

A Catholic Health Care Directive for Rhode Island

I believe that God created me for eternal life in union with Him, that my life is a precious gift from God and that this truth should inform all decisions with regards to my health care. Therefore, by this document, I, an adult eighteen (18) years of age and a resident of the State of Rhode Island, intend to create a durable power of attorney for health care.

MY HEALTH CARE AGENT

I, _____, trust and appoint _____ as my health care agent. As my health care agent, this person has the authority to make health care decisions for me and to receive and consent to the release of my medical information only if I am unable to make such decisions for myself. This document revokes any prior Living Will and Durable Power of Attorney for Health Care, and will remain effective until it is itself revoked. I have discussed my principles and beliefs with my agent, who shall decide for me in a manner consistent with my desires stated in this document or otherwise made known to my agent, including but not limited to, my desires concerning obtaining or refusing or withdrawing life-prolonging care, treatment, services and procedures, and informing my family and next of kin of my desire, if any, to be an organ or tissue donor. Subject to any limitations in this document, where necessary to fulfill the authority and responsibility conferred by this document, my agent has the power and authority to: (a) request, review, receive, and consent to the disclosure of any information, verbal or written, regarding my physical or mental health, including, but not limited to, medical and hospital records, and (b) execute on my behalf all of the following: any releases or other documents required to obtain confidential health care information, any documents titled or purporting to be a "Refusal to Permit Treatment" or "Leaving Hospital Against Medical Advice", and any necessary waivers or releases from liability required by a hospital or physician. If my health care agent is not reasonably available, I trust and appoint _____ to be my health care agent instead.

Note: If the agent you designate is your spouse, he or she becomes ineligible to act as your agent in the case that you become legally divorced.

MY DIRECTIONS

If I fall terminally ill, I ask that I be told of this so that I might prepare myself for death, and I ask that efforts be made that I be attended by a Catholic priest and receive the Sacraments of Reconciliation, Anointing, and Eucharist as viaticum (in the case that the principal is a non-Catholic, a minister of the principal's own faith tradition should be contacted).

The following is what I want my health care agent to do if I am unable to make or communicate health care decisions for myself. Most of what I state here is general in nature since I cannot anticipate all the possible circumstances of a future illness. I have provided a document bearing my original signature and that of my witnesses to my agent and to my alternate agent. Photocopies of the documents with my original signature may be made for informational purposes only.

- I direct that my agent request and consent to care, treatment, services, and procedures, including palliative care, which are appropriate to my condition and are beneficial for me, subject only to the limitations, provisions and directions expressed in this document. The meanings of the words "appropriate" and "beneficial," for the purpose of this direction, are those which I have discussed with my agent.
- I authorize my agent to withhold or withdraw consent to treatment, services and procedures, including palliative care, which are not appropriate to my condition and are not beneficial for me, subject only to the limitations, provisions and directions expressed in this document. The meanings of the words "not appropriate" and "not beneficial," for the purpose of this direction, are those which I have discussed with my agent.
- There should be a presumption in favor of providing me with nutrition and hydration, including medically assisted nutrition and hydration, unless death is inevitable and truly imminent so that the effort to sustain my life is futile or unless I am unable to assimilate food and fluids. The meanings of the words "imminent" and "futile" for the purpose of this direction are those which I have discussed with my agent.
- In accord with the teachings of the Catholic Church, I have no moral objection to the use of medication or procedures necessary for my comfort even if they may indirectly and unintentionally shorten my life.
- I direct that my agent make the determination of whether or if a Do Not Resuscitate (DNR) order is appropriate for me.
- I direct that my life is not to be ended by assisted suicide or by euthanasia, which the Catholic Church defines as "an action or omission which of itself and by intention causes death, with the purpose of eliminating all suffering." For the purpose of this direction, "euthanasia" means any action which would directly and intentionally cause my death.

Health Care Agent Information

Name: _____

Address: _____

Phone: _____ Cell: _____

Relationship to me: _____

Alternate Health Care Agent Information

Name: _____

Address: _____

Phone: _____ Cell: _____

Relationship to me: _____

None of the following may be designated as my agent or alternative agent:

1. My treating health care provider;
2. A non-relative employee of my treating health care provider;
3. An operator of a community care facility;
4. A non-relative employee of an operator of a community care facility;
5. Anyone under age 18.

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DATE AND SIGNATURE OF PRINCIPAL (person this document was created for). **This must be completed.**

I, an adult over the age of 18, sign this Health Care Directive on _____ (date) at _____ (city), _____ (state).

(Your signature)

(Print your name and address)

Making an Anatomical Gift (Optional)

So long as it is consistent with Catholic moral teaching, I would like to be an organ donor at the time of my death.

I wish to donate the following (initial one statement):

- Any needed organs and tissue.
 Only the following organs and tissue:

_____.

Acceptance of Appointment by Health Care Agent

I accept this appointment and agree to serve as a health care agent. I understand I have a duty to act in good faith, consistent with the desires expressed in this document, and that this document gives me authority to make health care decisions for the principal only when he or she is unable to make or communicate his or her own decisions. I understand that the principal may revoke this appointment at any time, in any manner. If I choose to withdraw during the time the principal is competent, I must notify the principal of my decision. If I choose to withdraw when the principal is not competent, I must notify the principal's physician.

(Signature of agent) (date)

(Signature of alternate agent) (date)

WITNESSES

Two qualified witnesses must sign the durable power of attorney for health care form at the same time the principal signs the document. The witnesses must be 18 or older and must **NOT** be any of the following:

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. An operator of a community care facility
5. An employee of an operator of a community care facility

This health care directive WILL NOT BE VALID UNLESS it is signed by TWO QUALIFIED WITNESSES or a NOTARY PUBLIC who are PRESENT when you sign or acknowledge your signature. 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 health care directive.

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 signed or acknowledged this durable power of attorney in my presence, that the principal appears to be of sound mind and under no duress, fraud, or undue influence, and that I meet the requirements for witnesses as stated above.

Option 1 – Two (2) Qualified Witnesses:

Witness One:

Signature: _____

Print Name: _____

Date: _____

Residence Address: _____

City: _____ State: _____

Phone: _____

Witness Two:

Signature: _____

Print Name: _____

Date: _____

Residence Address: _____

City: _____ State: _____

Phone: _____

Option 2 – One Notary Public

Witness One:

Signature: _____

Print Name: _____

Date: _____

My Commission expires on _____

At least one of the qualified witnesses or the notary public must make this additional declaration:

I further declare under penalty 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: _____

Print Name: _____