DISTRICT OF COLUMBIA
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 DISTRICT OF COLUMBIA ADVANCE HEALTH CARE DIRECTIVE

This packet contains a legal document, a **District of Columbia Advance Health Care 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.

The **District of Columbia Durable Power of Attorney for Health Care** lets you name someone to make decisions about your medical care — called an attorney in fact — if you can no longer speak for yourself. The **District of Columbia Declaration** is the District of Columbia's living will. It lets you state your wishes about medical care in the event that you develop a terminal condition and can no longer make your own medical decisions. Also included is a **District of Columbia Organ Donation Form.**

How do I make my District of Columbia Advance Health Care Directive legal?

Each of the three forms included in this packet must be signed in the presence of two adult witnesses. Each form has its own restrictions regarding who can witness your signature.

Your signature on your **Durable Power of Attorney for Health Care** cannot be witnessed by your attorney in fact, your health-care provider, or your health-care provider's employees. At least one of your witnesses must be a person who is not related to you (by blood, marriage, or adoption) and who will not inherit any part of your estate.

Your signature on your **Declaration** cannot be witnessed by a person signing on your behalf, anyone related to you (by blood, marriage, or adoption), anyone who will inherit any part of your estate, anyone directly financially responsible for your medical care, your attending doctor or an employee of your attending doctor, or an employee of a health- care facility in which you are a patient. If you are a patient in an intermediate care or skilled care facility, one of your witnesses must be a patient advocate or ombudsman.

At least one of the witnesses to your signature on your **Organ Donation Form** must be disinterested. This means that the witness should not be a person who could receive your organs or any portion of your estate.

Note: You do not need to notarize your Durable Power of Attorney for Health Care, Declaration, or Organ Donation Form.

Whom should I appoint as my attorney in fact?

Your attorney in fact is the person you appoint to make decisions about your healthcare if you become unable to make those decisions yourself. Your attorney in fact may be a family member

or a close friend whom you trust to make serious decisions. The person you name should clearly understand your wishes and be willing to accept the responsibility of making healthcare decisions for you. Your attorney in fact does not have to be a lawyer.

You can appoint a second and third person as your alternate attorneys in fact. An alternate will step in if the person(s) you name as attorney in fact is/are 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 **Durable Power of Attorney for Health Care** goes into effect when your doctor and one other qualified health professional (either a psychologist or a psychiatrist) certify that you lack sufficient mental capacity to appreciate the nature and implications of a healthcare decision, make a choice regarding the alternatives presented or communicate that choice in an unambiguous manner.

Your **Declaration** goes into effect when your doctor and one other doctor certify that you have an incurable condition that will lead to your death, with or without the use of life- sustaining medical care, and life-sustaining procedures would serve only to postpone your death.

Agent Limitations

Your attorney in fact, if you appoint one, does not have authority to authorize abortion, sterilization, psycho-surgery, or convulsive therapy or behavior modification involving aversive stimuli, unless authorized by a court.

Your agent will be bound by the current laws of District of Columbia as they regard pregnancy and termination of pregnancies.

What if I change my mind?

You may revoke your Durable Power of Attorney for Health Care by:

- notifying your attorney in fact orally or in writing,
- notifying your health-care provider orally or in writing, or
- executing a new durable Power of Attorney for Health Care.

If you name your spouse or domestic partner as your attorney in fact and your marriage or domestic partnership ends, your spouse's or domestic partner's power to act on your behalf will automatically be revoked.

You may revoke your declaration at any time, regardless of your mental condition, by:

- obliterating, burning, tearing, or otherwise destroying or defacing the document, or directing another person to do so in your presence;
- executing, or directing another person to execute, a dated and signed written revocation, which becomes effective when it is given to your doctor;
- orally revoking your declaration in the presence of a witness, 18 years or older, who must sign and date a written confirmation of your oral revocation. An oral revocation becomes effective once it is communicated to your doctor.

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.

INTRODUCTION

INFORMATION ABOUT THIS DOCUMENT

This is an important legal document. Before signing this document, it is vital for you to know and understand these facts:

This document gives the person you name as your attorney in fact the power to make health-care decisions for you if you cannot make the decisions for yourself.

After you have signed this document, you have the right to make health-care decisions for yourself if you are mentally competent to do so. In addition, after you have signed this document, no treatment may be given to you or stopped over your objection if you are mentally competent to make that decision.

You may state in this document any type of treatment that you do not desire and any that you want to make sure you receive.

You have the right to take away the authority of your attorney in fact, unless you have been adjudicated incompetent, by notifying your attorney in fact or health-care provider either orally or in writing. Should you revoke the authority of your attorney in fact, it is advisable to revoke in writing and to place copies of the revocation wherever this document is located.

If there is anything in this document that you do not understand, you should ask a social worker, lawyer, or other person to explain it to you.

You should keep a copy of this document after you have signed it. Give a copy to the person you name as your attorney in fact. If you are in a health-care facility, a copy of this document should be included in your medical record.

INSTRUCTIONS

PRINT YOUR NAME AND ADDRESS

PRINT THE NAME, HOME ADDRESS AND HOME AND WORK TELEPHONE NUMBERS OF YOUR ATTORNEY IN FACT

PRINT THE NAME, HOME ADDRESS AND HOME AND WORK TELEPHONE NUMBERS OF YOUR FIRST AND SECOND ALTERNATE ATTORNEYS IN FACT

DISTRICT OF COLUMBIA DURABLE POWER OF ATTORNEY FOR HEALTH CARE

I,_____, of
(name)
_____, hereby appoint:
(home address)

_____
(name of attorney in fact)

_____
(home address)

_____ _____
(work telephone number) (home telephone number)

as my attorney in fact to make health-care decisions for me if I become unable to make my own health-care decisions. This gives my attorney in fact the power to grant, refuse, or withdraw consent on my behalf for any health-care service, treatment, or procedure. My attorney in fact also has the authority to talk to health-care personnel, get information, and sign forms necessary to carry out these decisions.

If the person named as my attorney in fact is not available or is unable to act as my attorney in fact, I appoint the following person(s) to serve in the order listed below:

1. _____
(name of first alternate attorney in fact)

_____
(home address)

_____ _____
(work telephone number) (home telephone number)

2._____
(name of second alternate attorney in fact)

_____
(home address)

_____ _____
(work telephone number) (home telephone number)

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

PRINT THE DATE AND YOUR LOCATION AND SIGN THE DOCUMENT

YOUR WITNESSES MUST SIGN THE DOCUMENT ON THE NEXT PAGE

With this document, I intend to create a power of attorney for health care, which shall take effect if I become incapable of making my own health-care decisions and shall continue during that incapacity.

My attorney in fact shall make health-care decisions as I direct below or as I make known to my attorney in fact in some other way.

Statement of directives concerning life-prolonging care, treatment, services, and procedures:

_____
_____
_____
_____
_____

Special provisions and limitations:

_____
_____
_____
_____
_____

By my signature I indicate that I understand the purpose and effect of this document.

I sign my name to this form on _____
(date)

at: _____
(address of location)

_____
(signature)

WITNESSING PROCEDURE

WITNESSES MUST SIGN AND DATE THE DOCUMENT AND PRINT THEIR NAMES AND ADDRESSES

WITNESS #1

WITNESS #2

AT LEAST ONE OF YOUR WITNESSES MUST ALSO AGREE WITH THIS STATEMENT AND SIGN BELOW

WITNESSES

I declare that the person who signed or acknowledged this document is personally known to me, that the person signed or acknowledged this durable power of attorney for health care in my presence, and that the person appears to be of sound mind and under no duress, fraud, or undue influence. I am not the person appointed as the attorney in fact by this document, nor am I the health-care provider of the principal, or an employee of the health-care provider of the principal.

First Witness' Signature: _____

Home Address: _____

Print Name: _____

Date: _____

Second Witness' Signature: _____

Home Address: _____

Print Name: _____

Date: _____

(AT LEAST 1 OF THE WITNESSES LISTED ABOVE SHALL ALSO SIGN THE FOLLOWING DECLARATION.)

I further declare that I am not related to the principal by blood, marriage, adoption, or domestic partnership, and that I am not entitled to any part of the estate of the principal under a currently existing will or by operation of law. Signature:

Signature: _____ Date _____

Signature: _____ Date _____

INSTRUCTIONS

PRINT THE DATE

PRINT YOUR NAME

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

DISTRICT OF COLUMBIA DECLARATION – PAGE 1 OF 2

Declaration made this _____day of _____.
(date) (month, year)

I, _____
(name)

being of sound mind, willfully and voluntarily make known my desires that my dying shall not be artificially prolonged under the circumstances set forth below, do declare:

If at any time I should have an incurable injury, disease or illness certified to be a terminal condition by two physicians who have personally examined me, one of whom shall be my attending physician, and the physicians have determined that my death will occur whether or not life-sustaining procedures are utilized and where the application of life-sustaining procedures would serve only to artificially prolong the dying process, I direct that such procedures be withheld or withdrawn, and that I be permitted to die naturally with only the administration of medication or the performance of any medical procedure deemed necessary to provide me with comfort care or to alleviate pain.

Other directions:

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

In the absence of my ability to give directions regarding the use of such life-sustaining procedures, it is my intention that this declaration shall be honored by my family and physician(s) as the final expression of my legal right to refuse medical or surgical treatment and accept the consequences from such refusal.

I understand the full importance of this declaration and I am emotionally and mentally competent to make this declaration.

SIGN AND DATE THE DOCUMENT AND PRINT YOUR ADDRESS

Signed _____ Date_____

Address _____

WITNESSING PROCEDURE

I believe the declarant to be of sound mind. I did not sign the declarant's signature above for or at the direction of the declarant. I am at least eighteen years of age and am not related to the declarant by blood, marriage, or domestic partnership, entitled to any portion of the estate of the declarant according to the laws of intestate succession of the District of Columbia or under any will of the declarant or codicil thereto, or directly financially responsible for declarant's medical care. I am not the declarant's attending physician, an employee of the attending physician, or an employee of the health facility in which the declarant is a patient.

TWO WITNESSES MUST SIGN AND DATE HERE

Witness _____ Date_____

Witness _____ Date_____

Courtesy of CaringInfo
www.caringinfo.org

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

DISTRICT OF COLUMBIA ORGAN DONATION FORM

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 District of Columbia 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 District of Columbia 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 _____

_____