

CONNECTICUT

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 18 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 CONNECTICUT ADVANCE HEALTH CARE DIRECTIVE

This packet contains a **Connecticut Advance Directive**, which is a legal document 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 can complete any or all of the first four parts of this document, depending on your advance planning needs.

Part One is your **Living Will**. This part lets you state your wishes about medical care in the event that you are terminally ill and cannot make your own healthcare decisions, or are permanently unconscious.

Part Two is your **Appointment of a Health Care Representative**. This part allows you to appoint a person to make healthcare decisions for you in the event you can no longer make your own health care decisions.

Part Three, Designation of a Conservator, allows you to designate someone as your conservator in the event a court determines that one should be appointed for you. You may also designate, and the court may appoint, a successor conservator who will assume conservator duties if the original conservator resigns or is otherwise removed.

Part Four, Document of Anatomical Gift, allows you to document your organ donation wishes.

Part Five contains required signature and witnessing

Part Six is an optional **Witness Affidavit** section, which can be useful in the event your advance directive is challenged in court.

How do I make my Connecticut Advance Health Care Directive legal?

The law requires that you sign and date your document in the presence of two adult witnesses. The person you appoint as your health care representative cannot serve as a witness or sign the document. Each of your witnesses must also sign the document in the presence of the other witness.

If you are a resident of a facility operated or licensed by the Department of Mental Health and Addiction Services:

- at least one witness must be an individual who is not affiliated with your healthcare facility, and
- at least one witness must be a physician, advanced practiced registered nurse or licensed clinical psychologist with specialized training in treating mental illness.

If you are a resident of a facility operated or licensed by the Department of Developmental Services:

- at least one witness must be an individual who is not affiliated with your treating healthcare facility, and
- at least one witness must be a physician, advanced practice registered nurse or licensed clinical psychologist with specialized training in developmental disabilities.

You may also ask your witnesses to complete the optional Witness Affidavit on the last page of the form. This must be signed in front of a notary public or other officer authorized to administer oaths. If your advance directive were ever challenged legally, the witness affidavit would be accepted by a court as evidence of the document's validity.

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.

The person you appoint as your healthcare representative **cannot** be:

- your attending physician or advanced practice registered nurse,
- an operator, administrator, or employee of a healthcare facility in which you are a patient or resident or to which you have applied for admission, unless he or she is related to you by blood, marriage, or adoption, or
- an administrator or employee of a government agency that is financially responsible for your medical care, unless he or she is related to you by blood, marriage, or adoption.

You can appoint a second person as your alternate representative. The alternate will step in if the first person you name as Health Care Representative 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?

Your **Living Will** and **Appointment of a Health Care Representative** go into effect when this document is provided to your attending physician or advanced practice registered nurse, and your attending physician or advanced practice registered nurse determines that you are unable to understand and appreciate the nature and consequences of health care decisions, including the benefits and disadvantages of such treatment, and you are unable to reach and communicate an informed decision regarding treatment. However, if your attending physician or advanced practice registered nurse has not determined that you are terminally ill or permanently unconscious, you must be given beneficial medical treatment, including nutrition and hydration. You retain the primary authority for your healthcare decisions as long as you are able to make your wishes known.

Agent Limitations

Your agent will be bound by the current laws of Connecticut as they regard pregnancy and termination of pregnancies. Due to restrictions in the state law, a pregnant patient's Advance Directive will not be honored.

What if I change my mind?

You may revoke your **Part One** of your advance directive, the **Living Will**, at any time and in any manner, regardless of your mental or physical condition. You should be sure to notify your healthcare provider and healthcare representative of your revocation in order to ensure that your revocation is effective.

You may revoke **Part Two** of your advance directive, the **Appointment of a Health Care Representative**, only in a writing signed by you and two witnesses. You should be sure to notify your healthcare provider and health care representative of your revocation in order to ensure that your revocation is effective.

Unless you specify otherwise in the additional instructions portion of Part Two, page 4 of your advance directive, appointment of your spouse as your health care representative is automatically revoked if you are divorced or legally separated or upon the dissolution or annulment of your marriage.

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?

Unlike a healthcare representative, your **conservator** must comply with your properly-executed healthcare instructions. Your conservator may also carry out your wishes regarding cremation or other direction as to the disposal of your body after death, although further information and forms for this are not included in this packet. It is possible for the same person to serve as both your health care representative and conservator. In general, the decisions of a health care representative will override the decisions of a conservator, although some exceptions apply.

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.

THESE ARE MY HEALTH CARE INSTRUCTIONS, INCLUDING MY LIVING WILL, MY APPOINTMENT OF A HEALTH CARE REPRESENTATIVE, THE DESIGNATION OF MY CONSERVATOR OF THE PERSON FOR MY FUTURE INCAPACITY AND MY DOCUMENT OF ANATOMICAL GIFT

To any physician or advanced practice registered nurse who is treating me: These are my health care instructions including those concerning the withholding or withdrawal of life support systems, together with the appointment of my health care representative, the designation of my conservator of the person for future incapacity and my document of anatomical gift. If the time comes when I am incapacitated to the point when I can no longer actively take part in decisions for my own life, and am unable to direct my physician or advanced practice registered nurse as to my own medical care, I wish this statement to stand as a testament of my wishes. As my physician or advanced practice registered nurse, you may rely on any decision made by my health care representative, or conservator of my person, if I am unable to make a decision for myself.

Part One. LIVING WILL

PRINT YOUR NAME

I, _____,
(Name)

the author of this document, request that, if my condition is deemed terminal or if I am determined to be permanently unconscious, I be allowed to die and not be kept alive through life support systems. By terminal condition, I mean that I have an incurable or irreversible medical condition which, without the administration of life support systems, will, in the opinion of my attending physician or advanced practice registered nurse, result in death within a relatively short time. By permanently unconscious I mean that I am in a permanent coma or persistent vegetative state or other irreversible condition in which I am at no time aware of myself or the environment and show no behavioral response to the environment.

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Specific Instructions:

Listed below are my instructions regarding particular types of life support systems. This list is not all-inclusive. My general statement that I not be kept alive through life support systems provided to me is limited only where I have indicated that I desire a particular treatment to be provided.

(Initial your wishes below)

	Provide	Withhold
Cardiopulmonary Resuscitation	_____	_____
Artificial Respiration (including a respirator)	_____	_____
Artificial means of providing nutrition and hydration	_____	_____

I further direct that:

I do want sufficient pain medication to maintain my physical comfort. I do not intend any direct taking of my life, but only that my dying not be unreasonably prolonged.

INITIAL THE
OPTIONS THAT
REFLECT YOUR
WISHES

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

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PLEASE INITIAL
BELOW THE
OPTION THAT
REFLECTS YOUR
WISHES

ADD OTHER
INSTRUCTIONS, IF
ANY, REGARDING
YOUR ADVANCE
CARE PLANS IF YOU
ARE PREGNANT

ATTACH
ADDITIONAL PAGES
IF NEEDED

PLEASE INITIAL
BELOW YOUR
INSTRUCTIONS, IF
YOU CHOOSE TO
PROVIDE ANY

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Revised.

If I am pregnant:

- (1) I intend to accept life support systems if my doctor believes that doing so would allow my fetus to reach a live birth

(If selected, initial here)

- (2) I intend this document to apply without modifications

(If selected, initial here)

- (3) I intend this document to apply as follows:

(If selected, initial here)

PRINT THE NAME,
PHONE NUMBER
AND ADDRESS OF
YOUR HEALTH CARE
REPRESENTATIVE

Part Two. APPOINTMENT OF HEALTH CARE REPRESENTATIVE

I appoint _____,
(Health care representative)
_____, _____
(Telephone number) (Address)

to be my health care representative.

If my attending physician or advanced practice registered nurse determines that I am unable to understand and appreciate the nature and consequences of health care decisions and unable to reach and communicate an informed decision regarding treatment, my health care representative is authorized to make any and all health care decisions for me, including:

- (1) The decision to accept or refuse any treatment, service or procedure used to diagnose or treat my physical or mental condition, except as otherwise provided for by law such as for psychosurgery or shock therapy;
- (2) The decision to provide, withhold or withdraw life support systems;

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 my health care representative. In the event my wishes are not clear or a situation arises that I did not anticipate, my health care representative may make a decision in my best interests, based upon what is known of my wishes

PRINT THE NAME
AND PHONE
NUMBER OF YOUR
ALTERNATE
REPRESENTATIVE

If the person I have named above as my health care representative is unwilling or unable to serve as my health care representative,

I appoint _____,
(Health care representative)
_____, _____
(Telephone number) (Address)

to be my alternate health care representative.

ATTACH
ADDITIONAL PAGES
IF NEEDED

[illegible]

PRINT THE NAME,
PHONE NUMBER,
AND ADDRESS OF
YOUR
CONSERVATOR

Part Three. DESIGNATION OF A CONSERVATOR OF THE PERSON

If a conservator of my person should need to be appointed, I designate

(Conservator)

(Phone number)

(Address)

to be appointed my conservator.

If the person above is unwilling or unable to serve as my conservator,

I designate _____
(Alternate conservator)

(Phone number)

(Address)

I designate _____
(Successor conservator)

(Phone number)

(Address)

to be my successor conservator.

No bond shall be required of either of them in any jurisdiction.

PRINT THE NAME,
PHONE NUMBER,
AND ADDRESS OF
YOUR ALTERNATE
CONSERVATOR

PRINT THE NAME,
PHONE NUMBER,
AND ADDRESS OF
YOUR SUCCESSOR
CONSERVATOR

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Part Four. DOCUMENT OF ANATOMICAL GIFT

INITIAL ONLY ONE
CHOICE

I make no anatomical gift at this time.

(Initial here)

I hereby make this anatomical gift, if medically
acceptable, to take effect upon my death.

(Initial here)

INITIAL YOUR
CHOICE HERE

I give: (initial one)

_____(1) any needed organs or parts

_____(2) only the following organs or parts

PRINT THE ORGANS
YOU WANT TO
DONATE

INITIAL YOUR
CHOICE HERE

to be donated for: (initial one)

_____(1) any of the purposes stated in subsection (a) of
section 19a-289j of the general statutes

_____(2) these limited purposes

PRINT THE
PURPOSES FOR
WHICH YOU ARE
WILLING TO
DONATE YOUR
ORGANS

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Part Five. EXECUTION

SIGN, DATE, AND
PRINT YOUR NAME

These requests, appointments, and designations are made after careful reflection, while I am of sound mind. Any party receiving a duly executed copy or facsimile of this document may rely upon it unless such party has received actual notice of my revocation of it.

Signature _____

Print Name _____

Date _____

TWO WITNESSES
SIGN BELOW AND
PRINT THEIR
NAMES AND
ADDRESSES

WITNESSES' STATEMENTS

This document was signed in our presence by _____

_____, the author of this document, who appeared to be eighteen years of age or older, of sound mind and able to understand the nature and consequences of health care decisions at the time this document was signed. The author appeared to be under no improper influence. We have subscribed this document in the author's presence and at the author's request and in the presence of each other.

WITNESS # 1

Witness _____

Printed Name _____

Address _____

WITNESS #2

Witness _____

Printed Name _____

Address _____

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WITNESS AFFIDAVIT

STATE OF CONNECTICUT)
: ss. _____
COUNTY OF _____) (Town/City)

We, the subscribing witnesses, being duly sworn, say that we witnessed the execution of these health care instructions, the appointments of a health care representative, the designation of a conservator for future incapacity and a document of anatomical gift by the author of this document; that the author subscribed, published, and declared the same to be the author's instructions, appointments, and designation in our presence; that we thereafter subscribed the document as witnesses in the author's presence, at the author's request, and in the presence of each other; that at the time of the execution of said document the author appeared to us to be eighteen years of age or older, of sound mind, able to understand the nature and consequences of said document, and under no improper influence, and we make this affidavit at the author's request this _____ day of _____ 20_____.

Witness _____

Printed Name _____

Witness _____

Printed Name _____

Subscribed and sworn to before me this _____ day of _____ 20_____.

Commissioner of the Superior Court Notary Public

My commission expires: _____

THIS AFFIDAVIT IS
OPTIONAL

YOUR WITNESSES
MUST SIGN AND
PRINT THEIR
NAMES

A NOTARY PUBLIC
FILLS THIS PART
OUT