GEORGIA
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 GEORGIA ADVANCE DIRECTIVE FOR HEALTH CARE

This packet contains the **Georgia Advance Directive for Health Care**, which protects your right to refuse medical treatment that you do not want or to request treatment you do want, in the event you lose the ability to make decisions yourself.

Part One: **Health Care Agent**. This allows you to choose someone to make health care decisions for you if you cannot (or do not want to) make health care decisions for yourself. You may also have your health care agent make decisions for you after your death with respect to an autopsy, organ donation, body donation, and final disposition of your body.

Part Two: **Treatment Preferences**. This part allows you to state your treatment preferences if you are (1) unable to communicate your treatment preferences, and (2) your physician and one other physician determine that you either have a terminal condition or are in a state of permanent unconsciousness. If you also have a health care agent, then your agent is authorized to make all decisions discussed in Part Two, but will be guided by your written Treatment Preferences as well as any other factors you may have listed in section 4 of Part One.

Part Three: **Guardianship**. This part allows you to nominate a person to be your guardian should one ever be needed.

Part Four: **Signatures**. You may fill out any or all of the first three parts. **You must fill out Part Four.**

How do I make my Georgia Advance Directive for Health Care legal?

The law requires that you sign your document, or another person signs it in your presence and at your express direction, in the presence of two witnesses who must be at least 18 years of age and of sound mind.

Your witnesses cannot be your health care agent, someone who will knowingly inherit anything from you or otherwise gain a financial benefit from your death, or someone who is directly involved in your healthcare.

Only one witness can be an employee, agent, or medical staff member of the facility in which you are receiving healthcare.

Note: You do not need to notarize your Georgia Advance Directive for Health Care.

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.

No physician or health care provider may act as your health care agent if he or she is directly involved in your health care.

You can appoint a second and third person as your alternate agents. An alternate agent will step in if the person(s) you name as agent 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 health care agent's power becomes effective when your doctor determines that you are no longer able to make or communicate your health care decisions or when you decide to have your health care agent make decisions for you.

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 Georgia as they regard pregnancy and termination of pregnancies.

What if I change my mind?

You may revoke your Georgia advance directive for health care at any time, regardless of your mental or physical condition, by:

- obliterating, burning, tearing, or otherwise destroying your document,
- signing and dating a written revocation or directing another person to do so (if you are receiving healthcare in a healthcare facility, the revocation must be communicated to your attending physician), or
- orally revoking your document in the presence of a witness, at least 18 years of age, who must sign and date a written confirmation of your revocation within 30 days (if you are receiving health care in a health care facility, the revocation must be communicated to your attending physician).

- by completing a new advance directive for health care. A new advance directive will revoke an older advance directive to the extent that they are inconsistent with each other.

If you get married after completing your advance directive for health care and you have not named your spouse as your health care agent, your marriage automatically revokes the power of your health care agent. If you have appointed your spouse as your health care agent and you divorce or the marriage is annulled, your health care agent's power is automatically revoked. You can, however, specify that you do not want these changes to occur in section 8 in PART TWO of your advance directive for health care.

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?

If you are a woman and would like your treatment preferences regarding withholding or withdrawal of life-sustaining procedures, nourishment, or hydration to be honored even if you are pregnant, you must initial the statement in section 9 in PART TWO of the advance directive for health care form. State law requires that, before honoring a pregnant patient's Treatment Preferences, the attending physician must first determine whether the fetus is viable. If the fetus is viable, your treatment preferences will not be honored, even if you initial section 9.

Part III of your advance directive for health care provides space where you can nominate someone to serve as your guardian if there should come a time when you need a court-appointed guardian. Unless a court specifies otherwise, your guardian has no power to make any personal or health care decisions granted to your agent under your advance directive for health care.

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.

INSTRUCTIONS

PRINT YOUR NAME AND BIRTH DATE

INTRODUCTION

By: _____
(Print Name)

Date of Birth: _____
(Month/Day/Year)

This advance directive for health care has four parts:

PART ONE: HEALTH CARE AGENT. This part allows you to choose someone to make health care decisions for you when you cannot (or do not want to) make health care decisions for yourself. The person you choose is called a health care agent. You may also have your health care agent make decisions for you after your death with respect to an autopsy, organ donation, body donation, and final disposition of your body. You should talk to your health care agent about this important role.

PART TWO: TREATMENT PREFERENCES. This part allows you to state your treatment preferences if you have a terminal condition or if you are in a state of permanent unconsciousness. PART TWO will become effective only if you are unable to communicate your treatment preferences. Reasonable and appropriate efforts will be made to communicate with you about your treatment preferences before PART TWO becomes effective. You should talk to your family and others close to you about your treatment preferences.

PART THREE: GUARDIANSHIP. This part allows you to nominate a person to be your guardian should one ever be needed.

PART FOUR: EFFECTIVENESS AND SIGNATURES. This part requires your signature and the signatures of two witnesses. You must complete PART FOUR if you have filled out any other part of this form.

You may fill out any or all of the first three parts listed above. You must fill out PART FOUR of this form in order for this form to be effective.

You should give a copy of this completed form to people who might need it, such as your health care agent, your family, and your physician. Keep a copy of this completed form at home in a place where it can easily be found if it is needed. Review this completed form periodically to make sure it still reflects your preferences. If your preferences change, complete a new advance directive for health care.

Using this form of advance directive for health care is completely optional. Other forms of advance directives for health care may be used in Georgia.

You may revoke this completed form at any time.

Once completed, this form will replace any advance directive for health care, durable power of attorney for health care, health care proxy, or living will that you have completed before completing this form.

INSTRUCTIONS

PART ONE: HEALTH CARE AGENT

[PART ONE will be effective even if PART TWO is not completed. A physician or health care provider who is directly involved in your health care may not serve as your health care agent. Unless you specify otherwise in section 8 of PART TWO, if you are married, a future divorce or annulment of your marriage will revoke the selection of your current spouse as your health care agent. Unless you specify otherwise in section 8 of PART TWO, if you are not married, a future marriage will revoke the selection of your health care agent unless the person you selected as your health care agent is your new spouse.]

PRINT THE NAME AND ADDRESS OF YOUR HEALTH CARE AGENT

(1) HEALTH CARE AGENT

I select the following person as my health care agent to make health care decisions for me:

Name: _____

Address: _____

_____

Telephone Numbers: _____

(Home, Work, and Mobile)

(2) BACK-UP HEALTH CARE AGENT

[This section is optional. PART ONE will be effective even if this section is left blank.]

If my health care agent cannot be contacted in a reasonable time period and cannot be located with reasonable efforts or for any reason my health care agent is unavailable or unable or unwilling to act as my health care agent, then I select the following, each to act successively in the order named, as my back-up health care agent(s):

PRINT NAMES, ADDRESSES, AND TELEPHONE NUMBERS OF YOUR ALTERNATE HEALTH CARE AGENTS

Name: _____

Address: _____

_____

Telephone Numbers: _____

(Home, Work, and Mobile)

Name: _____

Address: _____

_____

Telephone Numbers: _____

(Home, Work, and Mobile)

INSTRUCTIONS

DESCRIPTION OF POWERS OF HEALTH CARE AGENT

(3) GENERAL POWERS OF HEALTH CARE AGENT

My health care agent will make health care decisions for me when I am unable to make my health care decisions or I choose to have my health care agent make my health care decisions. My health care agent will have the same authority to make any health care decision that I could make.

My health care agent's authority includes, for example, the power to:

- Admit me to or discharge me from any hospital, skilled nursing facility, hospice, or other health care facility or service;
- Request, consent to, withhold, or withdraw any type of health care; and
- Contract for any health care facility or service for me, and to obligate me to pay for these services (and my health care agent will not be financially liable for any services or care contracted for me or on my behalf).

My health care agent will be my personal representative for all purposes of federal or state law related to privacy of medical records (including the Health Insurance Portability and Accountability Act of 1996) and will have the same access to my medical records that I have and can disclose the contents of my medical records to others for my ongoing health care.

My health care agent may accompany me in an ambulance or air ambulance if in the opinion of the ambulance personnel protocol permits a passenger and my health care agent may visit or consult with me in person while I am in a hospital, skilled nursing facility, hospice, or other health care facility or service if its protocol permits visitation.

My health care agent may present a copy of this advance directive for health care in lieu of the original and the copy will have the same meaning and effect as the original.

I understand that, under Georgia law:

- My health care agent may refuse to act as my health care agent;
- A court can take away the powers of my health care agent if it finds that my health care agent is not acting properly; and
- My health care agent does not have the power to make health care decisions for me regarding psychosurgery, sterilization, or treatment or involuntary hospitalization for mental or emotional illness, mental retardation, or addictive disease.

(4) GUIDANCE FOR HEALTH CARE AGENT

When making health care decisions for me, my health care agent should think about what action would be consistent with past conversations we have had, my treatment preferences as expressed in PART TWO (if I have filled out PART TWO), my religious and other beliefs and values, and how I have handled medical and other important issues in the past. If what I would decide is still unclear, then my health care agent should make decisions for me that my health care agent believes are in my best interest, considering the benefits, burdens, and risks of my current circumstances and treatment options.

INSTRUCTIONS

(5) POWERS OF HEALTH CARE AGENT AFTER DEATH

(A) AUTOPSY
My health care agent will have the power to authorize an autopsy of my body unless I have limited my health care agent's power by initialing below.

INITIAL IF YOU DO NOT WANT YOUR HEALTH CARE AGENT TO HAVE POWER TO AUTHORIZE AN AUTOPSY

_____(Initials) My health care agent will not have the power to authorize an autopsy of my body (unless an autopsy is required by law).

(B) ORGAN DONATION AND DONATION OF BODY
My health care agent will have the power to make a disposition of any part or all of my body for medical purposes pursuant to the Georgia Anatomical Gift Act, unless I have limited my health care agent's power by initialing below.

[Initial each statement that you want to apply.]

INITIAL STATEMENTS THAT YOU WANT TO APPLY, IF ANY

_____(Initials) My health care agent will not have the power to make a disposition of my body for use in a medical study program.

_____(Initials) My health care agent will not have the power to donate any of my organs.

(C) FINAL DISPOSITION OF BODY
My health care agent will have the power to make decisions about the final disposition of my body unless I have initialed below.

INITIAL HERE IF YOU WANT SOMEONE OTHER THAN YOUR HEALTH CARE AGENT TO MAKE FINAL DISPOSITION DECISIONS

_____(Initials) I want the following person to make decisions about the final disposition of my body:

Name: _____

Address: _____

_____

Telephone Numbers: _____
(Home, Work, and Mobile)

INITIAL THE ONE STATEMENT THAT REFLECTS YOUR WISH

I wish for my body to be:
_____(Initials) Buried

OR
_____(Initials) Cremated

INSTRUCTIONS

PART TWO: TREATMENT PREFERENCES

[PART TWO will be effective only if you are unable to communicate your treatment preferences after reasonable and appropriate efforts have been made to communicate with you about your treatment preferences. PART TWO will be effective even if PART ONE is not completed. If you have not selected a health care agent in PART ONE, or if your health care agent is not available, then PART TWO will provide your physician and other health care providers with your treatment preferences. If you have selected a health care agent in PART ONE, then your health care agent will have the authority to make all health care decisions for you regarding matters covered by PART TWO. Your health care agent will be guided by your treatment preferences and other factors described in Section (4) of PART ONE.]

(6) CONDITIONS

PART TWO will be effective if I am in any of the following conditions:

[Initial each condition in which you want PART TWO to be effective.]

INITIAL THE STATEMENTS THAT REFLECT YOUR WISH

YOU MAY INITIAL BOTH STATEMENTS

_____(Initials) A terminal condition, which means I have an incurable or irreversible condition that will result in my death in a relatively short period of time.

_____(Initials) A state of permanent unconsciousness, which means I am in an incurable or irreversible condition in which I am not aware of myself or my environment and I show no behavioral response to my environment.

My condition will be certified in writing after personal examination by my attending physician and a second physician in accordance with currently accepted medical standards.

(7) TREATMENT PREFERENCES

[State your treatment preference by initialing (A), (B), or (C). If you choose (C), state your additional treatment preferences by initialing one or more of the statements following (C). You may provide additional instructions about your treatment preferences in the next section. You will be provided with comfort care, including pain relief, regardless of which choice you make, but you may also want to state your specific preferences regarding pain relief in the next section.]

If I am in any condition that I initialed in Section (6) above and I can no longer communicate my treatment preferences after reasonable and appropriate efforts have been made to communicate with me about my treatment preferences, then:

INITIAL ONE STATEMENT THAT REFLECTS YOUR WISH

INITIAL ONLY ONE (A, B, OR C)

(A) _____(Initials) Try to extend my life for as long as possible, using all medications, machines, or other medical procedures that in reasonable medical judgment could keep me alive. If I am unable to take nutrition or fluids by mouth, then I want to receive nutrition or fluids by tube or other medical means.

OR

(B) _____(Initials) Allow my natural death to occur. I do not want any medications, machines, or other medical procedures that in reasonable medical judgment could keep me alive but cannot cure me. I do not want to receive nutrition or fluids by tube or other medical means except as needed to provide pain medication.

OR

IF YOU INITIAL (C), INITIAL EACH STATEMENT THAT YOU WANT TO APPLY

(C) _____(Initials) I do not want any medications, machines, or other medical procedures that in reasonable medical judgment could keep me alive but cannot cure me, except as follows:
[Initial each statement that you want to apply to option (C).]

_____(Initials) If I am unable to take nutrition by mouth, I want to receive nutrition by tube or other medical means.

_____(Initials) If I am unable to take fluids by mouth, I want to receive fluids by tube or other medical means.

_____(Initials) If I need assistance to breathe, I want to have a ventilator used.

_____(Initials) If my heart or pulse has stopped, I want to have cardiopulmonary resuscitation (CPR) used.

INSTRUCTIONS

OPTIONAL SECTION

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

(8) ADDITIONAL STATEMENTS

[This section is optional. PART TWO will be effective even if this section is left blank. This section allows you to state additional treatment preferences, to provide additional guidance to your health care agent (if you have selected a health care agent in PART ONE), or to provide information about your personal and religious values about your medical treatment. For example, you may want to state your treatment preferences regarding medications to fight infection, surgery, amputation, blood transfusion, or kidney dialysis. Understanding that you cannot foresee everything that could happen to you after you can no longer communicate your treatment preferences, you may want to provide guidance to your health care agent (if you have selected a health care agent in PART ONE) about following your treatment preferences. You may want to state your specific preferences regarding pain relief.]

INSTRUCTIONS

INITIAL HERE IF YOU WANT PART TWO TO BE CARRIED OUT IF YOU ARE PREGNANT AND YOUR FETUS IS NOT VIABLE

(9) IN CASE OF PREGNANCY

[PART TWO will be effective even if this section is left blank.]

I understand that under Georgia law, PART TWO generally will have no force and effect if I am pregnant unless the fetus is not viable and I indicate by initialing below that I want PART TWO to be carried out.

_____(Initials) I want PART TWO to be carried out if my fetus is not viable.

INSTRUCTIONS

INITIAL YOUR PREFERENCE REGARDING NOMINATION OF YOUR GUARDIAN, IN THE EVENT YOU NEED TO HAVE ONE APPOINTED BY A COURT

PART THREE: GUARDIANSHIP

(10) GUARDIANSHIP

[PART THREE is optional. This advance directive for health care will be effective even if PART THREE is left blank. If you wish to nominate a person to be your guardian in the event a court decides that a guardian should be appointed, complete PART THREE. A court will appoint a guardian for you if the court finds that you are not able to make significant responsible decisions for yourself regarding your personal support, safety, or welfare. A court will appoint the person nominated by you if the court finds that the appointment will serve your best interest and welfare. If you have selected a health care agent in PART ONE, you may (but are not required to) nominate the same person to be your guardian. If your health care agent and guardian are not the same person, your health care agent will have priority over your guardian in making your health care decisions, unless a court determines otherwise.]

[State your preference by initialing (A) or (B). Choose (A) only if you have also completed PART ONE.]

(A) _____(Initials) I nominate the person serving as my health care agent under PART ONE to serve as my guardian.

OR

(B) _____(Initials) I nominate the following person to serve as my guardian:

Name: _____

Address: _____

Telephone Numbers: _____
(Home, Work, and Mobile)

INSTRUCTIONS

PART FOUR: EFFECTIVENESS AND SIGNATURES

This advance directive for health care will become effective only if I am unable or choose not to make or communicate my own health care decisions.
This form revokes any advance directive for health care, durable power of attorney for health care, health care proxy, or living will that I have completed before this date.

Unless I have initialed below and have provided alternative future dates or events, this advance directive for health care will become effective at the time I sign it and will remain effective until my death (and after my death to the extent authorized in Section (5) of PART ONE).

INITIAL HERE IF YOU WANT TO LIMIT WHEN THIS ADVANCE DIRECTIVE IS EFFECTIVE

_____(Initials) This advance directive for health care will become effective

on or upon _____

and will terminate on or upon _____.

[You must sign and date or acknowledge signing and dating this form in the presence of two witnesses.

Both witnesses must be of sound mind and must be at least 18 years of age, but the witnesses do not have to be together or present with you when you sign this form.
A witness cannot be:

- A person who was selected to be your health care agent or back-up health care agent in PART ONE;
- A person who will knowingly inherit anything from you or otherwise knowingly gain a financial benefit from your death; or
- A person who is directly involved in your health care.

Only one of the witnesses may be an employee, agent, or medical staff member of the hospital, skilled nursing facility, hospice, or other health care facility in which you are receiving health care (but this witness cannot be directly involved in your health care).]

SIGN AND DATE

By signing below, I state that I am emotionally and mentally capable of making this advance directive for health care and that I understand its purpose and effect.

_____ _____
(Signature of Declarant) (Date)

INSTRUCTIONS

HAVE YOUR WITNESSES SIGN, DATE AND PRINT THEIR ADDRESSES HERE

The declarant signed this form in my presence or acknowledged signing this form to me. Based upon my personal observation, the declarant appeared to be emotionally and mentally capable of making this advance directive for health care and signed this form willingly and voluntarily.

_____ _____
(Signature of witness) (Date)

Print Name: _____

Address: _____

_____ _____
(Signature of witness) (Date)

Print Name: _____

Address: _____

_____

[This form does not need to be notarized.]