ADVANCE HEALTH-CARE DIRECTIVE OF

_____

ABOUT THIS FORM

This form is a legal document that lets you name another individual or individuals as your "agent(s)" to make health-care decisions for you if you become incapable of making your own decisions (**Part 1**). It also allows you to communicate your wishes – ahead of time – regarding your care near the end of life (**Part 2**). If desired, you may also make choices about being an organ donor (**Part 3**). You can complete all of these parts, but each part can stand alone so you do no have to complete every part unless you choose.

IMPORTANT: Your agent will not be asked to make any decisions as long as you are capable and can communicate for yourself. You always have the right to give instructions about your own health care if you are able. However, if you do not write down your wishes about your health care in advance, and if you later become unable to understand, make, or communicate those wishes, they may not be honored because they may remain unknown to others.

USING THIS FORM

Part 1 of this form is a power of attorney for health care. You can name one or more persons as your agent(s) to make health-care decisions and you can decide if they may act together or one after the other.

Part 2 of this form provides you with the ability to give specific instructions regarding whether or not you wish to receive life-sustaining medical measures if you are ever declared "terminally ill" or "permanently unconscious" or "seriously ill or frail." There is also additional space in Part 2 for you to write out any additional instructions regarding your medical care.

Part 3 of this form lets you express an intention to donate your body, organs and/or tissues following your death, if you so choose.

HOW TO SIGN THIS FORM CORRECTLY SO THAT IT IS VALID

After you have finished filling this form out, sign and date it in front of two (2) qualified witnesses as described under "About the Witnesses" below. It does not need to be notarized to be effective. You will find the signature page following Part 3. Your witnesses will also have to sign this form on the last page, following your signature.

ABOUT THE WITNESSES:

- They cannot be related to you in any way (blood, marriage, or adoption).
- They cannot be a beneficiary of your estate.
- They cannot have a claim (actual or potential) against your estate.
- They cannot have direct financial responsibility for your medical care.
- If you are a resident in a long-term-care facility when you are signing, the witnesses cannot be owners, operators, or employees of the facility, and one of the witnesses must be a patient advocate or Ombudsman designated by the Delaware Department of Health and Social Services or the Delaware Public Guardian.
- They must be over 18 years old.

IF YOU HAVE QUESTIONS ABOUT THIS FORM,
YOU SHOULD SEEK LEGAL ADVICE BEFORE COMPLETING AND SIGNING IT.

ADVANCE HEALTH-CARE DIRECTIVE

I, _____ (*Your Full Name*), of _____ (*Name of County You Live In*) County, Delaware, declare this to be my Advance Health-Care Directive and revoke all previous Advance Health-Care Directives, Powers of Attorney for Health-care, Living Wills and similar documents made by me.

PART 1: POWER OF ATTORNEY FOR HEALTH CARE

(OPTIONAL—If you DO NOT wish to appoint someone to make health-care decisions for you when you are unable, cross out all of Part 1 and skip to Part 2)

About your Agent: If you are a resident in a long-term care facility, the agent or agents designated below may not have a controlling interest in nor be the operator or employee of the long-term care facility in which you reside, unless the agent or agents are related to you by blood, marriage or adoption

(1) DESIGNATION OF AGENT: I designate the following individual as my Agent to make health-care decisions for me:

Name: _____

Address: _____
(*Street*) (*City*) (*State*) (*Zip Code*)

Telephone: _____

OPTIONAL: I hereby designate additional or successor Agent(s):

Name: _____

Address: _____
(*Street*) (*City*) (*State*) (*Zip Code*)

Telephone: _____

Name: _____

Address: _____
(*Street*) (*City*) (*State*) (*Zip Code*)

Telephone: _____

If more than one Agent has been designated above, I intend for these Agents to (**initial ONE only**):

_____ Act in succession (if one is not available, the next shall serve)
_____ Act independently (any available Agent may serve solely and independently)
_____ Act jointly (all Agents must act together, not independently)

(2) AUTHORITY OF AGENT(S): My Agent(s) is authorized to (**initial ALL that apply**):

_____ Provide for my admission to, or discharge from, a medical, nursing, residential, mental health or similar facility

_____ Enter into agreements for my care at home or in a facility

_____ Employ and discharge medical personnel, including physicians, psychiatrists, dentists, nurses, and therapists

_____ Approve medical and surgical procedures, including administration of drugs

_____ Consent to and arrange for the administration of pain-relieving drugs

_____ Consent to psychiatric treatment

_____ Sign medical releases for medical personnel who provide treatment to me pursuant to instructions given by my Agent

_____ Sign, authorize or revoke a Delaware Medical Orders for Scope of Treatment ("DMOST") or similar document under the laws of other States unless prohibited by the terms of the DMOST or other document.

(3) WHEN AGENT'S AUTHORITY BECOMES EFFECTIVE: My Agent's authority becomes effective when my primary care physician or my currently treating physician determines I lack the capacity to make my own health-care decisions. When I want my agent to make decisions about providing, withholding or withdrawing a life-sustaining procedure, my agent's authority shall become effective only upon a determination that I lack capacity and am in a qualifying condition. I am in a qualifying condition if I am permanently unconscious or terminally ill or suffer from a serious illness or frailty that may cause me to die within the next year. When the condition in question is "permanently unconscious," the determination of qualifying condition must be made by my attending physician and by at least 1 other physician who shall be a board-certified neurologist and/or neurosurgeon.

(4) AGENT'S OBLIGATION: My Agent shall make health-care decisions for me in accordance with this power of attorney for health care, any instructions I give in Part 2 of this form, and my other wishes, to the extent they are known to my Agent. To the extent that my wishes are unknown, my Agent shall make health-care decisions for me in accordance with what my Agent determines to be in my best interest. In determining my best interest, my Agent shall consider my personal values to the extent known to my Agent.

NOTE: For your advance health-care directive to be effective, you must sign the page titled Administrative Provisions and your witnesses must sign the Statement of Witnesses.

(5) AUTHORIZATION TO RELEASE MEDICAL INFORMATION: Effective:

(Initial ONE only)

____ effective immediately notwithstanding the provisions of paragraph (3) above,

____ effective when my agent's authority becomes effective under the provisions of paragraph 3 above,

and continuously until my death or revocation by a writing signed by me or someone authorized to make health-care decisions for me, I authorize and request any physician, health-care professional, health-care provider, and medical care facility (collectively, "health-care providers") to provide to my Agent information, oral or written, relating to my physical and mental condition and the diagnosis, prognosis, care, and treatment thereof upon the request of my Agent I have appointed under this instrument, including, but not limited to, health information as defined and described in the Health Insurance Portability and Accountability Act of 1996 (Public Law 104-191, 110 Stat. 2024, generally referred to as "HIPAA"), the regulations promulgated thereunder and any other state or local laws and rules. Information disclosed by a health-care provider may be redisclosed and may no longer be subject to the privacy rules provided by Section 164 of Title 45 of the Code of Federal Regulations. It is my intent by this authorization for my Agent to be considered a personal representative under privacy regulations related to protected health information and for my Agent to be entitled to all health information in the same manner as if I personally were making the request. This authorization and request shall also be considered a consent to the release of such information under current laws, rules, and regulations as well as under future laws, rules, and regulations and amendments to such laws, rules, and regulations to include but not be limited to the express grant of authority to personal representatives as provided by Regulation Section 164.502(g) of Title 45 of the Code of Federal Regulations and the medical information privacy laws and regulations.

PART 2: END – OF – LIFE DECISIONS

(OPTIONAL—If you DO NOT wish make known your wishes, at this time, regarding end-of-life treatment, cross out all of Part 2 and skip to Part 3)

If you do not complete any part of Part 2, the agent appointed under Part 1, if any, will have the power to make all medical decisions for your benefit.

This form offers you ability to specify how you wish to be treated if you are diagnosed with one or more of three "Qualifying Conditions."

> "Qualifying condition" means the existence of one or more of the following conditions in the patient, certified in writing in the patient's medical record by the attending physician and by at least one other physician who, when the condition in question is "permanently unconscious" shall be a board-certified neurologist and/or neurosurgeon:
>
> (1) "Permanently unconscious" or "permanent unconsciousness" means a medical condition that has existed for at least 4 weeks and that has been diagnosed in accordance with currently

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accepted medical standards and with reasonable medical certainty as total and irreversible loss of consciousness and capacity for interaction with the environment. The term includes, without limitation, a persistent vegetative state or irreversible coma.

(2) "Terminal condition" means any disease, illness or condition sustained by any human being for which there is no reasonable medical expectation of recovery and which, as a medical probability, will result in the death of such human being regardless of the use or discontinuance of medical treatment implemented for the purpose of sustaining life or the life processes.

(3) "Serious illness or frailty" means a condition based on which the health-care practitioner would not be surprised if the patient died within the next year.

About your options: It is important to read each option fully before **choosing**. Please note that you **may** to choose only one option under each qualifying condition but you may choose a different option under a different qualifying condition. You will also have the opportunity to write-in any other medical instructions.

Qualifying Condition: Terminally Ill.

After you have read all options, **write your initials** on the line next to the option you have selected that represents your choice for treatment instructions. You may only select one option.

_____ **Option 1: My Agent will make decisions on my behalf:** In the event I become **terminally ill** and I am unable to understand, make or communicate my wishes, I direct that my Agent make all medical decisions on my behalf.

_____ **Option 2: Prolong Life:** In the event I become **terminally ill** and I am unable to understand, make or communicate my wishes, I direct that my life be prolonged as long as possible using all possible treatments within the limits of generally accepted health-care standards, with the following exceptions (initial those treatments – if any – you do not want, even if they could prolong your life):

I DO **NOT** WANT the treatments initialed below:

_____ heart-lung resuscitation (CPR)
_____ ventilator (breathing machine)
_____ dialysis (kidney machine)
_____ surgery
_____ blood transfusions
_____ chemotherapy or radiation treatment
_____ artificial nutrition or hydration through a conduit (tube feeding)
_____ antibiotics

NOTE: For your advance health-care directive to be effective, you must sign the page titled Administrative Provisions and your witnesses must sign the Statement of Witnesses.

_____ **Option 3: Do not Prolong Life:** In the event I become **terminally ill** and am unable to understand, make or communicate my wishes, I direct that no life sustaining measures be taken, with the following exceptions (initial those treatments – if any – you do want, even if they could sustain your life):

I **DO WANT** the treatments initialed below:

_____ heart-lung resuscitation (CPR)
_____ ventilator (breathing machine)
_____ dialysis (kidney machine)
_____ surgery
_____ blood transfusions
_____ chemotherapy or radiation treatment
_____ artificial nutrition or hydration through a conduit (tube feeding)
_____ antibiotics

Qualifying Condition: Permanently Unconscious

After you have read all options, **write your initials** on the line next to the option you have selected that represents your choice for treatment instructions. You may only select **ONE** option.

_____ **Option 1: My Agent will make decisions on my behalf:** In the event I become **permanently** unconscious and I am unable to understand, make or communicate my wishes, I direct that my Agent make all medical decisions on my behalf.

_____ **Option 2: Prolong Life:** In the event I become **permanently unconscious** and am unable to understand, make or communicate my wishes, I direct that my life be prolonged as long as possible using all possible treatments within the limits of generally accepted health-care standards, with the following exceptions (initial those treatments -- if any -- you do not want, even if they could prolong your life):

I DO **NOT** WANT the treatments initialed below:

_____ heart-lung resuscitation (CPR)
_____ ventilator (breathing machine)
_____ dialysis (kidney machine)
_____ surgery
_____ blood transfusions
_____ chemotherapy or radiation treatment
_____ artificial nutrition or hydration through a conduit (tube feeding)
_____ antibiotics

_____ **Option 3: Do Not Prolong Life:** In the event I become **permanently unconscious** and am unable to understand, make or communicate my wishes, I direct that no life sustaining measures be taken, with the following exceptions (initial those treatments -- if any -- you do want, even if they could sustain your life):

NOTE: For your advance health-care directive to be effective, you must sign the page titled Administrative Provisions and your witnesses must sign the Statement of Witnesses.

I DO WANT the treatments initialed below:

_____ heart-lung resuscitation (CPR)
_____ ventilator (breathing machine)
_____ dialysis (kidney machine)
_____ surgery
_____ blood transfusions
_____ chemotherapy or radiation treatment
_____ artificial nutrition or hydration through a conduit (tube feeding)
_____ antibiotics

Qualifying Condition 3: Serious Illness or Frailty.

Note. Whether you elect to complete this section of Part 2 or not, when you develop a "serious illness or frailty" as defined at the beginning of this Part 2, you or if you are unable, your agent under Part 1, can meet with your qualified health-care provider and execute a Delaware Medical Order for Life Sustaining Treatment which will create a medical order specifying your wishes for life sustaining treatment.

After you have read all options, **write your initials** on the line next to the option you have selected that represents your choice for treatment instructions. You may only select **ONE** option.

_____ **Option 1: My Agent will make decisions on my behalf:** In the event I have a "**serious illness or frailty"** and I am unable to understand, make or communicate my wishes, I direct that my Agent make all medical decisions on my behalf.

_____ **Option 2: Prolong Life:** In the event I have a "**serious illness or frailty**" and I am unable to understand, make or communicate my wishes, I direct that my life be prolonged as long as possible using all possible treatments within the limits of generally accepted health-care standards, with the following exceptions (initial those treatments -- if any -- you **do not want**, even if they could prolong your life):

I DO **NOT** WANT the treatments initialed below:

_____ heart-lung resuscitation (CPR)
_____ ventilator (breathing machine)
_____ dialysis (kidney machine)
_____ surgery
_____ blood transfusions
_____ chemotherapy or radiation treatment
_____ artificial nutrition or hydration through a conduit (tube feeding)
_____ antibiotic

_____ **Option 3: Not to Prolong Life:** In the event I have a "**serious illness or frailty**" and I am unable to understand, make or communicate my wishes, I direct that no life sustaining measures be taken, with the following exceptions (initial those treatments -- if any -- you do want, even if they could sustain your life):

NOTE: For your advance health-care directive to be effective, you must sign the page titled Administrative Provisions and your witnesses must sign the Statement of Witnesses.

I **DO WANT** the treatments initialed below:

_____ heart-lung resuscitation (CPR)
_____ ventilator (breathing machine)
_____ dialysis (kidney machine)
_____ surgery
_____ blood transfusions
_____ chemotherapy or radiation treatment
_____ artificial nutrition or hydration through a conduit (tube feeding)
_____ antibiotics

COMFORT CARE

Regardless of the option I chose above regarding end of life decisions. (Initial ONE choice below)

_____I wish to be treated to relieve pain or provide comfort, and I understand that such treatment might shorten my life or suppress my appetite or breathing.

_____I do not wish to be treated to relieve pain or provide comfort.

Other Medical Instructions: If you wish to add to the instructions you have given in this Part 2 of your Advance Health-Care Directive, you should do so in the space below:

NOTE: For your advance health-care directive to be effective, you must sign the page titled Administrative Provisions and your witnesses must sign the Statement of Witnesses.

PART 3: ANATOMICAL GIFT DECLARATION

(OPTIONAL—If you DO NOT wish to make anatomical gifts at this time, cross out all of Part 3 and skip to the ADMINISTRATIVE PROVISIONS section below.)

If you wish to make anatomical gifts of your body, organs and/or tissues upon your death, you may indicate your specific desires here I hereby make the following anatomical gift(s) to take effect upon my death.

I give (**initial ONE only**)

_____ my body
_____ any needed organs, tissues, or parts
_____ the following organs, tissues or parts (write in on the line below):

_____

to (**initial ONE only**)

_____ the physician in attendance at my death
_____ the hospital in which I die
_____ the following named physician, hospital, storage bank or other medical institution:

_____

for the following purpose(s) (**initial ALL that apply**)

_____ any purpose authorized by law
_____ transplantation
_____ therapy
_____ research
_____ medical education

NOTE: For your advance health-care directive to be effective, you must sign the page titled Administrative Provisions and your witnesses must sign the Statement of Witnesses.

ADMINISTRATIVE PROVISIONS

REVOCATION, REMOVAL, AMENDMENT, OR RESIGNATION: I understand that, if I am mentally competent, I may revoke all or part of this document by writing down my revocation instructions and signing them. I do not need an attorney, health care provider or witnesses to do so, although I understand that it is best to have two witnesses sign after my signature. I further understand that it is best to give a copy of such written revocation instructions to my agents and health care providers. (Note: while you can revoke all or part of this document as described above, adding to your Advance Heath Care Directive requires completing a new form or writing signed by two qualified witnesses.)

I understand that I may also revoke this health care directive in any manner that communicates an intent to revoke done in the presence of two competent persons, one of whom is a health care provider. I further understand that any revocation that is not in writing shall be memorialized in writing and signed and dated by both witnesses, and made a part of my medical record.

I understand that, if I have designated my spouse as my agent, a decree of annulment, divorce, dissolution of marriage or a filing of a petition for divorce revokes that designation unless otherwise specified in the decree or in a power of attorney for health care.

I understand that the initiation of emergency treatment shall be presumed to represent a suspension of an advance health-care directive while receiving such emergency treatment.

Also, I understand that, upon written notification to me or to anyone who is caring for me or has custody of me, one or more of my health-care Agents may resign.

EFFECT OF COPY: A copy of this form has the same effect as the original.

SIGNATURE

Having carefully read this document, I understand its purpose and effect, and hereby sign and date below:

_____ _____

(*Date*) (*Sign your name*)

_____

(*Print your name*)

_____

(*Street*)

_____

(*City, State, Zip Code*)

STATEMENT OF WITNESSES

SIGNED AND DECLARED by the above-named declarant as and for his/her written declaration under 16 Del. C. §§ 2502,2503, in our presence, who in his/her presence at his/her request, and in the presence of each other, have hereunto subscribed our names as witnesses, and state:

A. The Declarant is mentally competent.

B. That neither of us is prohibited by § 2503 of Title 16 of the Delaware Code from being a witness. Neither of us:

1. Is related to the declarant by blood, marriage, or adoption;
2. Is entitled to any portion of the estate of the declarant under any will of the declarant or codicil thereto then existing nor, at the time of the executing of the advance health-care directive, is so entitled by operation of law then existing;
3. Has, at the time of the execution of the advance health-care directive, a present or inchoate claim against any portion of the estate of the declarant;
4. Has a direct financial responsibility for the declarant's medical care;
5. Has a controlling interest in or is an operator or an employee of a health-care institution in which the declarant is a patient or resident; or
6. Is under eighteen years of age.

C. That if the declarant is a resident of a sanitarium, rest home, nursing home, boarding home or related institution, one of the witnesses, _____, is at the time of the execution of the advance health-care directive, a patient advocate or ombudsman designated by the Department of Health and Social Services or the Public Guardian.

Witness	Witness
_____	_____
(*Print name*)	(*Print name*)
_____	_____
(*Address*)	(*Address*)
_____	_____
(*City, State, Zip Code*)	(*City, State, Zip Code*)
_____	_____
(*Signature of Witness*) (*Date*)	(*Signature of Witness*) *(Date)*

You do not need to have this form notarized, but notarization may enhance its effectiveness in other states.

(Optional Notarization)

Sworn and subscribed to me this _____ day of _____, 20_____.

My term expires: _____ _____

(*Notary*)