Massachusetts Health Care Proxy

1. I, ____ Address: _________________________________,

appoint the following person to be my Health Care Agent with the authority to make health care decisions on my behalf. This authority becomes effective if my attending physician determines in writing that I lack the capacity to make or communicate health care decisions myself, according to Chapter 201D of the General Laws of Massachusetts.

2. My Health Care Agent is:

Name: _________________________________ Address: ___________________________________

Phone(s): _______________________; ________________________; _______________________

3. My Alternate Health Care Agent

If my Agent is not available, willing or competent, or not expected to make a timely decision, I appoint:

Name: __________________________________ Address: _________________________________

Phone(s): _______________________; ________________________; ________________________

4. My Health Care Agent's Authority

I give my Health Care Agent the same authority I have to make any and all health care decisions including life-sustaining treatment decisions, except (list limits to authority or give instructions, if any):

____

____.

I authorize my Health Care Agent to make health care decisions based on his or her assessment of my choices, values and beliefs if known, and in my best interest if not known. I give my Health Care Agent the same rights I have to the use and disclosure of my health information and medical records as governed by the Health Insurance Portability and Accountability Act of 1996 (HIPAA), 42 U.S.C. 1320d. Photocopies of this Health Care Proxy have the same force and effect as the original.

5. Signature and Date. I sign my name and date this Health Care Proxy in the presence of two witnesses.

SIGNED ____ **DATE** ____________

6. Witness Statement and Signature

We, the undersigned, have witnessed the signing of this document by or at the direction of the signatory above and state the signatory appears to be at least 18 years old, of sound mind and under no constraint or undue influence. Neither of us is the health care agent or alternate agent.

Witness One

Signed: ___________________________

Print Name: ___________________________

Date: ___________________________

Witness Two

Signed: ___________________________

Print Name: ___________________________

Date: ___________________________

7. Health Care Agent Statement (Optional):

We have read this document carefully and accept the appointment.

Health Care Agent ____ Date _____________

Alternate Health Care Agent ___________________________________ Date _____________

Honoring Choices®
MASSACHUSETTS

Personal Directive

Short Form: Instructions and Document

A Personal Directive is a personal document, not legally binding in Massachusetts, in which you give your Health Care Agent ("Agent"), family, doctors and care providers information about what's important to you and instructions about the kind of care you want and do not want. Your Personal Directive acts as your voice when you are unable to communicate or make care decisions for yourself.

- If you have chosen an Agent in a Health Care Proxy, your Agent uses your Personal Directive as a basis to make health care decisions on your behalf, and to talk with others about your care.
- If you have not chosen an Agent yet, your Personal Directive gives important information to your family, doctors and care providers to help them match quality care to your values and choices.

Instructions: Print this document and place the instructions page and blank form side by side in front of you. Follow the instructions and write in what you'd like others to know about your values, beliefs, goals and choices. Use both sides for more space. You can make changes anytime, as long as you are competent.

On the first line print your full name in the blank space, followed by your address. Check the box that applies about your Agent. If you have a Health Care Proxy, you can attach it to this document.

I. My Personal Preferences, Thoughts and Beliefs

- Let others know what's most important to you (family, friends, work, faith, activities…)
- Write in anything you like to help others match care & services to your values and choices.
- Add information to help others manage your personal affairs while you recover or longer.

II. People to Inform about My Choices and Preferences

- List the names of family, friends and others you'd like to inform, and how they can help.

III. My Medical Care: My Choices and Treatment Preferences

- A. Current Medical Condition: Share information and your care preferences.
- B. Life-Sustaining Treatments: Cardiopulmonary resuscitation (CPR), artificial ventilation and breathing, and artificial hydration and nutrition are treatments intended to prolong life by supporting an essential body function, when the body is not able to function on its own. Talk to your doctors about the risks, benefits and possible outcomes of attempting these treatments given your medical condition. Check the box or write in your instructions.

IV. Other Information, Instructions and Personal Messages:

- Write in (and attach additional pages) to provide information about your care, instructions for managing your personal affairs or pets, or personal messages to deliver to others.

V. SIGNATURE and Date

- Sign your full name and fill in the date as you sign it. You can revise or reaffirm this document.

Important: Keep the original and give a copy to your Agent, family, doctors and anyone else you would like. You can make changes or add information all through your life, as long as you are competent. Read more about the Personal Directive at www.honoringchoicesmass.com

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Personal Directive

I, ________________________________, residing at ______________________________________, write this directive for my Health Care Agent (Agent), family, friends, doctors and care providers to inform you of my choices and preferences for care.

- ☐ I have chosen a Health Care Agent in a Health Care Proxy. My Agent's Name & Contact Information is:
  ____
- ☐ I have not chosen a Health Care Agent in a Health Care Proxy.

I. My Personal Preferences, Thoughts and Beliefs

1. Here's what is most important to me, and the things that make my life worth living:

____

____

2. If I become ill or injured and I am expected to recover, possibly to a lesser degree, here's how I define having a good quality of life. I'd like to be able to:

____

____

3. Here are my personal values, my religious or spiritual beliefs, and my cultural norms and traditions to consider when making decisions about my care (list here if any):

____

____

4. Here's what worries me most about being ill or injured; here's what would help lessen my worry:

____

____

5. If I become seriously ill or injured and I am not expected to recover and regain the ability to know who I am, here are my thoughts about prolonging my life and what treatments are acceptable and not acceptable to me:

____

____

6. Here are my thoughts about what a peaceful death looks like to me:

____

____

II. People to Inform about My Choices and Preferences

Here's a list of people to inform (i.e. family, friends, clergy, attorneys, care providers) their contact information, and the role or action I'd like each to take (if any):

____

____

____

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III. My Medical Care: My Choices and Treatment Preferences

A. My Current Medical Condition

Here's information about my specific medical condition. Here are my preferences for medications, clinicians, treatment facilities or other care I want or do not want (if any):

____

____

B. Life-Sustaining Treatments

1. Cardiopulmonary Resuscitation (CPR) is a medical treatment used to restart the heartbeat and breathing when the heartbeat and breathing have stopped. My choices are:
   - ☐ I do not want CPR attempted but rather, I want to allow a natural death with comfort measures;
   - ☐ I want CPR attempted unless my doctor determines any of the following: • I have an incurable illness or irreversible injury and am dying • I have no reasonable chance of survival if my heartbeat and breathing stop • I have little chance of long-term survival if my heartbeat and breathing stop and the process of resuscitation would cause significant suffering;
   - ☐ I want CPR attempted if my heartbeat and breathing stop;
   - ☐ I do not know at this time and rely on my Health Care Agent to make care decisions.

____

____

2. Treatments to Prolong My Life

   If I reach a point where I am not expected to recover and regain the ability to know who I am, here are my choices and preferences for life-sustaining treatment:
   - ☐ I want to withhold or stop all life-sustaining treatments that are prolonging my life and permit a natural death. I understand I will continue to receive pain & comfort medicines;
   - ☐ I want all appropriate life-sustaining treatments for a short term as recommended by my doctor, until my doctor and Agent agree that such treatments are no longer helpful;
   - ☐ I want all appropriate life-sustaining treatments recommended by my doctor;
   - ☐ I do not know at this time and rely on my Health Care Agent to make care decisions.

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____

IV. Other Instructions, Information and Personal Messages

____

____

V. Signature and Date

I sign this Personal Directive after giving much thought to my choices and preferences for care.
I understand I can revise, review and affirm my decisions all through my life as long as I am competent.

SIGNED: ________________________________ Date: ________________

Reviewed and Reaffirmed________________________________ Date: ________________

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