

# **ARKANSAS Advance Directive Planning for Important Health Care Decisions**

Caring Connections  
1731 King St., Suite 100, Alexandria, VA 22314  
[www.caringinfo.org](http://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.

## **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:

- L**earn about options for end-of-life services and care
- I**mplement plans to ensure wishes are honored
- V**oice decisions to family, friends and health care providers
- E**ngage in personal or community efforts to improve end-of-life care

**Note:** The following is not a substitute for legal advice. While Caring Connections 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. **If you have other questions regarding these documents, we recommend contacting your state attorney general's office.**

## 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 Arkansas Declaration and Durable Power of Attorney for Health Care**

This packet contains your **Arkansas Declaration and Durable Power of Attorney for Health Care**. This legal document 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.

Page 1 of your document contains your **Declaration**, which 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) 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. Page 1 includes a space for you to include additional directions in the event you are terminally ill or permanently unconscious.

Pages 2 and 3 of your document contain your **Arkansas Durable Power of Attorney for Health Care**, which lets you name an **Agent** to make decisions about your medical care any time you lose the ability to make medical decisions for yourself. Page 3 of your document allows you to include directions in the event you lose the ability to make medical decisions for yourself. These directions are triggered any time you lose capacity, and are not dependent on you becoming terminally ill or permanently unconscious.

Your durable power of attorney for health care also appoints your agent as your **Health Care Proxy** to make decisions about your medical care — including decisions about life sustaining treatment — if you are terminally ill and can no longer make your own decisions about health care or are permanently unconscious.

Your durable power of attorney for health care goes into effect when your doctor determines that you are no longer able to make or communicate your health care decisions.

Page 4 of your document is your signature page. Your signature must be witnessed by two people who are 18 years of age or older, or, alternatively, your signature may be notarized on page 5.

**Note:** This form authorizes mental health care decisions to be made by your agent/proxy, but does not go into detail regarding mental health issues. If you would like to make advance care plans involving mental illness, you should talk to your physician and an attorney about a durable power of attorney.

Following your Arkansas declaration and durable power of attorney for health care is an organ donation form.

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

## **Instructions for Completing Your Arkansas Declaration and Durable Power of Attorney**

### **How do I make my Arkansas Declaration and Durable Power of Attorney for Health Care legal?**

The law requires that you sign or someone signs at your direction on your behalf your Declaration and Durable Power of Attorney for Health in the presence of two witnesses, who must be 18 years of age or older, or, alternatively, your signature may be notarized.

### **Whom should I appoint as my Agent/Proxy?**

Your agent/proxy is the person you appoint to make decisions about your medical care if you become unable to make those decisions yourself. Your agent/proxy may be a family member or a close friend whom you trust to make serious decisions. The person you name as your agent/proxy should clearly understand your wishes and be willing to accept the responsibility of making medical decisions for you. **To avoid any confusion, you should name the same person as your agent/proxy in the Directive section as you name in the Durable Power of Attorney section.**

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

### **Can I add personal instructions to my Declaration?**

One of the strongest reasons for naming an agent/proxy 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 it may help your agent/proxy carry out your wishes, but be careful that you do not unintentionally restrict your agent/proxy's power to act in your best interest. In any event, be sure to talk with your agent/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 the instructions in your 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 health care provider, who must then make the revocation a part of your medical record.

You may revoke your agent/proxy's power under your durable power of attorney for health care at any time by executing a new durable power of attorney for health care or by otherwise specifying in writing that you wish to revoke it.

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

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 Organ Donation Form**

### **How do I make my Arkansas Organ Donation Form legal?**

The law requires that you sign your Organ Donation Form in the presence of two witnesses. Both witnesses must be 18 years of age or older. At least one of the witnesses must be a disinterested party (i.e. not a family member nor potential recipient of your donation).

### **Who may receive my 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.

### **Can others make a gift for me?**

Unless you explicitly prohibit such gifts, your agent/proxy or a family member has the authority to make anatomical gifts on your behalf.

### **Can I refuse to make a gift?**

You can refuse to make a gift in any of these other ways: (1) any writing — including your Organ Donation Form — 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.

### **How can I revoke my 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; (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.

**ARKANSAS DECLARATION AND DURABLE POWER OF ATTORNEY  
FOR HEALTH CARE — PAGE 1 OF 5**

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**Declaration**

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 (initial only one)

INITIAL THE  
OPTION THAT  
REFLECTS YOUR  
WISHES (CHOOSE  
ONLY ONE OPTION)

IF YOU CHOOSE  
OPTION 2, PRINT  
THE NAME OF YOUR  
AGENT/PROXY—  
THIS SHOULD BE  
THE SAME  
AGENT/PROXY THAT  
YOU IDENTIFY ON  
P. 2

INITIAL THE  
OPTION(S) THAT  
REFLECT YOUR  
WISHES

ADD PERSONAL  
INSTRUCTIONS  
(IF ANY)

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Organization  
2022 Revised.

- \_\_\_\_\_ 1. Withhold or withdraw treatments that only prolong the process of dying and are not necessary to my comfort or to alleviate pain.
- \_\_\_\_\_ 2. Follow the instructions of \_\_\_\_\_, whom I appoint as my health care agent/proxy to decide whether life-sustaining treatment should be withheld or withdrawn.

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 in the event I am terminally ill and cannot make decisions, or I am permanently unconscious:

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**ARKANSAS DECLARATION AND DURABLE POWER OF ATTORNEY  
FOR HEALTH CARE — PAGE 2 OF 5**

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PRINT YOUR NAME

I, \_\_\_\_\_, hereby  
(your name)

appoint:

\_\_\_\_\_  
(name, home address and telephone number of agent/proxy)

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as my health care agent/proxy 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 of my disability or incapacity, such that I become unable to make my own health care decisions. My health care agent/proxy and any alternate health care agent/proxy 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/proxy and any alternate health care agent/proxy shall also have the authority to make decisions regarding the providing, withholding, or withdrawing of life sustaining treatment as my Proxy pursuant to the Arkansas Rights of the Terminally Ill or Permanently Unconscious Act.

If the health care agent/proxy I appoint is unable, unwilling or unavailable to act as my health care agent/proxy, then I appoint:

\_\_\_\_\_  
(name, home address and telephone number of alternate agent/proxy)

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as my alternate health care agent/proxy to make any and all health care decisions for me, except to the extent that I state otherwise.

PRINT THE NAME,  
ADDRESS AND  
TELEPHONE  
NUMBER OF YOUR  
AGENT/PROXY

PRINT THE NAME,  
ADDRESS AND  
TELEPHONE  
NUMBER OF YOUR  
ALTERNATE  
AGENT/PROXY

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**ARKANSAS DECLARATION AND DURABLE POWER OF ATTORNEY  
FOR HEALTH CARE — PAGE 4 OF 5**

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SIGN AND DATE  
THE DOCUMENT  
AND PRINT YOUR  
ADDRESS

Signed this \_\_\_\_\_ day of \_\_\_\_\_, \_\_\_\_\_.  
(day) (month) (year)

Signature \_\_\_\_\_

Address \_\_\_\_\_  
\_\_\_\_\_

Statement by Witnesses (must be 18 or older):

I declare that the person who signed above appeared to execute this declaration and 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.

Witness \_\_\_\_\_  
(Signature) (Date)

\_\_\_\_\_  
(Print name)

Address \_\_\_\_\_  
\_\_\_\_\_

Witness \_\_\_\_\_  
(Signature) (Date)

\_\_\_\_\_  
(Print name)

Address \_\_\_\_\_  
\_\_\_\_\_

WITNESSING  
PROCEDURE

YOUR WITNESSES  
MUST SIGN AND  
PRINT THEIR  
NAMES AND  
ADDRESSES

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**ARKANSAS DECLARATION AND DURABLE POWER OF ATTORNEY  
FOR HEALTH CARE — PAGE 5 OF 5**

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SIGNING BEFORE A  
NOTARY PUBLIC IS  
AN OPTION IF YOU  
DO NOT HAVE TWO  
WITNESSES

SIGN AND PRINT  
YOUR NAME, THE  
DATE, AND  
LOCATION HERE

A NOTARY PUBLIC  
MUST COMPLETE  
THIS SECTION

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**Alternative No. 2: Sign before a notary public.**

I sign my name to this Declaration and Power of Attorney for Health Care  
on

\_\_\_\_\_ at \_\_\_\_\_, \_\_\_\_\_.  
(date) (city) (state)

\_\_\_\_\_  
(signature)

\_\_\_\_\_  
(print name)

**CERTIFICATE OF ACKNOWLEDGMENT OF NOTARY PUBLIC**

State of Arkansas )  
) ss.  
County of \_\_\_\_\_ )

On this \_\_\_\_\_ day of \_\_\_\_\_, in the year \_\_\_\_\_,  
before me, \_\_\_\_\_, personally  
appeared

(name of notary public)

\_\_\_\_\_  
(name of principal)

personally known to me (or proved to me on the basis of satisfactory  
evidence) to be the person whose name is subscribed to this instrument,  
and acknowledged that he or she executed it. I declare under penalty of  
perjury that the person whose name is ascribed to this instrument appears  
to be of sound mind and under no duress, fraud or undue influence.

**NOTARY SEAL**

\_\_\_\_\_  
(signature of notary public)

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

**ARKANSAS ORGAN DONATION FORM - PAGE 1 OF 1**

ORGAN DONATION  
(OPTIONAL)

INITIAL THE  
OPTION THAT  
REFLECTS YOUR  
WISHES

ADD NAME OR  
INSTITUTION (IF  
ANY)

PRINT YOUR NAME,  
SIGN, AND DATE  
THE DOCUMENT

YOUR  
WITNESSES  
MUST SIGN AND  
PRINT THEIR  
ADDRESSES

AT LEAST ONE  
WITNESS MUST BE  
A DISINTERESTED  
PARTY

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Organization 2022  
Revised.

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, proxy, 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 attorney for health care, proxy, or other 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 \_\_\_\_\_ Date \_\_\_\_\_

Address \_\_\_\_\_

I am a disinterested party with regard to the declarant and his or her donation and estate. The declarant voluntarily signed or directed another person to sign this writing in my presence.

Witness \_\_\_\_\_ Date \_\_\_\_\_

Address \_\_\_\_\_

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

1. Your Arkansas Declaration and Durable Power of Attorney for Health Care 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 agent/proxy and alternate agent/proxy, 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 agent/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. 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 Arkansas document.
7. Be aware that your Arkansas 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 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.**

## Congratulations!

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

You are taking important steps to make sure your wishes are known. Please consider helping us keep this resource free.

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

**Please show your support for our mission and consider making a tax-deductible gift to the National Hospice Foundation 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 and palliative care, and providing ongoing professional education and skills development to hospice and palliative care professionals across the nation. To learn more, please visit [www.NationalHospiceFoundation.org](http://www.NationalHospiceFoundation.org)

You may wonder if a gift of \$35, \$50 or \$100 to the National Hospice Foundation would make a difference, but it is only because of the generosity of others like you that these FREE resources are made available.

Please consider supporting our mission by returning a **generous tax-deductible donation.** Every gift makes a difference! Your gift strengthens the Foundation's ability to provide FREE caregiver and family resources.

**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.**


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

<b>\$35</b>	helps us provide webinars to hospice professionals
<b>\$50</b>	helps us provide free advance directives
<b>\$100</b>	helps us maintain our free InfoLine
\$_____	to support the mission of the National Hospice Foundation.

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

2022AD



OR donate online today: [www.NationalHospiceFoundation.org/donate](http://www.NationalHospiceFoundation.org/donate)