

MAINE

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 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.

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.

How do I make my Maine 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.

Note: You do not need to have the advance directive notarized by a notary public.

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.

Unless related to you by blood, marriage or adoption, your agent cannot be an owner, operator, or employee of a residential, long-term healthcare 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 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 **Power of Attorney for Health Care** becomes effective when your doctor determines that you can no longer make or communicate your health care decisions.

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 Maine as they regard pregnancy and termination of pregnancies.

What if I change my mind?

Except for the appointment of your agent, you may revoke any portion or this entire 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, 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 healthcare provider of your intent to revoke or revoke your agent's 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.

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.

EXPLANATION

You have the right to give instructions about your own health-care. You also have the right to name someone else to make health care decisions for you. This form lets you do either or both of these things. It also lets you express your wishes regarding donation of organs and the designation of your primary physician. If you use this form, you may complete or modify all or any part of it. You are free to use a different form.

Part 1 of this form is a **power of attorney for health care**. Part 1 lets you name another individual as agent to make health-care decisions for you if you become incapable of making your own decisions or if you want someone else to make those decisions for you now even though you are still capable. You may also name an alternate agent to act for you if your first choice is not willing, able or reasonably available to make decisions for you. Unless related to you, your agent may not be an owner, operator or employee of a residential long-term health-care institution at which you are receiving care.

Unless the form you sign limits the authority of your agent, your agent may make all health-care decisions for you. This form has a place for you to limit the authority of your agent. You need not limit the authority of your agent if you wish to rely on your agent for all health-care decisions that may have to be made. If you choose not to limit the authority of your agent, your agent will have the right to:

- A) Consent or refuse consent to any care, treatment, service or procedure to maintain, diagnose or otherwise affect a physical or mental condition;
- B) Select or discharge health-care providers and institutions;
- C) Approve or disapprove diagnostic tests, surgical procedures, programs of medication, and orders not to resuscitate; and
- D) Direct the provision, withholding, or withdrawal of artificial nutrition and hydration and all other forms of health care, including life-sustaining treatment.

Part 2 of this form lets you give specific **instructions** about any aspect of your health care. Choices are provided for you to express your wishes regarding the provision, withholding, or withdrawal of treatment to keep you alive, including the provision of artificial nutrition and hydration, as well as the provision of pain relief. Space is also provided for you to add to the choices you have made or for you to write out any additional wishes.

Part 3 of this form lets you express an intention to donate your bodily organs and tissues following your death.

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.

After completing this form, sign and date the form at the end. You must have 2 other individuals sign as witnesses. Give a copy of the signed and completed form to your physician, to any other health-care providers you may have, to any health-care institution at which you are receiving care, and to any health-care agents you have named. You should talk to the person you have named as agent to make sure that he or she understands your wishes and is willing to take the responsibility.

You have the right to revoke this advance health-care directive or replace this form at any time.

EXPLANATION
(CONTINUED)

PART 1

PRINT YOUR NAME

PRINT THE NAME,
ADDRESS, AND
TELEPHONE
NUMBERS OF YOUR
PRIMARY
AGENT

PRINT THE NAME,
ADDRESS, AND
TELEPHONE
NUMBERS OF YOUR
FIRST
ALTERNATIVE
AGENT

PRINT THE NAME,
ADDRESS, AND
TELEPHONE
NUMBERS OF YOUR
SECOND
ALTERNATIVE
AGENT

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Revised.

Part 1: POWER OF ATTORNEY FOR HEALTH CARE

(1) DESIGNATION OF AGENT:

I, _____ designate the following person
as my agent to make health care decisions for me:

(name of agent)

(address)

(city) (state) (zip code)

(home phone)

(work phone)

If I revoke the authority of my agent or if my agent is not willing, able, or
reasonably available to make health care decisions for me, I designate as
my alternate agent:

(name of first alternative agent)

(address)

(city) (state) (zip code)

(home phone)

(work phone)

If I revoke the authority of my agent and first alternate agent or if neither
is willing, able or reasonably available to make a health care decision for
me, I designate as my second alternate:

(name of second alternative agent)

(address)

(city) (state) (zip code)

(home phone)

(work phone)

ADD
INSTRUCTIONS
HERE ONLY IF YOU
WANT TO LIMIT
THE POWER OF
YOUR AGENT

(2) **AGENT'S AUTHORITY:** My agent is authorized to make all health care decisions for me, including decisions to provide, withhold or withdraw artificial nutrition and hydration and all other forms of health care to keep me alive, **except** as I state here:

CROSS OUT AND
INITIAL ANY
STATEMENTS
WITHIN THE
FOLLOWING
PARAGRAPHS THAT
DO NOT REFLECT
YOUR WISHES

(3) **AGENT'S OBLIGATION:** My agent shall make health-care decisions for me in accordance with this power of attorney for health care, any instructions I give in Part 2 of this form, and my other wishes to the extent known to my agent. To the extent my wishes are unknown, my agent shall make health-care decisions for me in accordance with what my agent determines to be in my best interest. In determining my best interest, my agent shall consider my personal values to the extent known to my agent.

INITIAL THE BOX IN
PARAGRAPH (4)
ONLY IF YOU WANT
YOUR AGENT'S
AUTHORITY TO
TAKE EFFECT
IMMEDIATELY

(4) **WHEN AGENT'S AUTHORITY BECOMES EFFECTIVE:** My agent's authority becomes effective when my primary physician determines that I am unable to make my own health-care decisions unless I mark the following box. If I mark this box [], my agent's authority to make health-care decisions for me takes effect immediately.

(5) **NOMINATION OF GUARDIAN:** If a guardian of my person needs to be appointed for me by a court, I nominate the agent designated in this form. If that agent is not willing or reasonably available to act as guardian, I nominate the alternate agents whom I have named, in the order designated.

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:

 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:

 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 additional pages, if needed.)

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

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

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

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Revised.

(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

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

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

Part 5: EXECUTION

Sign and date the form here:

(signature)

(date)

(name)

(address)

WITNESSES

Witness 1:

(signature)

(date)

(name)

(address)

Witness 2:

(signature)

(date)

(name)

(address)