INTRODUCTION TO YOUR RHODE ISLAND ADVANCE DIRECTIVE

This packet contains a legal document, a **Rhode Island Advance 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 Part I, Part II, or both, depending on your advance-planning needs. You must complete Part III.

Part I contains a **Rhode Island Durable Power of Attorney for Health Care**. This part lets you name someone to make decisions about your medical care—including decisions about life-sustaining procedures—if you can no longer speak for yourself. The durable power of attorney for health care is especially useful because it appoints someone to speak for you any time you are unable to make your own medical decisions, not only at the end of life.

Your durable power of attorney for health care goes into effect when your doctor determines that you are no longer able to make or communicate your health care decisions.

Part II contains a **Rhode Island Declaration**, which is your state's living will. Your declaration lets you state your wishes about health care in the event that you can no longer make your own health care decisions and you are terminally ill.

Your living will goes into effect when your doctor determines that you are no longer able to make or communicate your health care decisions and you are terminally ill.

Part III 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: This document will be legally binding only if the person completing it is an individual of sound mind who is 18 years or older.

Completing Your Rhode Island Advance Directive

How do I make my Rhode Island Advance Directive legal?

If you complete Part I (Durable Power of Attorney), this document must be either

1. Witnessed by two (2) qualified adult witnesses. None of the following may be a witness:
    1. A person you designate as your agent or alternate agent,
    2. A health care provider,
    3. An employee of a health care provider,
    4. The operator of a community care facility,
    5. An employee of an operator of a community care facility.

    In addition, one of your witnesses must be unrelated to you and not entitled to any portion of your estate.

    OR

2. Witnessed by a notary public. Your Notary Public must be unrelated to you and not entitled to any portion of your estate.

If you complete Part II (Declaration), you must have your advance directive witnessed by two (2) qualified adult witnesses, both of whom must be unrelated to you and not entitled to any portion of your estate. If you completed ONLY Part II, your witnesses are subject only to the restriction that they must be unrelated to you and not entitled to any portion of your estate.

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.

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.

The person you appoint as your agent **cannot** be:

- your treating health care provider,
- an employee of your treating health care provider who is not related to you,
- an operator of a community care facility, or
- an employee of an operator of a community care facility who is not related to you.

Should I add personal instructions to my Rhode Island Advance Directive?

One of the strongest reasons for naming an agent is to have someone who can respond flexibly as your health care 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 medical care and describe what you consider to be an acceptable "quality of life."

What if I change my mind?

You may revoke your Rhode Island Advance Directive at any time and in any manner, regardless of your mental or physical condition. Your revocation becomes effective once you, or a witness to your revocation, communicate it to your doctor or any health care provider.

PART I

PART I: DURABLE POWER OF ATTORNEY FOR HEALTH CARE

This is an important legal document which is authorized by the general laws of this state. Before executing this document, you should know these important facts:

You must be at least eighteen (18) years of age and a resident of the state of Rhode Island for this document to be legally valid and binding.

This document gives the person you designate as your agent (the attorney in fact) the power to make health care decisions for you. Your agent must act consistently with your desires as stated in this document or otherwise made known.

NOTICE

Except as you otherwise specify in this document, this document gives your agent the power to consent to your doctor not giving treatment or stopping treatment necessary to keep you alive.

Notwithstanding this document, you have the right to make medical and other health care decisions for yourself so long as you can give informed consent with respect to the particular decision. In addition, no treatment may be given to you over your objection at the time, and health care necessary to keep you alive may not be stopped or withheld if you object at the time.

This document gives your agent authority to consent, to refuse to consent, or to withdraw consent to any care, treatment, service, or procedure to maintain, diagnose, or treat a physical or mental condition. This power is subject to any statement of your desires and any limitation that you include in this document. You may state in this document any types of treatment that you do not desire. In addition, a court can take away the power of your agent to make health care decisions for you if your agent:

(1) Authorizes anything that is illegal,
(2) Acts contrary to your known desires, or
(3) Where your desires are not known, does anything that is clearly contrary to your best interests.

Unless you specify a specific period, this power will exist until you revoke it. Your agent's power and authority ceases upon your death except to inform your next of kin of your desire to be an organ and tissue donor.

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You have the right to revoke the authority of your agent by notifying your agent or your treating doctor, hospital, or other health care provider orally or in writing of the revocation.

PART II

PRINT YOUR NAME

INITIAL ONLY ONE CHOICE REGARDING ARTIFICIAL FEEDING

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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PART II: DECLARATION (LIVING WILL)

I, _____,
(name)
being of sound mind, willfully and voluntarily make known my desire that my dying shall not be artificially prolonged under the circumstances set forth below, do hereby declare:

If I should have an incurable or irreversible condition that, without the administration of life-sustaining procedures, will cause my death, and if I am unable to make decisions regarding my medical treatment, I direct my attending physician to withhold or withdraw procedures that merely prolong the dying process and are not necessary to my comfort, or to alleviate pain.

This authorization (initial only one option)
_____ includes the withholding or withdrawal of artificial feeding.
_____ does not include the withholding or withdrawal of artificial feeding.

Other directions:

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(You may attach additional pages if you need more space to complete your statement. If you attach additional pages, you must date and sign EACH of the additional pages at the same time you date and sign this document.)

If you complete Part I, this document must be either

1. Witnessed by two (2) qualified adult witnesses. None of the following may be used as a witness:
    6. A person you designate as your agent or alternate agent,
    7. A health care provider,
    8. An employee of a health care provider,
    9. The operator of a community care facility,
    10. An employee of an operator of a community care facility.

In addition, one of your witnesses must be unrelated to you and not entitled to any portion of your estate.

OR

2. Witnessed by a notary public.

If you complete Part II, you must have your advance directive witnessed by two (2) qualified adult witnesses, both of whom must be unrelated to you and not entitled to any portion of your estate. If you completed ONLY Part II, your witnesses are subject only to the restriction that they must be unrelated to you and not entitled to any portion of your estate.

IF YOU HAVE YOUR SIGNATURE WITNESSED, USE ALTERNATIVE NO. 1 (P. 9)

IF YOU HAVE YOUR SIGNATURE NOTARIZED USE ALTERNATIVE NO. 2 (P. 10)

IF YOU COMPLETE PART II, YOU MUST HAVE YOUR ADVANCE DIRECTIVE WITNESSED BY TWO (2) QUALIFIED ADULT WITNESSES

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IF YOU HAVE ATTACHED ANY ADDITIONAL PAGES TO THIS FORM, YOU MUST DATE AND SIGN EACH OF THE ADDITIONAL PAGES AT THE SAME TIME YOU DATE AND SIGN THIS ADVANCE DIRECTIVE.

Alternative No. 1. Sign Before Witnesses.

PRINT YOUR NAME, THE DATE AND LOCATION

I _____(print name),

sign my name to this advance directive on

_____at _____, _____

(date) (city) (state)

SIGN HERE

_____

(Principal/Declarant Signature)

I declare under penalty of perjury that the person who signed or acknowledged this document is personally known to me to be the principal, that the principal/declarant signed or acknowledged this advance directive in my presence, and that the principal/declarant appears to be of sound mind and under no duress, fraud, or undue influence.

YOUR WITNESSES MUST SIGN, DATE AND PRINT THEIR NAMES AND ADDRESSES HERE

Signature: _____Date_____

Print Name: _____

Residence Address: _____

Signature: _____Date_____

Print Name: _____

Residence Address: _____

IF YOU COMPLETED PART I, YOUR WITNESSES MUST SIGN HERE

I further attest that I am not the person appointed as attorney in fact by this document, and that I am not a health care provider; an employee of a health care provider; the operator of a community care facility; nor an employee of an operator of a community care facility.

Signature: _____Date_____

IF YOU COMPLETED PART I, AT LEAST ONE OF YOUR WITNESSES MUST SIGN HERE
IF YOU COMPLETED PART II, BOTH OF YOUR WITNESSES MUST SIGN HERE

Signature: _____Date_____

I further attest that I am not related to the principal by blood, marriage, or adoption, and, to the best of my knowledge, I am not entitled to any part of the estate of the principal upon the death of the principal under a will now existing or by operation of law.

Signature: _____Date_____

Signature: _____Date_____

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Alternative No. 2. Sign Before a Notary Public

PRINT YOUR NAME, THE DATE AND LOCATION

I _____(print name),

sign my name to this advance directive on

_____ at _____,_____.
(date) (city) (state)

SIGN HERE

_____
(Principal/Declarant Signature)

Notary Public

_____ COUNTY,

A NOTARY PUBLIC MUST FILL OUT THIS PORTION OF YOUR FORM

In the City/Town of _____ and County and State aforesaid, on the

_____ day of _____ , 20 _____, personally came

_____ ,

IF YOU COMPLETE PART II, YOU MUST HAVE YOUR ADVANCE DIRECTIVE WITNESSED BY TWO (2) QUALIFIED ADULT WITNESSES

that the principal/declarant signed or acknowledged this advance directive in my presence, and that the principal appears to be of sound mind and under no duress, fraud, or undue influence. I further attest that I am not related to the principal by blood, marriage, or adoption, and, to the best of my knowledge, I am not entitled to any part of the estate of the principal upon the death of the principal under a will now existing or by operation of law.

_____
NOTARY PUBLIC

Commission expiration date: _____

_____Personally know by me

_____Produced identification

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

1. Your Rhode Island Advance 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 health care. 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 Rhode Island document.

7. Be aware that your Rhode Island 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," "do not resuscitate orders," or "medical orders for life sustaining treatment (MOLST)" 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.

Return to:
National Hospice Foundation
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Philadelphia, PA 19182-4401

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OR donate online today: www.NationalHospiceFoundation.org/donate