

ARKANSAS

Advance Directive

Planning for Important Healthcare Decisions

Courtesy of CaringInfo

www.caringinfo.org

800-658-8898

CaringInfo, a program of the National Hospice and Palliative Care Organization (NHPCO), 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 18 years of age or older, or an emancipated or married 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 ARKANSAS ADVANCE HEALTH CARE DIRECTIVE

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.

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. 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. **To avoid any confusion, you should name the same person as your agent/proxy in the Declaration section as you name in the Durable Power of Attorney section.**

Page 4 of your document is your signature page.

Following your Arkansas Declaration and Durable Power of Attorney for Health Care is an **Organ Donation** form.

How do I make my Arkansas Advance Health Care Directive 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.

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).

Whom should I appoint as my agent?

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

decisions for you. **To avoid any confusion, you should name the same person as your agent/proxy in the Declaration 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.

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 an agent 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 agent'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 agent and others about your future healthcare and describe what you consider to be an acceptable "quality of life."

When does my agent's authority become effective?

The **Declaration** becomes effective when you develop a terminal condition and are unable to make your own medical decisions or are in a permanently unconscious state and your doctor and one other doctor have determined you are in such a state, and the declaration has been communicated to your doctor.

The **Durable Power of Attorney** goes into effect any time you lose capacity, and your doctor determines that you are no longer able to make or communicate your healthcare decisions and is not dependent on you becoming terminally ill or permanently unconscious.

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

Agent Limitations

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 and your agent will be bound by the current laws of Arkansas as they regard pregnancy and termination of pregnancies.

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

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 healthcare 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.

You can revoke or amend an anatomical gift by:

- 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;
- 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.

Mental Health Issues

These forms do not *expressly* address mental illness, although you can state your wishes and grant authority to your agent 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 agent. 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.

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

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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Palliative Care
Organization
2023 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:

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

PRINT YOUR NAME

I, _____, hereby
(your name)

appoint:

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

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

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)

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

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.

**ARKANSAS DECLARATION AND DURABLE POWER OF ATTORNEY
FOR HEALTH CARE — PAGE 3 OF 5**

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, in the event of my disability or incapacitation, such that I become unable to make my own health care decisions:

This image shows a full page of blank handwriting practice paper. It features approximately 28 evenly spaced horizontal blue lines across the entire page, providing a guide for letter height and placement. The lines are consistent in color and thickness throughout.

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

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

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

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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Organization
2023 Revised.

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
www.caringinfo.org

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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Palliative Care
Organization 2023
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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