# ADVANCE HEALTH-CARE DIRECTIVE

(*Pursuant to the Uniform Health–Care Decisions Act of 2023*)

HOW YOU CAN USE THIS FORM

You can use this form if you wish to name someone to make health-care decisions for you in case you cannot make decisions for yourself. This is called giving the person a power of attorney for health care. This person is called your Agent.

You can also use this form to state your wishes, preferences, and goals for health care, and to say if you want to be an organ donor after you die.

YOUR NAME AND DATE OF BIRTH

Name: _____

Date of Birth: _____

**PART A: NAMING AN AGENT**

This part lets you name someone else to make health-care decisions for you. You may leave any item blank.

1. NAMING AN AGENT

I want the following person to make health-care decisions for me if I cannot make decisions for myself:

Name: _____

Optional contact information (*it is helpful to include information such as address, phone, and email*): _____

2. NAMING AN ALTERNATE AGENT

I want the following person to make health-care decisions for me if I cannot and my Agent is not able or available to make them for me:

Name: _____

Optional contact information (*it is helpful to include information such as address, phone, and email*): _____

3. LIMITING YOUR AGENT'S AUTHORITY

I give my Agent the power to make all health-care decisions for me if I cannot make those decisions for myself, except the following:

(*If you do not add a limitation here, your Agent will be able make all health-care decisions that an Agent is permitted to make under State law.)*

_____

_____

_____

**PART B: HEALTH-CARE INSTRUCTIONS**

This part lets you name someone else to make health-care decisions for you. You may leave any item blank. This part lets you state your priorities for health care and to state types of health care you do and do not want.

1. INSTRUCTIONS ABOUT LIFE-SUSTAINING TREATMENT

This section gives you the opportunity to say how you want your Agent to act while making decisions for you. You may mark or initial each choice. You also may leave any choice blank.

**Treatment**. Medical treatment needed to keep me alive but not needed for comfort or any other purpose should: (*mark or initial all that apply*):

(___) Always be given to me. (*If you mark or initial this choice, you should not mark or initial other choices in this "treatment" section.*)

(___) Not be given to me if I have a condition that is not curable and is expected to cause my death soon, even if treated.

(___) Not be given to me if I am unconscious and I am not expected to be conscious again.

(___) Not be given to me if I have a medical condition from which I am not expected to recover that prevents me from communicating with people I care about, caring for myself, and recognizing family and friends.

(___) Other (*write what you want or do not want below*):

_____

**Food and Liquids**. If I can't swallow and staying alive requires me to get food or liquids through a tube or other means for the rest of my life, then food or liquids should: (*mark or initial all that apply*)

(___) Always be given to me. (*If you mark or initial this choice, you should not mark or initial other choices in this "food and liquids" section.*)

(___) Not be given to me if I have a condition that is not curable and is expected to cause me to die soon, even if treated.

(___) Not be given to me if I am unconscious and am not expected to be conscious again.

(___) Not be given to me if I have a medical condition from which I am not expected to recover that prevents me from communicating with people I care about, caring for myself, and recognizing family and friends.

(___) Other (*write what you want or do not want below*):

_____

(___) **Pain Relief**. If I am in significant pain, care that will keep me comfortable but is likely to shorten my life should: (*mark or initial all that apply*)

(___) Always be given to me. (*If you mark or initial this choice, you should not mark or initial other choices in this "pain relief" section.*)

(___) Never be given to me. (*If you mark or initial this choice, you should not mark or initial other choices in this "pain relief" section.*)

(___) Be given to me if I have a condition that is not curable and is expected to cause me to die soon, even if treated.

(___) Be given to me if I am unconscious and am not expected to be conscious again.

(___) Be given to me if I have a medical condition from which I am not expected to recover that prevents me from communicating with people I care about, caring for myself, and recognizing family and friends.

(___) Other (*write what you want or do not want below*):

_____

2. MY PRIORITIES

You can use this section to indicate what is important to you, and what is not important to you. This information can help your Agent make decisions for you if you cannot. It also helps others understand your preferences.

You may mark or initial each choice. You also may leave any choice blank.

Staying alive as long as possible even if I have substantial physical limitations is:

(___) Very important

(___) Somewhat important

(___) Not important

Staying alive as long as possible even if I have substantial mental limitations is:

(___) Very important

(___) Somewhat important

(___) Not important

Being free from significant pain is:

(___) Very important

(___) Somewhat important

(___) Not important

Being independent is:

(___) Very important

(___) Somewhat important

(___) Not important

Having my Agent talk with my family before making decisions about my care is:

(___) Very important

(___) Somewhat important

(___) Not important

Having my Agent talk with my friends before making decisions about my care is:

(___) Very important

(___) Somewhat important

(___) Not important

3. OTHER INSTRUCTIONS

You can write in this section more information about your goals, values, and preferences for treatment, including care you want or do not want. You can also use this section to name anyone who you do not want to make decisions for you under any conditions.

_____

_____

_____

**PART C: OPTIONAL SPECIAL POWERS AND GUIDANCE**

This part lets you give your Agent additional powers, and to provide more guidance about your wishes. You may mark or initial each choice. You also may leave any choice blank.

1. OPTIONAL SPECIAL POWERS

My Agent can do the following things ONLY if I have marked or initialed them below:

(___) Admit me as a voluntary patient to a facility for mental health treatment for up to _____ days (*write in the number of days you want like 7, 14, 30 or another number*).

(*If I do not mark or initial this choice, my Agent MAY NOT admit me as a voluntary patient to this type of facility.*)

(___) Place me in a nursing home for more than 100 days even if my needs can be met somewhere else, I am not terminally ill, and I object.

(*If I do not mark or initial this choice, my Agent MAY NOT do this.*)

2. ACCESS TO MY HEALTH INFORMATION

My Agent may obtain, examine, and share information about my health needs and health care if I am not able to make decisions for myself.

If I mark or initial below, my Agent may also do that at any time my Agent thinks it will help me.

(___) I give my Agent permission to obtain, examine, and share information about my health needs and health care whenever my Agent thinks it will help me.

3. FLEXIBILITY FOR MY AGENT

(___) Mark or initial here if you want to give your Agent flexibility in following instructions you provide in this form. If you do not, your Agent must follow the instructions even if your Agent thinks something else would be better for you.

4. NOMINATION OF GUARDIAN

You can say who you would want as your guardian if you needed one. A guardian is a person appointed by a court to make decisions for someone who cannot make decisions.

Filling this out does NOT mean you want or need a guardian. There is no guarantee that the court will appoint the person you want as guardian.

If a court appoints a guardian to make personal decisions for me, I want the court to choose:

(___) My Agent named in this form. If my Agent cannot be a guardian, I want the Alternate Agent named in this form.

(___) Other (*write who you would want and their contact information below*):

_____

**PART D: ORGAN DONATION**

This part lets you donate your organs after you die. You may have already indicated a decision on your driver's license, identification card, or in another registry. You may leave any item blank.

1. DONATION

You may mark or initial only one choice. Leave this “donation” section blank if you do not want to include your decision here.

(___) I donate my organs, tissues, and other body parts after I die, even if it requires maintaining treatments that conflict with other instructions I have put in this form, EXCEPT for those I list below (*list any body parts you do NOT want to donate below*):

_____

_____

(___) I do not want my organs, tissues, or other body parts donated to anybody for any reason. (*If you mark or initial this choice, you should skip the "purpose of donation" section.*)

2. PURPOSE OF DONATION

You may mark or initial all that apply. (*If you do not mark or initial any of the purposes below, your donation can be used for all of them.*)

Organs, tissues, or other body parts that I donate may be used for:

(___) Transplant

(___) Therapy

(___) Research

(___) Education

(___) All of the above

**PART E: SIGNATURES**

YOUR SIGNATURE

Sign your name: _____

Today's date: _____

City/Town/Village and State (*optional*): _____

SIGNATURE OF A WITNESS

You need a witness if you are using this form to name an Agent. The witness must be an adult and cannot be the person you are naming as Agent or the Agent's spouse, domestic partner, or someone the Agent lives with as a couple.

If you live or are receiving care in a nursing home or long-term care facility, the witness cannot be an employee or contractor of the home or someone who owns or runs the home.

Name of Witness: _____

Signature of Witness: _____

(***Only sign as a witness if you think the person signing above is doing it voluntarily.***)

Date witness signed: _____

**PART F: INFORMATION FOR AGENTS**

1. If this form names you as an Agent, you can make decisions about health care for the person who named you when the person cannot make their own.

2. If you make a decision for the person, follow any instructions the person gave, including any in this form.

3. If you do not know what the person would want, make the decision that you think is in the person's best interest. To figure out what is in the person's best interest, consider the person's values, preferences, and goals if you know them or can learn them. Some of these preferences may be in this form. You should also consider any behavior or communication from the person that indicates what the person currently wants.

4. If this form names you as an Agent, you can also get and share the person's health information. But unless the person has said so in this form, you can get or share this information only when the person cannot make decisions about the person's health care.