MASSACHUSETTS
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.

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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 MASSACHUSETTS ADVANCE HEALTH CARE DIRECTIVE

This packet contains a legal document that protects your right to refuse medical treatment you do not want, or to request treatment you do want, by appointing an agent to act on your behalf in the event you lose the ability to make decisions yourself. Massachusetts does not have a statute governing the use of living wills, therefore there is no living will for the state of Massachusetts.

The **Massachusetts Health Care Proxy** lets you name someone to make decisions about your medical care—including decisions about life support—if you can no longer speak for yourself.

Following the Massachusetts Health Care Proxy is an optional organ donation form that allows you to make an anatomical gift of your organs for transplantation, therapy, medical research, or education upon your death. If you do not provide instructions regarding the disposition of your organs after your death, your family or your agent will have the authority to do so on your behalf.

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

The law requires that you sign your document, or direct another to sign it, in the presence of two adult witnesses, who must also sign the document to show that they believe you to be at least eighteen years of age, of sound mind, and under no constraint or undue influence. The person you appoint as your agent cannot serve as a witness.

Note: You do not need to notarize your Massachusetts Health Care Proxy.

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.

You can appoint a second person as your alternate agent. The alternate will step in if the first person you name as an agent 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 **Massachusetts Health Care Proxy** goes into effect when your doctor determines that you are no longer able to make or communicate your healthcare 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 Massachusetts as they regard pregnancy and termination of pregnancies.

What if I change my mind?

You may revoke your Health Care Proxy at any time by:

- notifying your agent or doctor orally or in writing;
- taking any action, such as tearing up or destroying the document that indicates your specific intent to revoke your Proxy; or
- executing another Health Care Proxy.

If you have appointed your spouse as your agent, and your marriage ends, your Health Care Proxy is automatically revoked.

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.

MASSACHUSETTS HEALTH CARE PROXY – PAGE 1 OF 4

APOINTMENT OF AGENT

PRINT YOUR NAME

(1) I, _____, hereby appoint

PRINT THE NAME, HOME ADDRESS AND TELEPHONE NUMBER OF YOUR AGENT

_____

_____

(name, home address and telephone number of proxy)

as my health care agent to make any and all health care decisions for me, except to the extent that I state otherwise below.

This Health Care Proxy shall take effect in the event that a determination is made by my attending physician that I lack the capacity to make or to communicate my own health care decisions. My attending physician shall make such determination in writing, and shall include his or her opinion regarding the cause and nature of my incapacity, as well as its extent and probable duration.

(OPTIONAL) PRINT THE NAME, HOME ADDRESS AND TELEPHONE NUMBER OF YOUR ALTERNATE AGENT

(2) Name of alternate agent if the person I appoint above is unable, unwilling, or unavailable to act as my health care agent (optional):

_____

_____

(name, home address and telephone number of alternate agent)

(3) I direct my agent to make health care decisions in accord with my wishes and limitations as may be stated below, or as he or she otherwise knows. If my wishes are unknown, I direct my agent to make health care decisions in accord with what he or she determines to be my best interest.

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INSTRUCTIONS

(OPTIONAL) 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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(4) Other directions (optional):

(Attach additional pages, if needed.)

DONATION OF ORGANS (OPTIONAL)

DONATION OF ORGANS (OPTIONAL)

Initial the line next to the statements below that best reflect your wishes. If you do not complete this section, your spouse, adult children, parents, adult siblings, or health care agent, in that order of priority, will have the authority to make a gift of a part of your body pursuant to law unless you give them notice orally or in writing that you do not want a gift made. The donation elections you make below survive your death.

I hereby make this organ and tissue gift, if medically acceptable, to take effect upon my death. The words and marks (or notations) below indicate my desires:

(7) Upon my death, I wish to donate:
_____ My body for anatomical study if needed.
_____ Any needed organs, tissues, or eyes.
_____ Only the following organs, tissues, or eyes;

INITIAL THE OPTION THAT REFLECTS YOUR WISHES

I authorize the use of my organs, tissues, or eyes:
_____For transplantation
_____ For therapy
_____ For research
_____ For medical education
_____ For any purpose authorized by law.

Limitations or special wishes, if any, list below:

LIST ANY LIMITAITONS OR SPECIAL WISHES

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

(Attach additional pages, if needed.)

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SIGN AND DATE THE DOCUMENT AND PRINT YOUR ADDRESS

EXECUTION

(5) Signature: _____

Name: _____

Date: _____

Address: _____

_____

Statement by Witnesses

I declare that the person who signed this document appears to be at least eighteen years of age, of sound mind, and under no constraint or undue influence. He or she signed (or asked another to sign for him or her) this document in my presence. I am not the person appointed as agent or alternate agent by this document.

Witness 1 Signature: _____

Name: _____

Address: _____

_____

Date: _____

YOUR WITNESSES MUST SIGN AND PRINT THEIR ADDRESSES

Witness 2 Signature: _____

Name: _____

Address: _____

_____

Date: _____

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