreversibly lost consciousness and my capacity for interaction with other people and my surroundings, I direct that life-sustaining measures be withheld or discontinued. I understand that I will not experience pain or discomfort in this condition, and I direct that I be given all medically appropriate care necessary to provide for my personal hygiene and dignity.

c. ____I realize that there may come a time when I am diagnosed as having an incurable and irreversible illness, disease, or condition which may not be terminal. My condition may cause me to experience severe and progressive physical or mental deterioration and/or a permanent loss of capacities and faculties I value highly. If, in the course of my medical care, the burdens of continued life with treatment become greater that the benefits I experience, I direct that life-sustaining measures be withheld or discontinued. I also direct that I be given all medically appropriate care necessary to make me comfortable and to relieve pain.

(Paragraph c. covers a wide range of possible situations in which you may have experienced partial or complete loss of certain mental or physical capacities you value highly. If you wish, in the space provided below you may specify in more detail the conditions in which you would choose to forego life-sustaining measures. You might include a description of the faculties or capacities, which, if irretrievably lost would lead you to accept death rather than continue living. You may want to express any special concerns you have about particular medical conditions or treatments, or any other considerations, which would provide further guidance to those

who may become responsible for your care. If necessary, you may attach a separate statement to this document or provide your wishes in the "Further Instructions" section, below.)

IF YOU INITIALED STATEMENT C, ABOVE, YOU MAY LIST CONDITIONS THAT YOU FIND UNNACCEPTABLE AND WOULD JUSTIFY THE WITHHOLDING OR DISCONTINUING OF LIFE-SUSTAINING MEASURES

Examples of conditions that I find unacceptable are:

_____
_____
_____
_____
_____
_____

Specific Instructions: Artificially Provided Fluids and Nutrition; Cardiopulmonary Resuscitation (CPR).

On page 4, above, you provided general instructions regarding life-sustaining measures. Here you are asked to give specific instructions regarding two types of life-sustaining measures—artificially provided fluids and nutrition and cardiopulmonary resuscitation.

In the space provided, initial the phrase with which you agree:

INITIAL YOUR PREFERENCE REGARDING ARTIFICIALLY PROVIDED FLUIDS AND NUTRITION (FOOD AND DRINK)

1. In the circumstances I initialed on page 4, I also direct that artificially provided fluids and nutrition, such as feeding tube or intravenous infusion,

____ be withheld or withdrawn and that I be allowed to die, or

____ be provided to the extent medically appropriate.

INITIAL YOUR PREFERENCE REGARDING CPR

2. In the circumstances I initialed on page 4, if I should suffer a cardiac arrest, I also direct that cardiopulmonary resuscitation (CPR)

____ not be provided and that I be allowed to die, or

____ be provided to preserve my life, unless medically inappropriate or futile.

YOU MAY ADD FURTHER INSTRUCTIONS REGARDING ARTIFICIALLY PROVIDED FLUIDS AND NUTRITION OR CPR HERE

3. If neither of the above statements adequately expresses your wishes concerning artificially provided fluids and nutrition or CPR, please explain your wishes below.

_____
_____
_____
_____
_____
_____

BRAIN DEATH:
The State of New Jersey has determined that an individual may be declared legally dead when there has been an irreversible cessation of all functions of the entire brain, including the brain stem (also known as whole brain death). However, individuals who do not accept this definition of brain death because of their personal religious beliefs may request that it not be applied in determining their death.

INITIAL HERE IF YOU HAVE AN OBJECTION TO NEW JERSEY'S BRAIN DEATH DEFINITION

Initial the following statement only if it applies to you:

____ To declare my death on the basis of the whole brain death standard would violate my personal religious beliefs. I therefore wish my death to be declared only when my heartbeat and breathing have irreversibly stopped.

ORGAN DONATION (OPTIONAL)
(It is now possible to transplant human organs and tissue in order to save and improve the lives of others. Organs, tissues, and other body parts are also used for therapy, medical research and education. This section allows you to indicate your desire to make an anatomical gift and if so, to provide instructions for any limitations or special uses.)

ORGAN DONATION (OPTIONAL)

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

OR

INITIAL THE STATEMENT THAT BEST REFLECTS YOUR WISHES

_____ Upon my death, I wish to donate:

_____ My body for anatomical study if needed.
_____ Any needed organs, tissues, or eyes.
_____ Only the following organs, tissues, or eyes:
_____
_____

I authorize the use of my organs, tissues, or eyes:
_____ For transplantation
_____ For therapy
_____ For research
_____ For medical education
_____ For any purpose authorized by law.

ADD OTHER INSTRUCTIONS, IF ANY, REGARDING YOUR ADVANCE CARE PLANS

THESE INSTRUCTIONS CAN FURTHER ADDRESS YOUR HEALTH CARE PLANS, SUCH AS YOUR WISHES REGARDING HOSPICE TREATMENT, BUT CAN ALSO ADDRESS OTHER ADVANCE PLANNING ISSUES, SUCH AS YOUR BURIAL WISHES

ATTACH ADDITIONAL PAGES IF NEEDED

FURTHER INSTRUCTIONS:

PART III

PART III: EXECUTION

This advance directive will not be valid unless it is EITHER:

USE ALTERNATIVE NO. 1 IF YOU PLAN TO SIGN BEFORE WITNESSES (P. 9)

Signed in the presence of two witnesses who must be at least 18 years of age. These witnesses must also sign the document to show that they believe you to be of sound mind, that you voluntarily signed the document, and that they are not your appointed health care representative or alternate health care representative (use Alternative No. 1 if you plan to sign before witnesses);

OR

USE ALTERNATIVE NO. 2 IF YOU PLAN TO HAVE YOUR SIGNATURE NOTARIZED (P. 10)

Signed before a notary public, an attorney at law, or another person authorized to administer oaths (use Alternative No. 2 if you plan to have your signature notarized).

Alternative No. 1.

By writing this advance directive, I inform those who may become responsible for my health care of my wishes and intend to ease the burdens of decision making which this responsibility may impose. I have discussed the terms of this designation with my health care representative(s) and my representative(s) has/have willingly agreed to accept the responsibility for acting on my behalf in accordance with this directive and my wishes. I understand the purpose and effect of this document and sign it knowingly, voluntarily and after careful deliberation.

SIGN AND DATE YOUR DOCUMENT AND PRINT YOUR ADDRESS

Signed this _____ day of _____ 20_____.

Signature _____

Address _____

City _____ State _____

I declare that the person who signed this document or asked another to sign this document on his or her behalf, did so in my presence and he or she appears to be of sound mind and free of duress or undue influence. I am 18 years of age or older, and am not designated by this or any other document as the person's health care representative or alternate health care representative.

YOUR WITNESSES MUST PRINT THEIR NAMES AND ADDRESSES AND SIGN AND DATE HERE

1. Witness _____

Address _____

City _____ State _____

Signature _____ Date _____

2. Witness _____

Address _____

City _____ State _____

Signature _____ Date _____

Alternative No. 2.

By writing this advance directive, I inform those who may become responsible for my health care of my wishes and intend to ease the burdens of decision making which this responsibility may impose. I have discussed the terms of this designation with my health care representative(s) and my representative(s) has/have willingly agreed to accept the responsibility for acting on my behalf in accordance with this directive and my wishes. I understand the purpose and effect of this document and sign it knowingly, voluntarily and after careful deliberation.

Signed this _____ day of _____ 20_____.

SIGN AND DATE YOUR DOCUMENT AND PRINT YOUR ADDRESS

Signature _____

Address _____

City _____ State _____

Notary, Attorney at Law, or other person authorized to administer oaths

On _____, before me came
(date)

_____,
(name of declarant)

A NOTARY PUBLIC OR ATTORNEY AT LAW SHOULD COMPLETE THIS SECTION

whom I know to be such person, and the declarant did then and there execute this declaration.

Sworn before me this _____ day of _____, 20 _____.

_____
Signature of: (check one)

_____Notary Public
_____ Attorney at Law

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

You Have Filled Out Your Health Care Directive, Now What?

1. Your *New Jersey Advance Directive* 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 representative and alternate representative, doctor(s), family, close friends, clergy, and anyone else who might become involved in your health care. If you enter a nursing home or hospital, have photocopies of your document placed in your medical records.

3. Be sure to talk to your representative(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. You may also want to save a copy of your form in an online personal health records application, program, or service that allows you to share your medical documents with your physicians, family, and others who you want to take an active role in your advance care planning.

5. If you want to make changes to your documents after they have been signed and witnessed, you must complete a new document.

6. Remember, you can always revoke your New Jersey document.

7. Be aware that your New Jersey document will not be effective in the event of a medical emergency. Ambulance and hospital emergency department personnel are required to provide cardiopulmonary resuscitation (CPR) unless they are given a separate directive that states otherwise. These directives called "prehospital medical care directives" or "do not resuscitate orders" are designed for people whose poor health gives them little chance of benefiting from CPR. These directives instruct ambulance and hospital emergency personnel not to attempt CPR if your heart or breathing should stop.

   Currently not all states have laws authorizing these orders. We suggest you speak to your physician if you are interested in obtaining one. **CaringInfo does not distribute these forms.**

Congratulations!

You've downloaded **your free, state specific advance directive.**

You are taking important steps to make sure your wishes are known. Help us keep this free.

Your generous support of the National Hospice Foundation and CaringInfo allows us to continue to provide these FREE resources, tools, and information to educate and empower individuals to access advance care planning, caregiving, hospice and grief services, and information.

I hope you will show your support for our mission and make a tax-deductible gift today.

Since 1992, the National Hospice Foundation has been dedicated to creating FREE resources for individuals and families facing a life-limiting illness, raising awareness for the need for hospice care, and providing ongoing professional education and skills development to hospice professionals across the nation.

Your gift strengthens the Foundation's ability to provide FREE caregiver and family resources.

Support your National Hospice Foundation by returning a **generous tax-deductible gift of $23, $47, $64,** or the most generous amount you can send.

You can help us provide resources like this advance directive FREE by sending in your gift to help others.

Please help to make this possible with your contribution! Cut along the dotted line and use the coupon below to return a check contribution of the most generous amount you can send. Thank you.

- -

YES! I want to support the important work of the National Hospice Foundation.

$23	helps us provide free advance directives
$47	helps us maintain our free InfoLine
$64	helps us provide webinars to hospice

Return to:
National Hospice Foundation
PO Box 824401
Philadelphia, PA 19182-4401

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OR donate online today: www.caringinfo.org/donate