INTRODUCTION TO YOUR MAINE ADVANCE HEALTH-CARE DIRECTIVE

This packet contains a legal document, a **Maine 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. You may complete any or all of the first four parts, depending on your advance planning needs. You must complete part 5.

Part 1 is a **Power of Attorney for Health Care**. This part lets you name someone (an agent) to make decisions about your health care. The power of attorney for health care becomes effective when your doctor determines that you can no longer make or communicate your health care decisions.

Part 2 includes your **Individual Instructions**. This is your state's living will. It lets you state your wishes about health care in the event that you can no longer speak for yourself, including end-of-life choices.

Part 3 allows you to express your wishes regarding organ donation.

Part 4 of this form lets you designate a physician to have primary responsibility for your health care.

Part 5 contains the signature and witnessing provisions so that your document will be effective.

This form does not expressly address mental illness. If you would like to make advance care plans regarding mental illness, you should talk to your physician and an attorney about an advance directive tailored to your needs.

Note: These documents 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.

INSTRUCTIONS FOR YOUR MAINE ADVANCE HEALTH-CARE DIRECTIVE

How do I make my advance health-care directive legal?

You must sign and date your advance directive or direct someone to do so for you if you are unable to sign it yourself.

Your signature must be witnessed by two witnesses.

Whom should I appoint as my agent?

Your agent is the person you appoint to make decisions about your health care 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 health care decisions for you.

Unless related to you by blood, marriage or adoption, your agent cannot be an owner, operator, or employee of a residential, long-term health-care institution where you receive care.

You can appoint a second and third person as your alternative agent(s). An alternative agent can 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 health-care directive?

One of the strongest reasons for naming an agent 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 carry out your wishes, but be careful that you do not unintentionally restrict your agent's power to act in your best interest. In any event, be sure to talk with your agent about your future health care and describe what you consider to be an acceptable "quality of life."

What if I change my mind?

Except for the appointment of your agent, you may revoke any portion or all of this advance directive at any time and in any way that communicates your intent to revoke. This could be by telling your agent or physician that you revoke your advance directive, by signing a revocation, or simply by tearing up your advance directive.

In order to revoke your agent's appointment, you must either tell your supervising health-care provider of your intent to revoke or revoke your agents appointment in a signed writing.

If you execute a new advance directive, it will revoke the old advance directive to the extent of any conflict between the two documents.

Unless you specify otherwise in Part 2, if you designate your spouse as your agent, that designation will automatically be revoked by divorce, legal separation, or annulment or dissolution of your marriage

PART 2

Part 2: INSTRUCTIONS FOR HEALTH CARE

(6) **END-OF-LIFE DECISIONS**: I direct that my health-care providers and others involved in my care provide, withhold or withdraw treatment in accordance with the choice I have marked below:

INITIAL THE PARAGRAPH THAT BEST REFLECTS YOUR WISHES REGARDING LIFE-SUPPORT MEASURES (INITIAL ONLY ONE)

____I Choose NOT To Prolong Life: I do not want my life to be prolonged if (i) I have an incurable or irreversible condition that will result in my death within a relatively short time; (ii) I become unconscious and, to a reasonable degree of medical certainty, I will not regain consciousness; or (iii) the likely risks and burdens of treatment would outweigh the expected benefits;

OR

____I Choose To Prolong Life: I want my life to be prolonged as long as possible within the limits of generally accepted health-care standards.

(7) **ARTIFICIAL NUTRITION AND HYDRATION**: I also specify that under the conditions mentioned in the above paragraph:

INITIAL YOUR PREFERENCE REGARDING ARTIFICIAL NUTRITION AND HYDRATION (INITIAL ONLY ONE)

____ I **do not** want artificial nutrition and hydration provided to me in order to prolong my life.

____ I **do** want artificial nutrition and hydration provided to me in order to prolong my life.

(8) **RELIEF FROM PAIN OR DISCOMFORT**: Except as I state in the following space, I direct that treatment for alleviation of pain or discomfort be provided at all times, even if it hastens my death.

ADD INSTRUCTIONS HERE ONLY IF YOU WANT TO LIMIT PAIN RELIEF OR COMFORT CARE

_____

_____

_____

_____

(Add additional pages, if needed.)

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

(9) **OTHER HEALTH CARE INSTRUCTIONS OR WISHES**:

(Add additional pages, if needed.)

PART 3

ORGAN DONATION (OPTIONAL)

INITIAL THE STATEMENT THAT AGREES WITH YOUR WISHES ABOUT ORGAN DONATION (INITIAL ONLY ONE)

STRIKE THROUGH ANY USES YOU DO NOT AGREE TO

Part 3: DONATION OF ORGANS AT DEATH

(10) Upon my death: (initial applicable box)

____ (a) I do not give any of my organs, tissues, or parts and do not want my agent, conservator, or family to make a donation on my behalf,

____ (b) I give any needed organs, tissues, or parts,

OR

____ (c) I give the following organs, tissues, or parts only:

_____

_____

_____

My gift is for the following purposes:
(strike any of the following you do not want)

(1) Transplant

(2) Therapy

(3) Research

(4) Education

PART 4

DESIGNATION OF PRIMARY PHYSICIAN (OPTIONAL)

PRINT THE NAME, ADDRESS, AND TELEPHONE NUMBER OF YOUR PRIMARY PHYSICIAN

PRINT THE NAME, ADDRESS, AND TELEPHONE NUMBER OF YOUR ALTERNATE PRIMARY PHYSICIAN

Part 4: DESIGNATION OF PRIMARY PHYSICIAN

(11) I designate the following physician as my primary physician:

_____
(name of physician)

_____
(address)

_____
(city) (state) (zip code)

_____
(phone)

If the physician I have designated is not willing, able, or reasonably available to act as my primary physician, I designate the following physician as my primary physician:

_____
(name of physician)

_____
(address)

_____
(city) (state) (zip code)

_____
(phone)

PART 5

Part 5: EXECUTION

Sign and date the form here:

SIGN YOUR DOCUMENT PRINT THE DATE, YOUR NAME, AND YOUR ADDRESS

_____
(signature) (date)

_____
(name)

_____
(address)

WITNESSES

Witness 1:

HAVE YOUR TWO WITNESSES SIGN AND DATE THE DOCUMENT, AND THEN PRINT THEIR NAMES AND ADDRESSES

_____
(signature) (date)

_____
(name)

_____
(address)

Witness 2:

_____
(signature) (date)

_____
(name)

_____
(address)

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

You Have Filled Out Your Advance Health-Care Directive, Now What?

1. Your advance health-care directive 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 and alternate agent, doctor(s), family, close friends, clergy, and anyone else who might become involved in your healthcare. 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(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 Maine document.

7. Be aware that your Maine 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 these orders. We suggest you speak to your physician if you are interested in obtaining one. **CaringInfo 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

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.

- -

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

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

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PO Box 824401
Philadelphia, PA 19182-4401

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