INTRODUCTION TO YOUR VERMONT ADVANCE DIRECTIVE

This packet contains a legal document, a **Vermont 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 and or all of the parts of this advance directive, depending on your advance-planning needs. You must complete Part 9.

Part 1. Appointment of an Agent. This part lets you name an adult, your "agent," to make decisions about your medical care—including decisions about life-sustaining procedures—if you can no longer speak for yourself. This 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 agent's authority will become effective:

- When your physician determines that you no longer have the **capacity** to make health care decisions, such as when you are unconscious or cannot communicate, and your physician has made reasonable efforts to notify you and your agent of such determination; or
- **Immediately** upon signing the advance directive if you so specify; or
- When a **condition** you specify is met, such as diagnosis of a debilitating disease such as Alzheimer's Disease or serious mental illness; or
- When an **event** occurs that you want to mark the start of your agent's authority, such as when you move to a nursing home or other institution.

Part 2 allows you to specify who may and may not be involved in determining your health care.

Part 3 allows you to record a statement of your values and goals to help guide your health care.

Part 4 allows you to record your health care treatment wishes if you are close to death or are unconscious and unlikely to become conscious again.

Part 5 allows you to record your wishes for treatment other than at the end of life.

Part 6 allows you to record your wishes regarding organ and tissue donation.

Part 7 allows you to appoint an agent for the disposition of your remains and to record your wishes regarding the final disposition of your remains.

Part 8 allows you to record any other advance planning consideration that you do not feel is adequately covered by the other parts.

Part 9 contains the witnessing and signature provisions to make your document 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 VERMONT ADVANCE DIRECTIVE

How do I make my Vermont Advance Directive legal?

In Part 9, you must sign and date your document in front of two witnesses, aged 18 or older. Neither witness can be your spouse, agent, parent, brother, sister, child, grandchild, or reciprocal beneficiary.

If you are in a hospital, nursing home, or residential care facility when you complete your advance directive, you will need a third person's signature to certify that he or she has explained the advance directive to you and that you understand the impact and effect of what you are doing. This third person may be a hospital designee, a long-term care ombudsman, an attorney licensed to practice in Vermont, a clergyperson, or a probate division of the superior court designee.

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 and third person as your alternate agent(s). The alternate will step in if the first person you name as an agent is unable, unwilling, or unavailable to act for you.

You cannot appoint your doctor or other health care clinician to be your agent. If you are in a residential facility, a health care facility, or a correctional facility, an owner, operator, employee and/or contractor of the facility cannot be your agent unless such person is related to you by blood, marriage, civil union, or adoption.

Part 7 allows you to appoint a person, also called an agent, to oversee the final disposition of your remains. This person may not be an unrelated funeral director, crematory operator, cemetery operator or an employee of a funeral director, crematory operator, or cemetery operator. He or she also may not be an unrelated employee or representative of an organ procurement organization.

Can I add personal instructions to my Vermont 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 Advance Directive by completing a new advance directive.

You may revoke or suspend all or part of your Advance Directive by doing any of the following things:

1. Signing a statement suspending or revoking the designation of your agent;
2. Personally informing your doctor and having him or her note that on your record;
3. By burning, tearing, or obliterating the Advance Directive either personally or at your direction when you are present;
4. For any provision (other than designation of your agent), when you state orally or in writing, or indicating by any other act of yours that your intent is to suspend or revoke any Part or statement contained in your Advance Directive; or
5. By executing a new Advance Directive.

What other important information should I know?

You may expressly provide in your Advance Directive that, in the event you lack capacity to make health care decisions, your agent may authorize or withhold health care over your objection. In order for this provision to be effective, the following must occur:

1. You must name an agent in your Advance Directive;
2. Your agent must accept in writing the responsibility for authorizing or withholding health care over your objection;
3. Your physician must sign this provision and affirm that you understood the benefits, risks, and alternatives of such a provision;
4. A long-term care ombudsman, an attorney licensed to practice in Vermont, a clergyperson, or a probate division of the superior court designee must sign a statement affirming that he or she has explained the provision to you and you appear to understand the provision and are free from duress or undue influence (this person must be a disinterested party and independent of the hospital if you are in the hospital when the provision is executed);
5. You must specify the treatments to which this provision applies; and
6. You must acknowledge that you are knowingly and voluntarily waiving the right to refuse or receive treatment at a time of incapacity, as determined by your physician and one other physician.

If you decide to include language regarding care given over your objection, you may wish to speak with your health care provider or an attorney with experience in drafting advance directives regarding this language. Any such language may be included in Part 8 of the Vermont Advance Directive.

Your agent does not have the authority to consent to voluntary sterilization.

PART 7 – DISPOSITION OF MY BODY AFTER DEATH

1. **My Directions for Burial or Disposition of My Remains after Death.**

INITIAL ONLY ONE

_____I want a funeral followed by burial in a casket at the following location, if possible (please tell us where the burial plot is located and whether it has been pre-purchased): _____ (or)

_____ I want to be cremated and want my ashes buried or distributed as follows:

_____ (or)

____ I want to have arrangements made at the direction of my agent or family.

Other instructions: _____

(for example, you may include contact information for Medical School programs if you have made arrangements to donate your body for research or education.)

2. Agent for disposition of my body (select one)**:**

INITIAL ONLY ONE

_____ I want my health care agent to decide arrangements after my death.
If he or she is not available, I want my alternate agent to decide.

_____ I appoint the following person to decide about and arrange for the disposition of my body after my death:

PRINT NAME, ADDRESS, TELEPHONE NUMBERS, AND EMAIL ADDRESS OF THE PERSON YOU WANT TO DECIDE ARRANGEMENTS AFTER YOUR DEATH

Name _____ Address _____

Telephone _____ Cell phone _____ Email _____

(or)

_____ I want my family to decide.

3. If an autopsy is suggested following my death:

INITIAL ONLY ONE

_____ I support having an autopsy performed.
_____ I would like my agent or family to decide whether to have it done.

4. I have already made funeral or cremation arrangements with:

PRINT NAME, ADDRESS, AND TELEPHONE NUMBER OF THE PERSON YOU MADE FUNERAL OR CREMATION ARRANGEMENTNTS WITH

Name _____ Tel. _____

Address _____

© 2005 National Hospice and Palliative Care Organization. 2022 Revised.

PART 8 – OTHER INSTRUCTIONS

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

I give the following instructions:

(attach additional pages if needed)

© 2005 National Hospice and Palliative Care Organization. 2022 Revised.

PART 9 – SIGNATURE AND WITNESSES

PRINT YOUR NAME, DATE OF BIRTH, AND TODAY'S DATE

My Name _____ **DOB** _____ **Date** _____

I declare that this document reflects my desires regarding my future health care, (organ and tissue donation and disposition of my body after death, and that I am signing this advance directive of my own free will.

SIGN AND DATE

Signed _____ Date _____

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

Acknowledgement of Witnesses

I affirm that the Principal appears to understand the nature of an Advance Directive and to be free from duress or undue influence.

Signed _____ Date _____

Print Name _____

Signed _____ Date _____

Print Name _____

IF YOU ARE IN A HOSPITAL, NURSING HOME, OR RESIDENTIAL CARE FACILITY, A THIRD PERSON MUST SIGN, DATE, AND PRINT HIS/HER NAME, ADDRESS, TITLE, AND TELEPHONE NUMBER

Acknowledgement by the person who explained the Advance Directive if the principal is a current patient or resident in a hospital, or other health care facility.

I affirm that:

- The maker of this Advance Directive is a current patient or resident in a hospital, nursing home or residential care facility,
- I am an ombudsman, recognized member of the clergy, an attorney licensed to practice in Vermont, or a probate division of the superior court designee or hospital designee, and
- I have explained the nature and effect of the Advance Directive to the Principal and it appears that the Principal is willingly and voluntarily executing it.

Signature_____Date _____

Name _____

Address _____

Title/position _____ Tel. _____

© 2005 National Hospice and Palliative Care Organization. 2022 Revised.

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

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

1. Your Vermont 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. Vermont maintains an Advance Directive Registry. By filing your advance directive with the registry, your health care provider and loved ones may be able to find a copy of your directive in the event you are unable to provide one. You can read more about the registry, including instructions on how to file your advance directive, at http://healthvermont.gov/vadr/index.aspx.

5. 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.

6. If you want to make changes to your documents after they have been signed and witnessed, you must complete a new document.

7. Remember, you can always revoke your Vermont document.

8. Be aware that your Vermont 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 "clinician orders for life-sustaining treatment" 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.

   Vermont authorizes a "Clinician Orders for Life-Sustaining Treatment" or "COLST" form that addresses these issues. 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
PO Box 824401
Philadelphia, PA 19182-4401

AD2022

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