***HEALTH CARE PLANNING***
***USING ADVANCE DIRECTIVES***
*Optional Form Included*
***Your Right To Decide***

Adults can decide for themselves whether they want medical treatment. This right to decide ） to say yes or no to proposed treatment ） applies to treatments that extend life, like a breathing machine or a feeding tube. Tragically, accident or illness can take away a person's ability to make health care decisions. But decisions still have to be made. If you cannot do so, someone else will. These decisions should reflect your own values and priorities.

A Maryland law called the Health Care Decisions Act says that you can do health care planning through "advance directives." An advance directive can be used to name a health care agent. This is someone you trust to make health care decisions for you. An advance directive can also be used to say what your preferences are about treatments that might be used to sustain your life.

The State offers a form to do this planning, included with this pamphlet. The form as a whole is called "Maryland Advance Directive: Planning for Future Health Care Decisions." It has three parts to it: Part I, Selection of Health Care Agent; Part II, Treatment Preferences ("Living Will"); and Part III, Signature and Witnesses. This pamphlet will explain each part.

The advance directive is meant to reflect your preferences. You may complete all of it, or only part, and you may change the wording. You are *not* required by law to use these forms. Different forms, written the way you want, may also be used. For example, one widely praised form, called *Five Wishes,* is available (for a small fee) from the nonprofit organization Aging With Dignity. You can get information about that document from the Internet at www.agingwithdignity.org or write to: Aging with Dignity, P.O. Box 1661, Tallahassee, FL 32302.

This optional form can be filled out without going to a lawyer. But if there is anything you do not understand about the law or your rights, you might want to talk with a lawyer. You can also ask your doctor to explain the medical issues, including the potential benefits or risks to you of various options. You should tell your doctor that you made an advance directive and give your doctor a copy, along with others who could be involved in making these decisions for you in the future.

In Part III of the form, you need two witnesses to your signature. Nearly any adult can be a witness. If you name a health care agent, though, that person may not be a witness. Also, one of the witnesses must be a person who would not financially benefit by your death or handle your estate. You do not need to have the form notarized.

This pamphlet also contains a separate form called "After My Death." Like the advance directive, using it is optional. This form has four parts to it: Part I, Organ Donation; Part II, Donation of Body; Part III, Disposition of Body and Funeral Arrangements; and Part IV, Signature and Witnesses.

Once you make an advance directive, it remains in effect unless you revoke it. It does not expire, and neither your family nor anyone except you can change it. You should review what you've done once in a while. Things might change in your life, or

your attitudes might change. You are free to amend or revoke an advance directive at any time, as long as you still have decision-making capacity. Tell your doctor and anyone else who has a copy of your advance directive if you amend it or revoke it.

If you already have a prior Maryland advance directive, living will, or a durable power of attorney for health care, that document is *still valid*. Also, if you made an advance directive in another state, it is valid in Maryland. You might want to review these documents to see if you prefer to make a new advance directive instead.

**Part I of the Advance Directive: Selection of Health Care Agent**

You can name anyone you want (except, in general, someone who works for a health care facility where you are receiving care) to be your health care agent. **To name a health care agent, use Part I of the advance directive form**. (Some people refer to this kind of advance directive as a "durable power of attorney for health care.") Your agent will speak for you and make decisions based on what you would want done or your best interests. You decide how much power your agent will have to make health care decisions. You can also decide when you want your agent to have this power ） right away, or only after a doctor says that you are not able to decide for yourself.

You can pick a family member as a health care agent, but you don't have to. Remember, your agent will have the power to make important treatment decisions, even if other people close to you might urge a different decision. Choose the person best qualified to be your health care agent. Also, consider picking one or two back-up agents, in case your first choice isn't available when needed. Be sure to inform your chosen person and make sure that he or she understands what's most important to you. When the time comes for decisions, your health care agent should follow your written directions.

We have a helpful booklet that you can give to your health care agent. It is called *"Making Medical Decisions for Someone Else: A Maryland Handbook."* You or your agent can get a copy on the Internet by visiting to the Attorney General's home page at: http://www.oag.state.md.us, then clicking on "Guidance for Health Care Proxies." You can also request a copy by calling 410-576-7000.

The form included with this pamphlet
does *not* give anyone power to handle your money. We do not have a standard form to send. Talk to your lawyer about planning for financial issues in case of incapacity.

**Part II of the Advance Directive: Treatment Preferences ("Living Will")**

You have the right to use an advance directive to say what you want about future life-sustaining treatment issues. You can do this in Part II of the form. If you both name a health care agent and make decisions about treatment in an advance directive, it's important that you say (in Part II, paragraph G) whether you want your agent to be strictly bound by whatever treatment decisions you make.

Part II is a living will. It lets you decide about life-sustaining procedures in three situations: when death from a terminal condition is imminent despite the application of life-sustaining procedures; a condition of permanent unconsciousness called a persistent vegetative state; and end-stage condition, which is an advanced, progressive, and incurable condition resulting in complete physical dependency. One example of end-stage condition could be advanced Alzheimer's disease.

## *FREQUENTLY ASKED QUESTIONS ABOUT ADVANCE DIRECTIVES IN MARYLAND*

***1. Must I use any particular form?***

No. An optional form is provided, but you may change it or use a different form altogether. Of course, no health care provider may deny you care simply because you decided not to fill out a form.

***2. Who can be picked as a health care agent?***

Anyone who is 18 or older except, in general, an owner, operator, or employee of a health care facility where a patient is receiving care.

***3. Who can witness an advance directive?***

Two witnesses are needed. Generally, any competent adult can be a witness, including your doctor or other health care provider (but be aware that some facilities have a policy against their employees serving as witnesses). If you name a health care agent, that person cannot be a witness for your advance directive. Also, **one** of the two witnesses must be someone who (i) will not receive money or property from your estate and (ii) is not the one you have named to handle your estate after your death.

***4. Do the forms have to be notarized?***

No, but if you travel frequently to another state, check with a knowledgeable lawyer to see if that state requires notarization.

***5. Do any of these documents deal with financial matters?***

No. If you want to plan for how financial matters can be handled if you lose capacity, talk with your lawyer.

***6. When using these forms to make a decision, how do I show the choices that I have made?***

Write your **initials** next to the statement that says what you want. **Don't** use checkmarks or X's. If you want, you can also draw lines all the way through other statements that do not say what you want.

***7. Should I fill out both Parts I and II of the advance directive form?***

It depends on what you want to do. If all you want to do is name a health care agent, just fill out Parts I and III, and talk to the person about how they should decide issues for you. If all you want to do is give treatment instructions, fill out Parts II and III. If you want to do both, fill out all three parts.

***8. Are these forms valid in another state?***

It depends on the law of the other state. Most state laws recognize advance directives made somewhere else.

***9. How can I get advance directive forms for another state?***

Contact Caring Connections (NHPCO) at 1-800-658-8898 or on the Internet at: http://www.caringinfo.org.

***10. To whom should I give copies of my advance directive?***

Give copies to your doctor, your health care agent and backup agent(s), hospital or nursing home if you will be staying there, and family members or friends who should know of your wishes.

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Consider carrying a card in your wallet saying you have an advance directive and who to contact.

***11. Does the federal law on medical records privacy (HIPAA) require special language about my health care agent?***

Special language is not required, but

it is prudent. Language about HIPAA has been incorporated into the form.

***12. Can my health care agent or my family decide treatment issues differently from what I wrote?***

It depends on how much flexibility you want to give. Some people want to give family members or others flexibility in applying the living will. Other people want it followed very strictly. Say what you want in Part II, Paragraph G.

***13. Can my doctor override my living will?***

Usually, no. However, a doctor is not required to provide a "medically ineffective" treatment even if a living will asks for it.

***14. If I have an advance directive, do I also need an Emergency Medical Services Palliative Care/Do Not Resuscitate Order?***

Yes. If you **don't** want ambulance personnel to try to resuscitate you in the event of cardiac or respiratory arrest, you must have an EMS Palliative Care/DNR Order signed by your doctor.

***15. Does the EMS Palliative Care/DNR Order have to be in a particular form?***

Yes. Ambulance personnel have very little time to evaluate the situation and act appropriately. So, it is not practical to ask them to interpret documents that may vary in form and content. Instead, a standardized order form has been developed. Have your doctor or health care facility contact the Maryland Institute for Emergency Medical Services System at (410) 706-4367 to obtain information on EMS Palliative Care/DNR Orders.

***16. Can I fill out a form to become an organ donor?***

Yes. Use Part I of the "After My Death" form.

***17. What about donating my body for medical education or research?***

Part II of the "After My Death" form is a general statement of these wishes. The State Anatomy Board has a specific donation program, with a pre-registration form available. Call the Anatomy Board at 1-877-463-3464 for that form and additional information.

**REVISED MARCH 2007**

***IF YOU HAVE OTHER QUESTIONS, PLEASE TALK TO YOUR DOCTOR OR YOUR LAWYER. OR, IF YOU HAVE A QUESTION ABOUT THE FORMS THAT IS NOT ANSWERED IN THIS PAMPHLET, YOU CAN CALL THE HEALTH POLICY DIVISION OF THE ATTORNEY GENERAL'S OFFICE AT (410) 576-6327 OR EMAIL US AT ADFORMS@OAG.STATE.MD.US.***

***MORE INFORMATION ABOUT ADVANCE DIRECTIVES CAN BE OBTAINED FROM OUR WEBSITE AT:***

***http://www.oag.state.md.us/Healthpol/***

MILITARY ADVANCE MEDICAL DIRECTIVE PREAMBLE: This is a MILITARY ADVANCE MEDICAL DIRECTIVE prepared pursuant to Title 10 United States Code, Sections1044c, and executed by a person authorized to receive legal assistance from the military services. Federal law exempts this advance medical directive from any requirement of form, formality, or recording that is prescribed for

similar documents under the laws of a state, the District of Columbia, or a territory, commonwealth or possession of the United States. Federal law specifies that this advance medical directive shall be given the same legal effect as an advance medical directive prepared and executed in accordance with the laws of the jurisdiction in which it is presented. It shall remain valid unless and until the undersigned person revokes it.

# MARYLAND ADVANCE DIRECTIVE: PLANNING FOR FUTURE HEALTH CARE DECISIONS

**By**: _____ **Date of Birth:**_____
(Print Name) (Month/Day/Year)

Using this advance directive form to do health care planning is completely optional. Other forms are also valid in Maryland. No matter what form you use, talk to your family and others close to you about your wishes.

This form has two parts to state your wishes, and a third part for needed signatures. Part I of this form lets you answer this question: If you cannot (or do not want to) make your own health care decisions, who do you want to make them for you? The person you pick is called your health care agent. **Make sure you talk to your health care agent (and any back-up agents) about this important role.** Part II lets you write your preferences about efforts to extend your life in three situations: terminal condition, persistent vegetative state, and end-stage condition. In addition to your health care planning decisions, you can choose to become an organ donor after your death by filling out the form for that too.

You can fill out Parts I and II of this form, or only Part I, or only Part II. Use the form to reflect your wishes, then sign in front of two witnesses (Part III). If your wishes change, make a new advance directive. »

Make sure you give a copy of the completed form to your health care agent, your doctor, and others who might need it. Keep a copy at home in a place where someone can get it if needed. Review what you have written periodically.

## PART I: SELECTION OF HEALTH CARE AGENT

### A. Selection of Primary Agent

I select the following individual as my agent to make health care decisions for me:

**Name:**

_____

**Address:**_____

**Telephone Numbers:**

(home and cell)

**B. Selection of Back-up Agents**
(Optional; form valid if left blank)

1. If my primary agent cannot be contacted in time or for any reason is unavailable or unable or unwilling to act as my agent, then I select the following person to act in this capacity:
**Name:**

**Address:**

**Telephone Numbers:**

(home and cell)

2. If my primary agent and my first back-up agent cannot be contacted in time or for any reason are unavailable or unable or unwilling to act as my agent, then I select the following person to act in this capacity:
**Name:**

**Address:**

**Telephone Numbers:**

(home and cell)

**C. Powers and Rights of Health Care Agent**
I want my agent to have full power to make health care decisions for me, including the power to:

1. Consent or not to medical procedures and treatments which my doctors offer, including things that are intended to keep me alive, like ventilators and feeding tubes;
2. Decide who my doctor and other health care providers should be; and
3. Decide where I should be treated, including whether I should be in a hospital, nursing home, other medical care facility, or hospice program.
4. I also want my agent to:
    a. Ride with me in an ambulance if ever I need to be rushed to the hospital; and

b. Be able to visit me if I am in a hospital or any other health care facility.

*THIS ADVANCE DIRECTIVE DOES NOT MAKE MY AGENT RESPONSIBLE FOR ANY OF THE COSTS OF MY CARE.*

This power is subject to the following conditions or limitations:
(Optional; form valid if left blank)

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

**D. How my Agent is to Decide Specific Issues**

I trust my agent's judgment. My agent should look first to see if there is anything in Part II of this advance directive that helps decide the issue. Then, my agent should think about the conversations we have had, my religious and other beliefs and values, my personality, and how I handled medical and other important issues in the past. If what I would decide is still unclear, then my agent is to make decisions for me that my agent believes are in my best interest. In doing so, my agent should consider the benefits, burdens, and risks of the choices presented by my doctors.

**E. People My Agent Should Consult**
(Optional; form valid if left blank)

In making important decisions on my behalf, I encourage my agent to consult with the following people. By filling this in, I do not intend to limit the number of people with whom my agent might want to consult or my agent's power to make decisions.

**Name(s)** **Telephone Number(s):**

_____ _____
_____ _____

_____ _____
_____ _____

**F. In Case of Pregnancy**
(Optional, for women of child-bearing years only; form valid if left blank)

If I am pregnant, my agent shall follow these specific instructions:
_____
_____
_____

**G. Access to my Health Information – Federal Privacy Law (HIPAA) Authorization**

1. If, prior to the time the person selected as my agent has power to act under this document, my doctor wants to discuss with that person my capacity to make my own health care decisions, I authorize my doctor to disclose protected health information which relates to that issue.
2. Once my agent has full power to act under this document, my agent may request, receive, and review any information, oral or written, regarding my physical or mental health, including, but not limited to, medical and hospital records and other protected health information, and consent to disclosure of this information.
3. For all purposes related to this document, my agent is my personal representative under the Health Insurance Portability and Accountability Act (HIPAA). My agent may sign, as my personal representative, any release forms or other HIPAA-related materials.

**H. Effectiveness of this Part**
(Read both of these statements carefully. Then, initial **one** only.)

My agent's power is in effect:
1. Immediately after I sign this document, subject to my right to make any decision about my health care if I want and am able to. _____

**>>OR<<**

2. Whenever I am not able to make informed decisions about my health care, either because the doctor in charge of my care (attending physician) decides that I have lost this ability **temporarily**, or my attending physician and a consulting doctor agree that I have lost this ability **permanently.** _____

**If the only thing you want to do is select a health care agent, skip Part II. Go to Part III to sign and have the advance directive witnessed. If you also want to write your treatment preferences, go to Part II. Also consider becoming an organ donor, using the separate form for that.**

## PART II: TREATMENT PREFERENCES ("LIVING WILL")

**A. Statement of Goals and Values**
(Optional: Form valid if left blank)
I want to say something about my goals and values, and especially what's most important to me during the last part of my life:

_____
_____
_____
_____

**B. Preference in Case of Terminal Condition**
(If you want to state what your preference is, initial **one** only. If you do not want to state a preference here, cross through the whole section.)

**If my doctors certify that my death from a terminal condition is imminent, even if lifesustaining procedures are used:**

1. Keep me comfortable and allow natural death to occur. I do not want any medical interventions used to try to extend my life. I do not want to receive nutrition and fluids by tube or other medical means._____

**>>OR<<**

2. Keep me comfortable and allow natural death to occur. I do not want medical interventions used to try to extend my life. If I am unable to take enough nourishment by mouth, however, I want to receive nutrition and fluids by tube or other medical means._____

**>>OR<<**

3. Try to extend my life for as long as possible, using all available interventions that in reasonable medical judgment would prevent or delay my death. If I am unable to take enough nourishment by mouth, I want to receive nutrition and fluids by tube or other medical means._____

**C. Preference in Case of Persistent Vegetative State**
(If you want to state what your preference is, initial **one** only. If you do not want to state a preference here, cross through the whole section.)

**If my doctors certify that I am in a persistent vegetative state, that is, if I am not conscious and am not aware of myself or my environment or able to interact with others, and there is no reasonable expectation that I will ever regain consciousness:**

1. Keep me comfortable and allow natural death to occur. I do not want any medical interventions used to try to extend my life. I do not want to receive nutrition and fluids by tube or other medical means._____

**>>OR<<**

2. Keep me comfortable and allow natural death to occur. I do not want medical interventions used to try to extend my life. If I am unable to take enough nourishment by mouth, however, I want to receive nutrition and fluids by tube or other medical means._____

**>>OR<<**

3. Try to extend my life for as long as possible, using all available interventions that in reasonable medical judgment would prevent or delay my death. If I am unable to take enough nourishment by mouth, I want to receive nutrition and fluids by tube or other medical means._____

**D. Preference in Case of End-Stage Condition**
(If you want to state what your preference is, initial **one** only. If you do not want to state a preference here, cross through the whole section.)

**If my doctors certify that I am in an end-state condition, that is, an incurable condition that will continue in its course until death and that has already resulted in loss of capacity and complete physical dependency:**

1. Keep me comfortable and allow natural death to occur. I do not want any medical interventions used to try to extend my life. I do not want to receive nutrition and fluids by tube or other medical means._____

**>>OR<<**

2. Keep me comfortable and allow natural death to occur. I do not want medical interventions used to try to extend my life. If I am unable to take enough nourishment by mouth, however, I want to receive nutrition and fluids by tube or other medical means._____
**>>OR<<**

3. Try to extend my life for as long as possible, using all available interventions that in reasonable medical judgment would prevent or delay my death. If I am unable to take enough nourishment by mouth, I want to receive nutrition and fluids by tube or other medical means._____

**E. Pain Relief**

No matter what my condition, give me the medicine or other treatment I need to relieve pain.

**F. In Case of Pregnancy**
(Optional, for women of child-bearing years only; form valid if left blank)

If I am pregnant, my decision concerning life-sustaining procedures shall be modified as follows:

_____
_____
_____
_____

**G. Effect of Stated Preferences**
(Read both of these statements carefully. Then, initial **one** only.)

1. I realize I cannot foresee everything that might happen after I can no longer decide for myself. My stated preferences are meant to guide whoever is making decisions on my behalf and my health care providers, but I authorize them to be flexible in applying these statements if they feel that doing so would be in my best interest._____

**>>OR <<**

2. I realize I cannot foresee everything that might happen after I can no longer decide for myself. Still, I want whoever is making decisions on my behalf and my health care providers to follow my stated preferences exactly as written, even if they think that some alternative is better._____

## PART III: SIGNATURE AND WITNESSES

By signing below as the Declarant, I indicate that I am emotionally and mentally competent to make this advance directive and that I understand its purpose and effect. I also understand that this document replaces any similar advance directive I may have completed before this date.

_____ _____
(Signature of Declarant) (Date)

The Declarant signed or acknowledged signing this document in my presence and, based upon personal observation, appears to be emotionally and mentally competent to make this advance directive.

_____ _____
(Signature of Witness) (Date)

_____
Telephone Number(s):

_____ _____
(Signature of Witness) (Date)

_____
Telephone Number(s):

(**Note:** Anyone selected as a health care agent in Part I may not be a witness. Also, at least one of the witnesses must be someone who will not knowingly inherit anything from the Declarant or otherwise knowingly gain a financial benefit from the Declarant's death.)

WITH THE UNITED STATES ARMED FORCES

AT DOVER AIR FORCE BASE, DELAWARE

The foregoing instrument was acknowledged before me on the ____ day of _____, 20___, by _____.

I, the undersigned officer, do hereby certify that I am, on the date of this certificate, a person with the power described in Title 10 U.S.C. 1044a of the grade, branch of service, and organization stated below in the active service of the United States Armed Forces.

_____

## AFTER MY DEATH

(This document is optional. Do only what reflects your wishes.)

**By:** _____ **Date of Birth:** _____
(Print Name) (Month/Day/Year)

### PART I: ORGAN DONATION

(Initial the ones that you want. Cross through any that you do not want.)

Upon my death I wish to donate:

Any needed organs, tissues, or eyes. _____
Only the following organs, tissues, or eyes: _____
_____

*I authorize the use of my organs, tissues, or eyes:*
For transplantation _____
For therapy _____

For research _____
For medical education _____
For any purpose authorized by law _____

I understand that no vital organ, tissue, or eye may be removed for transplantation until after I have been pronounced dead. *This document is not intended to change anything about my health care while I am still alive.* After death, I authorize any appropriate support measures to maintain the viability for transplantation of my organs, tissues, and eyes until organ, tissue, and eye recovery has been completed. I understand that my estate will not be charged for any costs related to this donation.

## PART II: DONATION OF BODY

After any organ donation indicated in Part I, I wish my body to be donated for use in a medical study program. (Initials) _____

## PART III: DISPOSITION OF BODY AND FUNERAL ARRANGEMENTS

I want the following person to make decisions about the disposition of my body and my funeral arrangements: (Either initial the first or fill in the second.)

The health care agent who I named in my advance directive. _____

**>>OR<<**

This person:
Name: _____
Address: _____
Telephone Number(s): _____
(Home and Cell)

If I have written my wishes below, they should be followed. If not, the person I have named should decide based on conversations we have had, my religious or other beliefs and values, my personality, and how I reacted to other peoples' funeral arrangements. My wishes about the disposition of my body and my funeral arrangements are:

_____
_____
_____

## PART IV: SIGNATURE AND WITNESSES

By signing below, I indicate that I am emotionally and mentally competent to make this donation and that I understand the purpose and effect of this document.

_____ _____

(Signature of Donor) (Date)

The Donor signed or acknowledged signing the foregoing document in my presence and, based upon personal observation, appears to be emotionally and mentally competent to make this donation.

_____ _____

(Signature of Witness) (Date)

_____

Telephone Number(s):

_____ _____

(Signature of Witness) (Date)

_____

Telephone Number(s):