ALABAMA
Advance Directive
Planning for Important Healthcare Decisions

Courtesy of CaringInfo
www.caringinfo.org

CaringInfo, a program of the National Alliance for Care at Home (the Alliance), is a national consumer engagement initiative to improve care and the experience of caregiving during serious illness and at the end of life. As part of that effort, CaringInfo provides detailed guidance for completing advance directive forms in all 50 states, the District of Columbia, and Puerto Rico.

This package includes:

- 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.

BEFORE YOU BEGIN

Check to be sure that you have the materials for each state in which you may receive healthcare. Because documents are state-specific, having a state-specific document for each state where you may spend significant time can be beneficial. A new advance directive is not necessary for ordinary travel into other states. The advance directives in this package will be legally binding only if the person completing them is a competent adult who is 19 years of age or older, or an emancipated minor.

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, scan, or take a photo of 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.

5. You may also want to save a copy of your form in your electronic healthcare record, or 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 ALABAMA ADVANCE HEALTH CARE DIRECTIVE

This packet contains an Alabama Advance Directive for Health Care 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. This document is in substantially the same form as set forth in the Alabama Natural Death Act.

Section 1 of this document is your state's **Living Will**. It lets you discuss your wishes about medical care in the event that you are permanently unconscious or develop a terminal condition and can no longer make your own medical decisions.

Section 2 of this document permits the appointment of a **Health Care 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.

Section 3 explains some of the limitations of this document and allows you to list the people you want your doctor to talk to if the time comes for you to stop receiving life-sustaining treatment.

Section 4 of this document is an optional organ donation form that will allow you to make or refuse to make a donation of your organs and tissues.

Section 5 is for your signature. Your advance directive must be signed in the presence of two witnesses.

Section 6 is a proxy signature form. Alabama law requires that your proxy accept his or her role in writing. If your proxy is unavailable to sign this document immediately, a copy of the entire form should be mailed to the proxy, who should then return a signed copy of the proxy signature page.

How do I make my Alabama Advance Health Care Directive 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.

Your witnesses **cannot** be:

- your appointed health care 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,
- directly financially responsible for your medical care, or
- the person who signed your document on your behalf.

These witnesses must also sign the document to show that they personally know you, believe you to be of sound mind, and that they do not fall into any of the categories of people who cannot be witnesses.

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

Whom should I appoint as my proxy?

Your proxy is the person you appoint to make decisions about your healthcare if you become unable to make those decisions yourself. 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 healthcare decisions for you.

Should I add personal instructions to my advance directive?

Yes! One of the most important reasons to execute an advance directive is to have your voice heard. When you name a proxy and clearly communicate to them what you want and don't want, they are in the strongest position to advocate for you. Because the future is unpredictable, be careful that you do not unintentionally restrict your proxy's power to act in your best interest. Be especially careful with the words "always" and "never." In any event, be sure to talk with your proxy and others about your future healthcare and describe what you consider to be an acceptable "quality of life."

When does my proxy's authority become effective?

Your Alabama advance directive for health care goes into effect when your doctor determines that you are no longer able to understand, appreciate, and direct your medical treatment, and your doctor and one other doctor experienced in making the diagnosis determine that you are permanently unconscious or terminally ill and document such diagnosis in your medical record.

You retain the primary authority for your healthcare decisions as long as you are able to make your wishes known.

Proxy Limitations

Your proxy, if you appoint one, does not have authority to authorize psychosurgery, sterilization, or abortion—unless it is necessary to save your life—or to have you involuntarily hospitalized or treated for mental illness.

The directions of a pregnant patient's Alabama Advance Directive for Health Care 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 and your proxy will be bound by the current laws of Alabama as they regard pregnancy and termination of pregnancies.

What if I change my mind?

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

- obliterating, burning, tearing or otherwise destroying or defacing the document,
- executing, or directing another person to execute, a signed and dated written revocation (formal statement that you have changed your mind), or
- orally expressing your intent to revoke the Advance Directive for Health Care 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.

Mental Health Issues

These forms do not *expressly* address mental illness, although you can state your wishes and grant authority to your proxy regarding mental health issues. The National Resource Center on Psychiatric Advance Directives maintains a website (https://nrc-pad.org/) with links to each state's psychiatric advance directive forms. If you would like to make more detailed advance care plans regarding mental illness, you could talk to your physician and an attorney about a durable power of attorney tailored to your needs.

What other important facts should I know?

Be aware that your advance directive will not be effective in the event of a medical emergency, except to identify your proxy. Ambulance and hospital emergency department personnel are required to provide cardiopulmonary resuscitation (CPR) unless you have a separate physician's order, which are typically called "prehospital medical care directives" or "do not resuscitate orders." DNR forms may be obtained from your state health department or department of aging (https://www.hhs.gov/aging/state-resources/index.html). Another form of orders regarding CPR and other treatments are state-specific POLST (portable orders for life sustaining treatment) (https://polst.org/form-patients/). Both a POLST and a DNR form MUST be signed by a healthcare provider and MUST be presented to the emergency responders when they arrive. These directives instruct ambulance and hospital emergency personnel not to attempt CPR (or to stop it if it has begun) if your heart or breathing should stop.

INSTRUCTIONS

PRINT YOUR NAME

PLACE YOUR INITIALS BY EITHER YES OR NO

PLACE YOUR INITIALS BY EITHER YES OR NO

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_____

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

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:

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

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_____

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

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

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

_____No, I do not have other directions.

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

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.

This Section 2 creates a power of attorney that shall become effective upon the disability, incompetence, or incapacity of the principal, and is in substantially the same form as set forth in the Alabama Natural Death Act.

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:_____

INITIAL
YES OR NO

PLACE YOUR INITIALS BEFORE ONE OF THE THREE OPTIONS

LIST THE PEOPLE YOU WOULD WANT YOUR DOCTOR TO TALK WITH

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 that 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:

_____

_____

_____

ORGAN DONATION (OPTIONAL)

Section 4.

ORGAN DONATION (OPTIONAL)

In the space below you may make a gift yourself or state that you do not want to make a gift. **The donation elections you make below survive your death.**

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 proxy and your family will have the authority to make a gift of all or part of your body under Alabama law.**

CHECK THE OPTION THAT REFLECTS YOUR WISHES

_____ I do not want to make an organ or tissue donation and I do not want my proxy 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:

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

For the following purpose: (Select one)

_____ Any legally authorized purpose.

_____Transplant or therapeutic purposes only.

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

Section 5. Execution

My signature

Your Name_____

The Month, Day, and Year of your birth: _____

Your signature:_____

Date signed:_____

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:_____

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

IF EITHER PROXY IS UNAVAILABLE TO SIGN THIS DOCUMENT IMMEDIATELY, A COPY OF THE ENTIRE FORM SHOULD BE MAILED TO THE PROXY, WHO SHOULD THEN RETURN A SIGNED COPY OF THE PROXY SIGNATURE PAGE.

Section 6. Signature of Proxy

I, _____, am willing to serve as the health care

proxy for _____.

Signature: _____

Date:_____

Signature of second choice for proxy:

I, _____, am willing to serve as the health care

proxy for _____if the first choice cannot serve.

Signature: _____

Date:_____