ADVANCE DIRECTIVE

Hackensack Meridian *Health*

ADVANCE DIRECTIVES

Your values and priorities are important. An **Advance Directive** is a legal document you fill out to communicate your preferences about your health care, in case you cannot make health care decisions for yourself.

This packet includes the two kinds of Advance Directive: a **Proxy Directive and an Instruction Directive**, as well as instructions about how to complete these documents.

> A **Proxy Directive** is used to appoint someone to make health care decisions for you in case you are unable to make them yourself. That person will be your Health Care Representative. You may also appoint additional individuals to act as your Health Care Representative in the event that your primary Health Care Representative is unable, unwilling or unavailable to act in that capacity.
>
> An **Instruction Directive**, also called a Living Will, is used to state your values and preferences about your health care in case you cannot make your own health care decisions.

It is up to you if you choose to have an Advance Directive. You may choose to have a Proxy Directive, an Instruction Directive, both, or neither.

If you already have an Advance Directive and it still reflects your current preferences, you do not need to complete new documents, even if it was completed in a state other than New Jersey.

HOW TO FILL OUT ADVANCE DIRECTIVES

The information provided in this packet guides you through the process of filling out valid Advance Directives.

STEP 1: Think about what is important to you.

- Think about your values and priorities and about what is important to you about your health care decisions.
- Decide who you want to make your decisions if you cannot make them yourself. Consider who knows you best, who you trust, and who will honor your choices.
- Decide what you would like your health care team to know about you.
- Consider talking with people close to you. Although it can be difficult, the best time to start the conversation and to complete an Advance Directive is when you are able to carefully consider your choices.
- Consider talking to your health care team about what kinds of health care decisions are important for you to think about.

STEP 2: Fill out a Proxy Directive (also called a Health Care Proxy or Durable Power of Attorney for Health Care).

- If you choose to appoint someone to make your health care decisions in case you cannot make them yourself, fill out the Proxy Directive on page 6.
- You may choose as your Health Care Representative your spouse/domestic partner, adult child, parent, family member, friend, religious or spiritual advisor or any other adult.
- You may also appoint additional individuals to act as your Health Care Representative in the event that your Health Care Representative is unable, unwilling or unavailable to act in that capacity.

- You may appoint a physician as your Health Care Representative, but they cannot serve as your physician and Health Care Representative at the same time. You cannot appoint as your Health Care Representative any other employee or administrator of a health care institution in which you are a patient or resident, unless they are related to you by blood, marriage, civil union, domestic partnership, or adoption.
- In order for the Proxy Directive to be valid, you must sign and date the document in front of two witnesses OR a notary.
  The witnesses cannot be anyone you named to be your Health Care Representative or an alternate.

STEP 3: Fill out an Instruction Directive (also called a Living Will).

- If you choose to complete an Instruction Directive, in order to communicate your values and preferences about specific treatments in case you cannot make your own decisions, fill out the Instruction Directive on pages 7-8.
- In order for the Instruction Directive to be valid, you must sign and date the document in front of two witnesses OR a notary. The witnesses cannot be anyone you named to be your Health Care Representative or an alternate.

STEP 4: Make copies of the documents. Give them to your Health Care Representative(s) and your doctor(s).

- An Advance Directive goes into effect when it is given to your doctor or health care institution and you cannot make your own health care decisions, whether that inability is temporary or permanent.
- Keep the original Advance Directive for yourself.
- Make copies and give one to each of your doctors and to anyone you have selected to make decisions on your behalf.

FAQS

Who should have an Advance Directive?

Advance Directives help those close to you and your health care team know what is important to you.

All adults are encouraged to complete a Proxy Directive to appoint a Health Care Representative (and alternate representatives). A Proxy Directive lets members of your health care team know who they should turn to in the event that you cannot make decisions for yourself.

Any adult who wants to specify their values, goals, and preferences about their future treatment may complete an Instruction Directive. An Instruction Directive may be especially helpful for people who have serious health conditions or information that they want their health care teams and representatives to know.

When is an Advance Directive used?

An Advance Directive goes into effect when it is provided to your doctor or health care institution and you cannot make your own health care decisions, whether that inability is temporary or permanent.

How will the health care team use the document?

In order to develop a care plan in line with your goals, values, and preferences, the health care team will review your Advance Directive documents. The health care team will work with your Health Care Representative, if you have appointed one.

Who should have a copy of my Advance Directives?

You should keep the original document handy and bring it with you if you come to the hospital. Your doctors, other members of your health care team, and your designated Health Care Representative(s) should all have copies.

Do I need an attorney to complete an Advance Directive?

No, you do not need to consult an attorney to complete an Advance Directive. You may choose to do so if you wish.

Who is needed to witness or notarize an Advance Directive?

A valid Advance Directive must be signed and dated by you in front of either two witnesses OR a notary, who also sign and date the document. Your appointed Health Care Representative or alternate(s) may not serve as a witness to any of your Advance Directive documents.

What if I change my mind?

You may change, revoke, or update your Advance Directive at any time. An Advance Directive does not expire. It is recommended that you review it regularly.

If you have any questions or would like additional resources, please reach out to your health care practitioner or the
Office of Patient Experience at your local hospital.

TERMS TO KNOW

Witness is the person who, by signing your Advance Directive, attests that you signed it in their presence and that you are of sound mind and free of undue influence. Your Advance Directive is valid if it is signed and dated by two witnesses or notarized. The witnesses cannot be anyone you appointed to be your Health Care Representative(s).

A Notary is appointed by the state government to ensure the true identity of a person signing a document, their willingness to sign without duress or intimidation, and their awareness of the contents of the document. Your Advance Directive is valid if it is signed and dated by two witnesses or notarized.

Life Sustaining Treatment is the use of medical devices or procedures, artificially provided fluids and nutrition, drugs, surgery or therapy that uses mechanical or other artificial means to sustain, restore, or supplant a vital bodily function, and thereby may increase the expected life span of a patient.

Health Care Representative is the person you appoint to make health care decisions for you if you are unable to make them yourself. You may choose as your Health Care Representative your spouse/ domestic partner, adult child, parent, family member, friend, religious or spiritual advisor, or any other adult.

You may also appoint additional individuals to act as your Health Care Representative in the event that your Health Care Representative is unable, unwilling or unavailable to act in that capacity. You may appoint a physician as your Health Care Representative, but they cannot serve as your physician and Health Care Representative at the same time. You cannot appoint as your Health Care Representative any other employee or administrator of a health care institution in which you are a patient or resident, unless they are related to you by blood, marriage, civil union, domestic partnership, or adoption.

Permanently Unconscious means a medical condition that results in total and irreversible loss of consciousness and capacity for interaction with the environment. Permanently unconscious includes without limitation a persistent vegetative state or irreversible coma.

Terminal Condition is the terminal stage of an irreversibly fatal illness, disease, or condition, regardless of life expectancy.
A prognosis of a life expectancy of six months or less is considered a terminal condition.

PROXY DIRECTIVE (HEALTH CARE PROXY)

This is a legal document which appoints a person or persons to make health care decisions on your behalf if you are unable to do so yourself (temporarily or permanently). This document is valid only if it is signed by you in the presence of either (a) two adult witnesses who are not named as a Health Care Representative or an alternate representative OR (b) by a Notary or an attorney.

I, (print name)_____, hereby designate the following person as my Health Care Representative, to make any and all health care decisions for me, except to the extent that I state otherwise. This directive shall take effect when and if I become unable to make my health care decisions.

Name _____Relationship _____

Street _____ City _____ State ____Zip _____ Telephone _____

Email _____ Preferred language_____

If the person I have designated above is unable, unwilling or unavailable to act as my Health Care Representative, I hereby designate the following person(s) to act as my Health Care Representative, in the order or priority stated:

1. Name_____ Relationship _____
   Street _____ City _____ State_____ Zip _____
   Telephone_____ Email_____

2. Name_____ Relationship_____
   Street _____ City _____ State_____ Zip _____
   Telephone_____ Email_____

Use this space for any additional instructions you may have: _____

_____

_____

By signing below, I indicate that I understand the purpose and effect of this document and sign it knowingly, voluntarily, and after careful deliberation.

Signature _____ **Date** _____

WITNESS OR NOTARY

☐ **WITNESS:**

I declare that the person who signed this document, or asked another to sign this document on their behalf, did so in my presence, that they have been clearly identified to me, and that they appear to be of sound mind and free of duress or undue influence. I am 18 years of age or older, and am not designated by this or any other document as the person's Health Care Representative or alternate Health Care Representative.

1. Witness Name_____ 2. Witness Name_____

Address _____ Address _____

Signature_____**Date** _____ **Signature**_____**Date** _____

OR

☐ **NOTARY:**

1. For an acknowledgment in an individual capacity:

State of_____County of_____

This record was acknowledged before me on _____(date) by

_____

(Name(s) of individual(s))

_____

Signature of notarial officer

NOTARY STAMP HERE

Name _____

INSTRUCTION DIRECTIVE (LIVING WILL)

This is a legal document which states your values and preferences about your health care in case you cannot make your own health care decisions (temporarily or permanently). This document is valid only if it is signed by you in front of either (a) two adult witnesses who are not named as a Health Care Representative or an alternate representative OR (b) a Notary or an attorney.

I. The following values and goals should guide my treatment if I am unable to make decisions for myself:

_____

_____

_____

II. I have initialed the statement below that reflects my values and preferences. (Initial EITHER A OR B)
Please initial either of the following if they apply to you:

A._____ I want to live as long as possible, regardless of my physical or mental condition, and direct that all medically appropriate measures to sustain my life be provided. **OR**

B._____ I do not wish my life to be prolonged if my quality of life is unacceptable to me. I have initialed those circumstances in which I would choose to forgo life-sustaining measures.

_____ When the life-sustaining treatment is experimental and not a proven therapy, or is likely to be ineffective or futile in prolonging my life, or is likely to merely prolong an imminent dying process.

_____ I am permanently unconscious, as determined by my attending physician and confirmed by a second qualified physician.

_____ I am in a terminal condition, as determined by my attending physician and confirmed by a second qualified physician.

_____ I am diagnosed as having a serious and irreversible illness or condition and the likely risks and burdens of continued life with treatment outweigh the benefits or the medical intervention may cause me to experience severe and progressive physical or mental deterioration and/or a permanent loss of capacities and faculties that I value highly. You will still be provided medically appropriate treatment, including to treat symptoms._____

_____

_____

Use this space below to list specific treatment that you would want to limit or avoid in the circumstances that you initialed above (such as cardiopulmonary resuscitation (CPR), mechanical ventilation, dialysis, feeding tube, etc.). You will still be provided medically appropriate care, including to treat symptoms. _____

_____

_____

III. The following are most important to me to guide treatment choices. (Initial those that apply)

_____ Pain control, even if it makes me less aware or able to interact OR _____Awareness of my environment, even if I experience some discomfort

_____ Minimizing time in the hospital

_____ Being at home, if possible, in my last days to weeks

_____ Spending time with my loved ones

_____ Access to spiritual care and religious rituals

_____ Other goals, preferences, and priorities that are important to me:

_____

_____

IV: The person(s) appointed by me as my Health Care Representative should: (initial EITHER A OR B to indicate how much leeway you want your Health Care Representative to have when making decisions for you.)

The person(s) appointed by me as my Health Care Representative should: (initial one)

A. _____ Utilize this document and our conversations about my values and preferences to interpret how to best apply my values and preferences in the context of my clinical situation **OR**

B. _____ Be limited to only those values, preferences, and treatment choices identified in this document.

V. Other things I want my health care team and others to know: _____

_____

_____

VI. Organ Donation/Anatomical Gift: (If you choose to complete this section, initial your choices below.)

A. _____ I wish to make the following organ donation/anatomical gift to take effect upon my death for the purposes of transplantation, therapy, medical research, and/or education.

I donate:

_____ any needed organs, tissues, or body parts **OR**

_____ only the following organs, tissues, or body parts_____

_____ I authorize a donation of my whole body for anatomical study

_____ Special instructions and/or limitations, if any_____

OR

B. _____ I do not wish to make an anatomical gift upon my death.

VII. In the absence of my ability to give directions regarding my health care, it is my intention that this declaration shall be honored by my family and physician(s) as the final expression of my legal right to accept or to refuse medical care. In the event that my wishes are not clear, my representative is authorized to make decisions in my best interests, based on what is known of my wishes. By signing below, I indicate that I understand the purpose and effect of this document and sign it knowingly, voluntarily, and after careful deliberation.

Signature _____ **Date** _____

WITNESS OR NOTARY

☐ **WITNESS:**

I declare that the person who signed this document, or asked another to sign this document on their behalf, did so in my presence, that they have been clearly identified to me, and that they appear to be of sound mind and free of duress or undue influence. I am 18 years of age or older, and am not designated by this or any other document as the person's Health Care Representative or alternate Health Care Representative.

1. Witness Name_____ 2. Witness Name_____

Address _____ Address _____

Signature_____**Date** _____ **Signature**_____**Date** _____

OR

☐ **NOTARY:**

1. For an acknowledgment in an individual capacity:

State of_____County of_____

This record was acknowledged before me on _____(date) by

_____

(Name(s) of individual(s))

_____

Signature of notarial officer

NOTARY STAMP HERE