

RHODE ISLAND
Advance Directive
Planning for Important Healthcare Decisions

Caring Connections
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Caring Connections, a program of the National Hospice and Palliative Care Organization (NHPCO), is a national consumer engagement initiative to improve care at the end of life, supported by a grant from The Robert Wood Johnson Foundation.

Caring Connections tracks and monitors all state and federal legislation and significant court cases related to end-of-life care to ensure that our advance directives are up to date.

It's About How You LIVE

It's About How You LIVE is a national community engagement campaign encouraging individuals to make informed decisions about end-of-life care and services. The campaign encourages people to:

- L**earn about options for end-of-life services and care
- I**mplement plans to ensure wishes are honored
- V**oice decisions to family, friends and health care providers
- E**ngage in personal or community efforts to improve end-of-life care

Please call the HelpLine at 800/658-8898 to learn more about the LIVE campaign, obtain free resources, or join the effort to improve community, state and national end-of-life care.

If you would like to make a contribution to help support our work, please visit www.nationalhospicefoundation.org/donate. Contributions to national hospice programs can also be made through the Combined Health Charities or the Combined Federal Campaign by choosing #0544.

Support for this program is provided by a grant from
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Using These Materials

BEFORE YOU BEGIN

1. Check to be sure that you have the materials for each state in which you could receive health care.
2. These materials include:
 - Instructions for preparing your advance directive.
 - Your state-specific advance directive forms, which are the pages with the gray instruction bar on the left side.

PREPARING TO COMPLETE YOUR ADVANCE DIRECTIVE

3. Read the HIPAA Privacy Rule Summary on page 4.
4. Read all the instructions, on pages 7 through 9, as they will give you specific information about the requirements in your state.
5. Refer to the Glossary of Terms About End-of-Life Decision-making if any of the terms are unclear, located in Appendix A.

ACTION STEPS

6. You may want to photocopy these forms before you start so you will have a clean copy if you need to start over.
7. When you begin to fill out the forms, refer to the gray instruction bars - they will guide you through the process.
8. 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.
9. Once the form is completed and signed, photocopy the form and give it to the person you have appointed to make decisions on your behalf, your family, friends, health care providers and/or faith leaders so that the form is available in the event of an emergency.

If you have questions or need guidance in preparing your advance directive or about what you should do with it after you have completed it, please refer to the list of state-specific contacts for Legal Assistance for Questions Pertaining to Health Care Advance Directives located in Appendix B.

Summary of the HIPAA Privacy Rule

HIPAA is a federal law that gives you rights over your health information and sets rules and limits on who can look at and receive your health information.

Your Rights

You have the right to:

- Ask to see and get a copy of your health records.
- Have corrections added to your health information.
- Receive a notice that tells you how your health information may be used and shared.
- Decide if you want to give your permission before your health information can be used or shared for certain purposes, such as marketing.
- Get a report on when and why your health information was shared for certain purposes.
- If you believe your rights are being denied or your health information isn't being protected, you can
 - File a complaint with your provider or health insurer
 - File a complaint with the U.S. Government

You also have the right to ask your provider or health insurer questions about your rights. You also can learn more about your rights, including how to file a complaint from the Web site at www.hhs.gov/ocr/hipaa/ or by calling 1-866-627-7748.

Who Must Follow this Law?

- Doctors, nurses, pharmacies, hospitals, clinics, nursing homes, and many other health care providers.
- Health insurance companies, HMOs, most employer group health plans.
- Certain government programs that pay for health care, such as Medicare and Medicaid.

What Information is Protected?

- Information your doctors, nurses, and other health care providers put in your medical record.
- Conversations your doctor has about your care or treatment with nurses and others.
- Information about you in your health insurer's computer system.
- Billing information about you by your clinic / health care provider.
- Most other health information about you held by those who must follow this law.

Summary of the HIPAA Privacy Rule (continued)

Providers and health insurers who are required to follow this law must keep your information private by:

- Teaching the people who work for them how your information may and may not be used and shared.
- Taking appropriate and reasonable steps to keep your health information secure.

To make sure that your information is protected in a way that does not interfere with your health care, your information can be used and shared:

- For your treatment and care coordination.
- To pay doctors and hospitals for your health care and help run their businesses.
- With your family, relatives, friends or others you identify who are involved with your health care or your health care bills, unless you object.
- To make sure doctors give good care and nursing homes are clean and safe.
- To protect the public's health, such as by reporting when the flu is in your area.
- To make required reports to the police, such as reporting gunshot wounds.

Your health information cannot be used or shared without your written permission unless this law allows it. For example, without your authorization, your provider generally cannot:

- Give your information to your employer.
- Use or share your information for marketing or advertising purposes.
- Share private notes about your mental health counseling sessions.

Introduction to Your Rhode Island Advance Directive

This packet contains two legal documents that protect 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:

1. The **Rhode Island Durable Power of Attorney for Health Care** lets you name someone to make decisions about your medical care – including decisions about life support – if you can no longer speak for yourself. The Durable Power of Attorney for Health Care is especially useful because it appoints someone to speak for you any time you are incapacitated, not only at the end of life.

2. The **Rhode Island Declaration** is your state's living will. It lets you state your wishes about medical care in the event that you develop an incurable or irreversible condition and can no longer make your own medical decisions. The Declaration becomes effective if, in your doctor's opinion, your death would occur without the use of life-sustaining medical care.

Caring Connections recommends that you complete both of these documents to best ensure that you receive the medical care you want when you can no longer speak for yourself.

Note: These documents will be legally binding only if the person completing them is a competent adult (at least 18 years old).

Completing Your Rhode Island Durable Power of Attorney for Health Care

Whom should I appoint as my agent?

Your agent is the person you appoint to make decisions about your medical care if you become unable to make those decisions yourself. The person you name as your agent should clearly understand your wishes and be willing to accept the responsibility of making medical decisions for you. Your agent may be a family member or a close friend whom you trust to make serious decisions. (An agent may also be called an “attorney-in-fact” or “proxy.”)

The person you appoint as your agent **cannot** be:

- your treating health care provider,
- an employee of your treating health care provider who is not related to you,
- an operator of a community care facility, or
- an employee of an operator of a community care facility who is not related to you.

You can appoint a second and third person as alternate agents. The alternates will step in, by order of selection, if the first person you name as agent is unable, ineligible or unavailable to act for you. If you appoint your spouse as your agent, he or she will become ineligible to act as your agent if your marriage is dissolved.

How do I make my Rhode Island Durable Power of Attorney for Health Care legal?

The law requires that you sign and date your Durable Power of Attorney for Health Care in the presence of two witnesses or one notary public. The witnesses sign the document to show that they know you and believe you to be of sound mind and under no duress, fraud or undue influence, that you signed or acknowledged the signature of the document in their presence, and that they do not fall into any of the categories of people who cannot be witnesses.

These witnesses **cannot** be:

- the person you name as your agent or alternate agent(s),
- a health care provider,
- an employee of a health care provider,
- the operator of a community care facility, or
- an employee of an operator of a community care facility.

At least one of your witnesses or the notary public cannot be related to you by blood, marriage or adoption, or be entitled to any part of your estate under an existing will or by operation of law.

Note: You do not need to notarize your Rhode Island Durable Power of Attorney for Health Care if it is signed by two qualified witnesses.

Completing Your Rhode Island Durable Power of Attorney for Health Care (continued)

Should I add personal instructions to my Rhode Island Durable Power of Attorney for Health Care?

Caring Connections advises you not to add instructions to this document. One of the strongest reasons for naming an agent is to have someone who can respond flexibly as your medical situation changes and deal with situations that you did not foresee. If you add instructions to this document, you might unintentionally restrict your agent's power to act in your best interest. A statement such as, "My agent knows my wishes concerning all forms of medical treatment" is sufficient. Then, we urge you to talk with your agent about your future medical care and describe what you consider to be an acceptable "quality of life." If you want to record your wishes about specific treatments or conditions, you should use the Rhode Island Declaration (the living will).

What if I change my mind?

You may revoke your Rhode Island Durable Power of Attorney for Health Care at any time and in any manner, regardless of your mental or physical condition. Your revocation becomes effective once you, or a witness to your revocation, communicate it to your doctor or any health care provider, who must then make it part of your medical record.

What other important facts should I know?

Due to restrictions in the state law, a pregnant patient's Rhode Island Durable Power of Attorney for Health Care will not be honored if it is probable that the fetus could develop to the point of live birth with continued application of life-sustaining procedures.

Completing Your Rhode Island Declaration

How do I make my Declaration legal?

In order to make your Declaration legally binding, you must sign your Declaration in the presence of two witnesses, who must also sign the document to show that they personally know you, that you voluntarily signed the document in their presence, and that they are not related to you by blood or marriage.

Note: You do not need to notarize your Rhode Island Declaration.

The Declaration becomes effective when it is communicated to your doctor, the doctor determines that you are in a terminal condition and you are unable to make treatment decisions.

Can I add personal instructions to my Declaration?

Yes. You can add personal instructions in the part of the document called "Other directions." For example, you may want to refuse specific treatments by a statement such as, "I especially do not want cardiopulmonary resuscitation, tube feeding, a respirator, or antibiotics." You may also want to emphasize pain control by adding instructions such as, "I want to receive as much pain medication as necessary to ensure my comfort, even if it may hasten my death."

If you have appointed an agent, it is a good idea to write a statement such as, "Any questions about how to interpret or when to apply my Declaration are to be decided by my agent."

It is important to learn about the kinds of life-sustaining treatment you might receive. Consult your doctor or order the Caring Connections booklet, "Advance Directives and End-of-Life Decisions."

What if I change my mind?

You can revoke your Rhode Island Declaration at any time and in any manner, regardless of your physical or mental condition. Your revocation becomes effective once you, or a witness to your revocation, notify your doctor or health care provider, who must then make the revocation part of your medical record.

What other important facts should I know?

Due to restrictions in the state law, a pregnant patient's Rhode Island Declaration will not be honored if it is probable that the fetus could develop to the point of live birth with continued application of life-sustaining procedures.

If you have questions about filling out your advance directive, please consult the list of state-based resources located in Appendix B.

You Have Filled Out Your Advance Directive, Now What?

1. Your Rhode Island Durable Power of Attorney for Health Care and Rhode Island Declaration are important legal documents. Keep the original signed documents in a secure but accessible place. Do not put the original documents in a safe deposit box or any other security box that would keep others from having access to them.
2. Give photocopies of the signed originals to your agent and alternate agent(s), 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 documents placed in your medical records.
3. Be sure to talk to your agent and alternates, doctor(s), clergy, and family and friends about your wishes concerning medical treatment. Discuss your wishes with them often, particularly if your medical condition changes.
4. If you want to make changes to your documents after they have been signed and witnessed, you must complete new documents.
5. Remember, you can always revoke one or both of your Rhode Island documents.
6. Be aware that your Rhode Island documents will not be effective in the event of a medical emergency. Ambulance personnel are required to provide cardiopulmonary resuscitation (CPR) unless they are given a separate order that states otherwise. These orders, commonly called "non-hospital do-not-resuscitate orders," are designed for people whose poor health gives them little chance of benefiting from CPR. **Caring Connections does not distribute these forms.**

These orders must be signed by your physician and instruct ambulance personnel not to attempt CPR if your heart or breathing should stop. Currently not all states have laws authorizing non-hospital do-not-resuscitate orders. **Caring Connections does not distribute these forms.** We suggest you speak to your physician.

If you would like more information about this topic contact Caring Connections or consult the Caring Connections booklet "Cardiopulmonary Resuscitation, Do-Not-Resuscitate Orders and End-Of-Life Decisions."

**RHODE ISLAND STATUTORY FORM
DURABLE POWER OF ATTORNEY FOR HEALTH CARE – PAGE 1 OF 7**

**WARNING TO PERSON EXECUTING THIS DOCUMENT
(R.I. Gen. Laws 23-4.10-1 to 23-4.10-2 [1989])**

This is an important legal document which is authorized by the general laws of this state. Before executing this document, you should know these important facts:

You must be at least eighteen (18) years of age and a resident of the state of Rhode Island for this document to be legally valid and binding.

This document gives the person you designate as your agent (the attorney in fact) the power to make health care decisions for you. Your agent must act consistently with your desires as stated in this document or otherwise made known.

Except as you otherwise specify in this document, this document gives your agent the power to consent to your doctor not giving treatment or stopping treatment necessary to keep you alive.

Notwithstanding this document, you have the right to make medical and other health care decisions for yourself so long as you can give informed consent with respect to the particular decision. In addition, no treatment may be given to you over your objection at the time, and health care necessary to keep you alive may not be stopped or withheld if you object at the time.

This document gives your agent authority to consent, to refuse to consent, or to withdraw consent to any care, treatment, service, or procedure to maintain, diagnose, or treat a physical or mental condition. This power is subject to any statement of your desires and any limitation that you include in this document. You may state in this document any types of treatment that you do not desire. In addition, a court can take away the power of your agent to make health care decisions for you if your agent:

- (1) Authorizes anything that is illegal,
- (2) Acts contrary to your known desires, or
- (3) Where your desires are not known, does anything that is clearly contrary to your best interests.

Unless you specify a specific period, this power will exist until you revoke it. Your agent's power and authority ceases upon your death except to inform your next of kin of your desire to be an organ and tissue donor.

You have the right to revoke the authority of your agent by notifying your agent or your treating doctor, hospital, or other health care provider orally or in writing of the revocation.

Your agent has the right to examine your medical records and to consent to their disclosure unless you limit this right in this document.

This document revokes any prior durable power of attorney for health care.

You should carefully read and follow the witnessing procedure described at the end of this form. This document will not be valid unless you comply with the witnessing procedure.

If there is anything in this document that you do not understand, you should ask a lawyer to explain it to you.

Your agent may need this document immediately in case of an emergency that requires a decision concerning your health care. Either keep this document where it is immediately available to your agent and alternate agents or give each of them an executed copy of this document. You may also want to give your doctor an executed copy of this document.

**RHODE ISLAND DURABLE POWER OF ATTORNEY FOR HEALTH CARE
— PAGE 2 OF 7**

**RHODE ISLAND STATUTORY FORM DURABLE POWER OF ATTORNEY
FOR HEALTH CARE**

1. DESIGNATION OF HEALTH CARE AGENT.

I, _____,
(name)

(address)

do hereby designate and appoint:

(name of agent)

(address)

(home telephone number) (work telephone number)

(insert name, address, and telephone number of one individual only as your agent to make health care decisions for you. None of the following may be designated as your agent: (1) your treating health care provider, (2) a non-relative employee of your treating health care provider, (3) an operator of a community care facility, or (4) a non-relative employee of an operator of a community care facility.) as my attorney in fact (agent) to make health care decisions for me as authorized in this document. For the purposes of this document, "health care decision" means consent, refusal of consent, or withdrawal of consent to any care, treatment, service, or procedure to maintain, diagnose, or treat an individual's physical or mental condition.

2. CREATION OF DURABLE POWER OF ATTORNEY FOR HEALTH CARE. By this document I intend to create a durable power of attorney for health care.

3. GENERAL STATEMENT OF AUTHORITY GRANTED. Subject to any limitations in this document, I hereby grant to my agent full power and authority to make health care decisions for me to the same extent that I could make such decisions for myself if I had the capacity to do so. In exercising this authority, my agent shall make health care decisions that are consistent with my desires as 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 or next of kin of my desire, if any, to be an organ or tissue donor. *(If you want to limit the authority of your agent to make health care decisions for you, you can state the limitations in paragraph 4 ["Statement of Desires, Special Provisions, and Limitations"] below. You can indicate your desires by including a statement of your desires in the same paragraph.)*

PRINT YOUR
NAME AND
ADDRESS

PRINT THE NAME,
ADDRESS, AND
TELEPHONE
NUMBERS OF YOUR
AGENT

RHODE ISLAND DURABLE POWER OF ATTORNEY FOR HEALTH CARE
— PAGE 3 OF 7

4. STATEMENT OF DESIRES, SPECIAL PROVISIONS, AND LIMITATIONS. *(Your agent must make health care decisions that are consistent with your known desires. You can, but are not required to, state your desires in the space provided below. You should consider whether you want to include a statement of your desires concerning life-prolonging care, treatment, services, and procedures. You can also include a statement of your desires concerning other matters relating to your health care. You can also make your desires known to your agent by discussing your desires with your agent or by some other means. If there are any types of treatment that you do not want to be used, you should state them in the space below. If you want to limit in any other way the authority given your agent by this document, you should state the limits in the space below. If you do not state any limits, your agent will have broad powers to make health care decisions for you, except to the extent that there are limits provided by law.)*

In exercising the authority under this durable power of attorney for health care, my agent shall act consistently with my desires as stated below and is subject to the special provisions and limitations stated below:

a. Statement of desires concerning life-prolonging care, treatment, services, and procedures:

b. Additional statements of desires, special provisions, and limitations regarding health care decisions:

(You may attach additional pages if you need more space to complete your statement. If you attach additional pages, you must date and sign EACH of the additional pages at the same time you date and sign this document.)

ADD PERSONAL
INSTRUCTIONS
(IF ANY)

ADD PERSONAL
INSTRUCTIONS
(IF ANY)

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**RHODE ISLAND DURABLE POWER OF ATTORNEY FOR HEALTH CARE
— PAGE 4 OF 7**

If you wish to make a gift of any bodily organ you may do so pursuant to the Uniform Anatomical Gift Act.

_____ I want to be an organ donor. In the event of my death I request that my agent inform my family/next of kin of my desires to be an organ and tissue donor if possible. My wishes are indicated below.

I wish to give:

_____ any needed organs/ tissues: or

_____ only the following organs/tissues: _____

5. INSPECTION AND DISCLOSURE OF INFORMATION RELATING TO MY PHYSICAL OR MENTAL HEALTH. Subject to any limitations in this document, my agent has the power and authority to do all of the following:

- a. Request, review, and receive any information, verbal or written, regarding my physical or mental health, including, but not limited to, medical and hospital records.
- b. Execute on my behalf any releases or other documents that may be required in order to obtain this information.
- c. Consent to the disclosure of this information. (If you want to limit the authority of your agent to receive and disclose information relating to your health, you must state the limitations in paragraph 4 ["Statement of desires, special provisions, and limitations"] above.)

6. SIGNING DOCUMENTS, WAIVERS, AND RELEASES. Where necessary to implement the health care decisions that my agent is authorized by this document to make, my agent has the power and authority to execute on my behalf all of the following:

- a. Documents titled or purporting to be a "Refusal to Permit Treatment" and "Leaving Hospital Against Medical Advice."
- b. Any necessary waiver or release from liability required by a hospital or physician.

ORGAN
DONATION
(INITIAL IF
APPLICABLE)

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**RHODE ISLAND DURABLE POWER OF ATTORNEY FOR HEALTH CARE
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PRINT EXPIRATION
DATE OF YOUR
DURABLE POWER
OF ATTORNEY
(OPTIONAL)

7. DURATION. *(Unless you specify a shorter period in the space below, this power of attorney will exist until it is revoked.)*

This durable power of attorney for health care expires on

(Fill in this space ONLY if you want the authority of your agent to end on a specific date.)

ALTERNATE
AGENTS

8. DESIGNATION OF ALTERNATE AGENTS. *(You are not required to designate any alternate agents but you may do so. Any alternate agent you designate will be able to make the same health care decisions as the agent you designated in paragraph 1, above, in the event that agent is unable or ineligible to act as your agent. If the agent you designated is your spouse, he or she becomes ineligible to act as your agent if your marriage is dissolved.)*

PRINT THE NAME,
ADDRESS AND
TELEPHONE
NUMBER OF
TWO ALTERNATE
AGENTS

If the person designated as my agent in paragraph 1 is not available or becomes ineligible to act as my agent to make a health care decision for me or loses the mental capacity to make health care decisions for me, or if I revoke that person's appointment or authority to act as my agent to make health care decisions for me, then I designate and appoint the following persons to serve as my agent to make health care decisions for me as authorized in this document, such persons to serve in the order listed below:

A. First Alternate Agent:

ALTERNATE #1

(Insert name, address, and telephone number of first alternate agent.)

B. Second Alternate Agent:

ALTERNATE #2

(Insert name, address, and telephone number of second alternate agent.)

9. PRIOR DESIGNATIONS REVOKED. I revoke any prior durable power of attorney for health care.

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**RHODE ISLAND DURABLE POWER OF ATTORNEY FOR HEALTH CARE
— PAGE 6 OF 7**

DATE AND SIGNATURE OF PRINCIPAL
(YOU MUST DATE AND SIGN THIS POWER OF ATTORNEY)

I sign my name to this Statutory Form Durable Power of Attorney For

Health Care on _____ at _____,
(date) (city)

(state)

(you sign here)

(THIS POWER OF ATTORNEY WILL NOT BE VALID UNLESS IT IS SIGNED BY TWO (2) QUALIFIED WITNESSES 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 POWER OF ATTORNEY.) YOU ARE NOT REQUIRED TO HAVE THIS POWER OF ATTORNEY NOTARIZED

STATEMENT OF WITNESSES

(This document must be witnessed by two (2) qualified adult witnesses or one (1) notary public. None of the following may be used as a witness:

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

At least one of the witnesses or the notary public must make the additional declaration set out following the place where the witnesses sign.)

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, that I am not the person appointed as attorney in fact by this document, and that I am not a health care provider; an employee of a health care provider; the operator of a community care facility; nor an employee of an operator of a community care facility.

DATE YOUR DOCUMENT AND PRINT YOUR CITY AND STATE OF RESIDENCE

SIGN YOUR DOCUMENT HERE

WITNESSING PROCEDURE

YOUR WITNESSES MUST DATE AND SIGN YOUR DOCUMENT ON THE NEXT PAGE THEY MUST ALSO PRINT THEIR NAMES AND ADDRESSES

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**RHODE ISLAND DURABLE POWER OF ATTORNEY FOR HEALTH CARE
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WITNESS #1

Signature: _____

Print Name: _____

Residence Address: _____

Date: _____

Signature: _____

Print Name: _____

Residence Address: _____

Date: _____

(AT LEAST ONE OF THE ABOVE WITNESSES MUST ALSO SIGN THE FOLLOWING DECLARATION.)

I further declare under penalty of perjury 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: _____

Signature: _____

Print Name: _____

ONE WITNESS
MUST AGREE WITH
THIS STATEMENT
AND SIGN AND
PRINT HIS OR
HER NAME
BELOW

RHODE ISLAND DECLARATION – PAGE 1 OF 2

INSTRUCTIONS

PRINT YOUR NAME

I,

(name)

being of sound mind, willfully and voluntarily make known my desire that my dying shall not be artificially prolonged under the circumstances set forth below, do hereby declare:

If I should have an incurable or irreversible condition that, without the administration of life-sustaining procedures, will cause my death, and if I am unable to make decisions regarding my medical treatment, I direct my attending physician to withhold or withdraw procedures that merely prolong the dying process and are not necessary to my comfort, or to alleviate pain.

Other directions:

ADD PERSONAL INSTRUCTIONS (IF ANY)

CHECK THE OPTION THAT REFLECTS YOUR WISHES

This authorization _____ includes _____ does not include the withholding or withdrawal of artificial feeding. (check only one option)

SIGN AND DATE THE DOCUMENT AND PRINT YOUR ADDRESS

Signed this _____ day of _____, 20
(date) (month)

(year)

Signature _____

Address _____

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RHODE ISLAND DECLARATION - PAGE 2 OF 2

WITNESSING
PROCEDURE

YOUR
WITNESSES
MUST SIGN AND
PRINT THEIR
ADDRESSES

The declarant is personally known to me and voluntarily signed this document in my presence. I am not related to the declarant by blood or marriage.

Witness

Address

Witness

Address

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*Courtesy of Caring Connections
1700 Diagonal Road, Suite 625, Alexandria, VA 22314
www.caringinfo.org, 800/658-8898*

Appendix A

Glossary of Terms About End-of-life Decision Making

Advance directive - A general term that describes two kinds of legal documents, living wills and medical powers of attorney. These documents allow a person to give instructions about future medical care should he or she be unable to participate in medical decisions due to serious illness or incapacity. Each state regulates the use of advance directives differently.

Artificial nutrition and hydration – Artificial nutrition and hydration (or tube feeding) supplements or replaces ordinary eating and drinking by giving a chemically balanced mix of nutrients and fluids through a tube placed directly into the stomach, the upper intestine or a vein.

Assisted Suicide - Providing someone the means to commit suicide, such as a supply of drugs or a weapon, knowing the person will use these to end his or her life.

Best Interest - In the context of refusal of medical treatment or end-of-life court opinions, a standard for making health care decisions based on what others believe to be "best" for a patient by weighing the benefits and the burdens of continuing, withholding or withdrawing treatment.

Brain Death -The irreversible loss of all brain function. Most states legally define death to include brain death.

Capacity - In relation to end-of-life decision-making, a patient has medical decision making capacity if he or she has the ability to understand the medical problem and the risks and benefits of the available treatment options. The patient's ability to understand other unrelated concepts is not relevant. The term is frequently used interchangeably with competency but is not the same. Competency is a legal status imposed by the court.

Cardiopulmonary Resuscitation - Cardiopulmonary resuscitation (CPR) is a group of treatments used when someone's heart and/or breathing stops. CPR is used in an attempt to restart the heart and breathing. It may consist only of mouth-to-mouth breathing or it can include pressing on the chest to mimic the heart's function and cause blood to circulate. Electric shock and drugs also are used frequently to stimulate the heart.

Do-Not-Resuscitate (DNR) order - A DNR order is a physician's written order instructing health care providers not to attempt cardiopulmonary resuscitation (CPR) in case of cardiac or respiratory arrest. A person with a valid DNR order will not be given CPR under these circumstances. Although the DNR order is written at the request of a person or his or her family, it must be signed by a physician to be valid. A non-hospital DNR order is written for individuals who are at home and do not want to receive CPR.

Emergency Medical Services (EMS): A group of governmental and private agencies that provide emergency care, usually to persons outside of health care facilities; EMS personnel generally include paramedics, first responders and other ambulance crew.

Euthanasia - The term traditionally has been used to refer to the hastening of a suffering person's death or "mercy killing". Voluntary active euthanasia involves an intervention requested by a competent individual that is administered to that person to cause death, for example, if a physician gives a lethal injection with the patient's full informed consent. Involuntary or non-voluntary active euthanasia involves

a physician engaging in an act to end a patient's life without that patient's full informed consent. See also Physician-hastened Death (sometimes referred to as Physician-assisted Suicide).

Guardian ad litem - Someone appointed by the court to represent the interests of a minor or incompetent person in a legal proceeding.

Healthcare Agent: The person named in an advance directive or as permitted under state law to make healthcare decisions on behalf of a person who is no longer able to make medical decisions.

Hospice care - A program model for delivering palliative care to individuals who are in the final stages of terminal illness. In addition to providing palliative care and personal support to the patient, hospice includes support for the patient's family while the patient is dying, as well as support to the family during their bereavement.

Incapacity - A lack of physical or mental abilities that results in a person's inability to manage his or her own personal care, property or finances; a lack of ability to understand one's actions when making a will or other legal document.

Incompetent - Referring to a person who is not able to manage his/her affairs due to mental deficiency (lack of I.Q., deterioration, illness or psychosis) or sometimes physical disability. Being incompetent can be the basis for appointment of a guardian or conservator.

Intubation- Refers to "endotracheal intubation" the insertion of a tube through the mouth or nose into the trachea (windpipe) to create and maintain an open airway to assist breathing.

Life-Sustaining Treatment - Treatments (medical procedures) that replace or support an essential bodily function (may also be called life support treatments). Life-sustaining treatments include cardiopulmonary resuscitation, mechanical ventilation, artificial nutrition and hydration, dialysis, and certain other treatments.

Living Will - A type of advance directive in which an individual documents his or her wishes about medical treatment should he or she be at the end of life and unable to communicate. It may also be called a "directive to physicians", "health care declaration," or "medical directive." The purpose of a living will is to guide family members and doctors in deciding how aggressively to use medical treatments to delay death.

Mechanical ventilation - Mechanical ventilation is used to support or replace the function of the lungs. A machine called a ventilator (or respirator) forces air into the lungs. The ventilator is attached to a tube inserted in the nose or mouth and down into the windpipe (or trachea). Mechanical ventilation often is used to assist a person through a short-term problem or for prolonged periods in which irreversible respiratory failure exists due to injuries to the upper spinal cord or a progressive neurological disease.

Medical power of attorney - A document that allows an individual to appoint someone else to make decisions about his or her medical care if he or she is unable to communicate. This type of advance directive may also be called a health care proxy, durable power of attorney for health care or appointment of a health care agent. The person appointed may be called a health care agent, surrogate, attorney-in-fact or proxy.

Palliative care - A comprehensive approach to treating serious illness that focuses on the physical, psychological, spiritual, and existential needs of the patient. Its goal is to achieve the best quality of life available to the patient by relieving suffering, by controlling pain and symptoms, and by enabling the patient to achieve maximum functional capacity. Respect for the patient's culture, beliefs, and values are an essential component. Palliative care is sometimes called "comfort care" or "hospice type care."

Power of Attorney – A legal document allowing one person to act in a legal matter on another's behalf pursuant to financial or real estate transactions.

Respiratory Arrest: The cessation of breathing - an event in which an individual stops breathing. If breathing is not restored, an individual's heart eventually will stop beating, resulting in cardiac arrest.

Surrogate Decision-Making - Surrogate decision-making laws allow an individual or group of individuals (usually family members) to make decisions about medical treatments for a patient who has lost decision-making capacity and did not prepare an advance directive. A majority of states have passed statutes that permit surrogate decision making for patients without advance directives.

Ventilator – A Ventilator, also known as a respirator, is a machine that pushes air into the lungs through a tube placed in the trachea (breathing tube). Ventilators are used when a person cannot breathe on his or her own or cannot breathe effectively enough to provide adequate oxygen to the cells of the body or rid the body of carbon dioxide.

Withholding or withdrawing treatment - Forgoing life-sustaining measures or discontinuing them after they have been used for a certain period of time.

Appendix B

Legal & End-Of-Life Care Resources Pertaining to Health Care Advance Directives

LEGAL SERVICES

The State Rhode Island Department of Elder Affairs provides legal services for individuals 60 and older with low to moderate incomes.

They can assist anyone over 60 with legal information and advice on most issues, including:

- Nursing homes
- Advance Directives
- Living Wills and Trusts
- Power of Attorney and more

For more information please call toll free: 1-800-662-5034

OR

Visit their website for other referrals and information:

http://www.dea.state.ri.us/programs/legal_assist.php

ENND-OF-LIFE SERVICES

Individuals over the age 60 with low to moderate incomes can visit Rhode Island Department of Elder Affairs website for services in their area.

They provide resources and services including, but not limited to:

- Housing
 - Prescription drug programs
 - Medicare and Medicaid
 - Legal assistance
 - Meals and transportation
 - Programs, services and more
-
- Must be 60 and older
 - Free for individuals with low to moderate incomes

For more information about services call:

1-401-462-0740 or 1-401-462-4000

OR

Visit their website for information about other services and programs:

<http://www.dea.state.ri.us/programs/>