VERMONT
Advance Directive
Planning for Important Healthcare Decisions

Courtesy of CaringInfo
www.caringinfo.org
800-658-8898

CaringInfo, a program of the National Hospice and Palliative Care Organization (NHPCO), 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.

6. Vermont maintains an Advance Directive Registry. By filing your advance directive with the registry, your healthcare provider and loved ones may be able to find a copy of your advance 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 https://www.healthvermont.gov/systems/advance-directives/create-register-and-make-changes-advance-directive.

INTRODUCTION TO YOUR VERMONT ADVANCE HEALTH CARE 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.

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.

How do I make my Vermont Advance Health Care 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 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 and third person as your alternate agents. An alternate agent will step in if the person(s) you name as agent is/are 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.

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 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.

You retain the primary authority for your healthcare decisions as long as you are able to make your wishes known.

Agent Limitations

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

Your agent will be bound by the current laws of Vermont as they regard pregnancy and termination of pregnancies.

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.

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?

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.

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.

ADVANCE DIRECTIVE

My Name _____ Date of Birth _____

Date signed _____

Address _____ City _____ Zip _____

Phone _____ Email _____

PRINT YOUR NAME, DATE OF BIRTH, DATE, ADDRESS, TELEPHONE NUMBER, AND EMAIL ADDRESS

PART 1 – APPOINTMENT OF AN AGENT

1. I want my agent to make decisions for me: (choose one statement below)

INITIAL ONLY ONE

_____ when I am no longer able to make health care decisions for myself, or

_____ immediately, allowing my agent to make decisions for me right now, or

_____ when the following condition or event occurs (to be determined as follows):

_____

_____

PRINT THE NAME OF YOUR AGENT

2. I appoint _____ as my health care Agent to make any and all health care decisions for me, except to the extent that I state otherwise in this Advance Directive. (You may cross out the italicized phrase if authority is unrestricted.)

PRINT ADDRESS, RELATIONSHIP, DAY TELEPHONE NUMBERS, AND EMAIL ADDRESS OF YOUR AGENT

Address _____ Relationship (optional) _____

_____

Tel. (daytime) _____ cell phone _____

(evening) _____ email _____

PRINT THE NAME OF YOUR ALTERNATE AGENT

PRINT ADDRESS, RELATIONSHIP, TELEPHONE NUMBERS, AND EMAIL ADDRESS OF YOUR ALTERNATE AGENT

PRINT THE NAME OF YOUR SECOND ALTERNATE AGENT

PRINT ADDRESS, RELATIONSHIP, TELEPHONE NUMBERS AND EMAIL ADDRESS OF YOUR NEXT ALTERNATE AGENT

PRINT ADDITIONAL INSTRUCTIONS, IF ANY, FOR YOUR AGENT HERE

ATTACH ADDITIONAL PAGES IF NEEDED

3. If this health care agent is unavailable, unable or unwilling to do this for me, I appoint _____ to be my Alternate Agent.

Address _____Relationship (optional) _____

Tel. (daytime) _____cell phone _____

(evening) _____email _____

And if my Alternate Agent is unavailable, unable or unwilling to do this, I appoint _____ as my Next Alternate Agent.

Address _____ Relationship (optional) _____

Tel. (daytime) _____cell phone _____

(evening) _____ email _____

4. General guidance for my agent: When making health care decisions for me, my agent should think about what action would be consistent with past conversations we have had, my treatment preferences as expressed in this or any other document, my religious and other beliefs and values, and how I have handled medical and other important issues in the past. If what I would decide is still unclear, then my agent should make decisions for me that my agent believes are in my best interest, considering the benefits, burdens, and risks of my current circumstances and treatment options.

5. I give the following further instructions, if any, for my agent's guidance:

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

(attach additional pages if needed)

PART 2 – OTHERS WHO MAY BE INVOLVED IN MY CARE

PRINT YOUR DOCTOR'S OR CLINICIAN'S NAME, ADDRESS AND PHONE NUMBER

1. My Doctor or other Health Care Clinician:

Name _____ Phone _____

Address _____

OR

Name _____ Phone _____

Address _____

LIST PEOPLE WHO MAY BE CONSULTED ABOUT YOUR HEALTH CARE DECISIONS

2. Other people whom my agent MAY consult about medical decisions on my behalf;

_____

_____

LIST PEOPLE WHO SHOULD NOT BE CONSULTED ABOUT YOUR HEALTH CARE DECISIONS

Those who should NOT be consulted by my agent include:

_____

LIST PEOPLE YOU WANT TO HAVE INFORMATION ABOUT YOUR CONDITION

3. My health agent or health care provider may give information about my condition to the following adults and minors:

_____

_____

LIST PEOPLE YOU DON'T WANT TO BE ABLE TO CHALLENGE YOUR AGENT OR CLINICIAN IN COURT REGARDING THE INSTRUCTIONS AND/OR APPOINTMENTS IN THIS DOCUMENT

4. The person(s) named below shall NOT be entitled to bring a court action on my behalf concerning matters covered by this advance directive, nor serve as a health care decision maker for me.

_____
_____
_____
_____
_____
_____
_____
_____

(attach additional pages if needed)

INITIAL TO INDICATE WHO YOU WANT NOMINATED AS YOUR GUARDIAN, IN THE EVENT A COURT DECIDES THAT YOU NEED ONE

LIST ALTERNATE GUARDIANS, IF ANY

LIST PEOPLE YOU DON'T WANT NOMINATED AS YOUR GUARDIAN

5. If I need a guardian in the future, I ask the court to consider appointing the following person:

_____ My health care agent

_____ The following person:

Name _____ Phone _____

Address _____

You may also list alternative preferred guardians, or persons that you would not want to have appointed as guardians.

Alternate preferred guardians:_____

Persons I would not want to be my guardian: _____

_____

PART 3 – STATEMENT OF VALUES AND GOALS

STATE IN YOUR OWN WORDS WHAT IS MOST IMPORTANT TO YOU REGARDING YOUR HEALTH CARE

Use the space below to state in your own words what is most important to you.

STATE GENERAL ADVICE ABOUT HOW TO APPROACH YOUR HEALTH CARE CHOICES

General advice about how to approach health care choices depending upon your current or future state of health or the chances of success of various treatments.

STATE OTHER VALUES AND GOALS TO HELP GUIDE HEALTH CARE DECISIONS MADE ON YOUR BEHALF

Other statement of values and goals to help guide health care decisions made on your behalf.

PART 4 – END-OF-LIFE WISHES

If the time comes when I am close to death or am unconscious and unlikely to become conscious again (initial all that apply):

INITIAL ONLY ONE OF CHOICES 1-3

1. _____ I **do** want all possible treatments to extend my life.

   - or -

2. _____ I **do not** want my life extended by any of the following means:

   _____ breathing machines (ventilator or respirator)

   _____tube feeding (feeding and hydration by medical means)

   _____ antibiotics

   _____ other medications whose purpose is to extend my life

   _____ any other means

   _____ Other (specify) _____

INITIAL ALL THAT APPLY TO YOU OF CHOICES 4-7

3. ___ I want my **agent to decide** what treatments I receive, including tube feeding.

4. _____ I want care that preserves my dignity and that provides **comfort and relief** from symptoms that are bothering me.

5. _____ I want **pain medication** to be administered to me even though this may have the unintended effect of hastening my death.

6. _____ I want **hospice** care when it is appropriate in any setting.

7. _____ I would prefer to **die at home** if this is possible.

ADD OTHER WISHES AND INSTRUCTIONS, IF ANY

8. Other wishes and instructions: (state below or use additional pages):

_____

_____

_____

_____

_____

PART 5 – OTHER TREATMENT WISHES

INITIAL ALL THAT APPLY TO YOU

1. _ I wish to have a **Do Not Resuscitate (DNR) Order** written for me.

2. _ If I am in a critical health crisis that may not be life-ending and more time is needed to determine if I can get better, I want treatment started. If, after a reasonable period of time, it becomes clear that I will not get better, I want all life extending treatment stopped. This includes the use of breathing machines or tube feeding.

3. If I am conscious but become unable to think or act for myself and will likely not improve, I do not want the following life-extending treatment:
   - _____ breathing machines (ventilators or respirators)
   - _____ feeding tubes (feeding and hydration by medical means)
   - _____ antibiotics
   - _____ other medications whose purpose is to extend life
   - _____ other treatment to extend my life
   - _____ other _____

4. _ If the likely cost, risks and burdens of treatment are more than I wish to endure, I do not want life-extending treatment. The costs, risks and burdens that concern me the most are: _____

   _____

5. _ If it is determined that I am pregnant at the time this Advance Directive becomes effective, I want:
   - _____ all life sustaining treatment, (or)
   - _____ only the following life sustaining treatments:
     - _____ breathing machines (ventilators or respirators)
     - _____ feeding tubes (feeding and hydration by medical means)
     - _____ antibiotics
     - _____ other medications whose purpose is to extend life
     - _____ any other treatment to extend my life
   - _____ other _____
   - _____ no life sustaining treatment.

LIST HOSPITALS OR TREATMENT FACILITIES NAME, ADDRESS AND PHONE NUMBERS

6. **Hospitalization** – If I need care in a hospital or treatment facility, the following facilities are listed in order of preference:

Hospital/Facility _____ Address _____
Tel. # _____

Hospital/Facility _____ Address _____
Tel. # _____

LIST HOSPITALS OR TREATMENT FACILITIES YOU WANT TO AVOID, AND REASON

I would like to avoid being treated in **the following facilities:**

Hospital/Facility _____

Hospital/Facility _____

LIST MEDICATIONS OR TREATMENTS YOU WOULD LIKE TO RECEIVE

7. **I prefer the following medications or treatments:** Use more space or additional sheets for this section, if needed.

_____

LIST MEDICATIONS OR TREATMENTS YOU WOULD LIKE TO AVOID AND REASONS

Avoid **use of the following medications or treatments:**

List medications/treatments:

_____

_____

INITIAL AND CIRCLE THE ONE THAT APPLIES TO YOU

8. **Consent for Student Education, Treatment Studies, or Drug Trials**

_____**I do / do not** (circle one) wish to participate in student medical education.

_____**I do / do not** (circle one) wish to participate in treatment studies or drug trials.

(or)

_____ I authorize **my agent to consent** to any of the above.

PART 6 – ORGAN AND TISSUE DONATION

I want my agent (if I have appointed one) and all who care about me to follow my wishes about organ donation if that is an option at the time of my death. (Initial below all that apply.)

INITIAL ONLY ONE

_____I do not wish to be an organ donor.

_____I wish to donate the following organs and tissues:

INITIAL YOUR ORGAN DONATION CHOICES

_____ any needed organs or tissues
_____major organs (heart, lungs, kidneys, etc.)
_____tissues such as skin and bones
_____eye tissue such as corneas

Agent for organ donation (optional)

YOU MAY CHOOSE SOMEONE TO MAKE ORGAN DONATION DECISIONS FOR YOU

_____ I wish my agent to make any decisions for anatomical gifts

OR

_____ I wish the following person(s) to make any decisions:

_____

_____

INITIAL HERE IF YOU WANT TO DONATE YOUR BODY TO SCIENCE

_____I desire to donate my body to research or educational programs.

(Note: you will have to make your own arrangements through a Medical School or other program.)

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 ARRANGEMENTS WITH

Name _____ Tel. _____

Address _____

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)

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 _____

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.

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

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. _____

Courtesy of CaringInfo

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