ADVANCE HEALTH-CARE DIRECTIVE OF

_____

You can use this form if you wish to name someone to make health-care decisions for you in case you cannot make decisions yourself. This is called giving the person a power of attorney for health care. This person is called your agent.

You can also use this form to state your wishes, preferences, and goals for health care, and to say you want to be an organ donor after you die.

Your Name: _____ Date of Birth: _____

PART A: NAMING AN AGENT

This part lets you name someone else to make health-care decisions for you. You may leave any item blank.

1. NAMING AN AGENT

I want the following person to make health-care decisions for me if I cannot make decisions for myself:

Name: _____

Contact Info (Phone, Address): _____

_____

_____

2. NAMING AN ALTERNATIVE AGENT

I want the following person to make health-care decisions for me if I cannot and my agent is not available to make them for me:

Name: _____

Contact Info (Address, Phone):

_____

_____

_____

3. LIMITING YOUR AGENT'S AUTHORITY

_____ I give my Agent the power to make all health-care decisions for me if I cannot make those decisions for myself, except the following:

_____

_____

_____

(If you do not add a limitation here, your Agent will be able to make all health-care decisions that an Agent is permitted to make under State law.)

PART B: HEALTH-CARE INSTRUCTIONS

This part lets you state your priorities for health care and to state types of health care you do and do not want.

1. INSTRUCTIONS ABOUT LIFE-SUSTAINING TREATMENT

This section gives you the opportunity to say how you want your Agent to act while making decisions for you. You may mark or initial your choice. You also may leave any choice blank.

Treatment. Medical treatment to keep me alive but not needed for comfort or any other purpose should (mark all that apply):

_____ Always be given me. (If you mark or initial this choice, you should not mark or initial other choices in this "treatment" section.)

_____ Not be given to me if I have a condition that is not curable and is expected to cause my death soon, even if treated.

_____ Not be given to me if I am unconscious and I am not expected to be conscious again.

_____ Not be given to me if I have a medical condition from which I am not expected to recover that prevents me from communicating with people I care about, caring for myself, and recognizing family and friends.

_____ Other (write what you want or do not want)

_____

_____

_____

_____

Food or liquids: If I cannot swallow and staying alive requires me to get food or liquids through tube or other means for the rest of my life, then food or liquids should (mark all that apply):

_____ Always be given me. (If you mark or initial this choice, you should not mark or initial other choices in this "treatment" section.)

_____ Not be given to me if I have a condition that is not curable and is expected to cause me to die soon, even if treated.

_____ Not be given to me if I am unconscious and I am not expected to be conscious again.

_____ Not be given to me if I have a medical condition from which I am not expected to recover that prevents me from communicating with people I care about, caring for myself, and recognizing family and friends.

_____ Other (write what you want or do not want)

_____

_____

_____

_____

Pain Relief. If I am in significant pain, care that will keep me comfortable but is likely to shorten my life should (mark or initial all that apply):

_____ Always be given me. (If you mark or initial this choice, you should not mark or initial other choices in this "pain relief" section.)

_____ Never be given to me. (If you mark or initial this choice, you should not mark or initial other choices in this "pain relief" section.)

_____ Be given to me if I have a condition that is not curable and is expected to cause me to die soon, even if treated.

_____ Be given to me if I am unconscious and I am not expected to be conscious again.

_____ Be given to me if I have a medical condition from which I am not expected to recover that prevents me from communicating with people I care about, caring for myself, and recognizing family and friends.

_____ Other (write what you want or do not want)

_____

_____

2. MY PRIORITIES

You can use this section to indicate what is important to you, and what is not important to you. This information can help your Agent make decisions for you if you cannot. It also helps others understand your preferences. (You may mark or initial each choice. You may also leave any choice blank.)

Staying alive as long as possible even if I have substantial physical limitations is:

_____ Very important

_____ Somewhat important

_____ Not Important

Staying alive as long as possible even if I have substantial mental limitations is:

_____ Very important

_____ Somewhat important

_____ Not Important

Being free from significant pain is:

_____ Very important

_____ Somewhat important

_____ Not Important

Being independent:

_____ Very important

_____ Somewhat important

_____ Not Important

Having my Agent talk with my friends before making decisions about my care is:

_____ Very important

_____ Somewhat important

_____ Not Important

3. Other instructions

You can write in this section more information about your goals, values, and preferences for treatment, including care you want or do not want. You can also use this section to name anyone who you do not want to make decisions for you under any conditions.

_____

_____

_____

_____

PART C: OPTIONAL SPECIAL POWERS AND GUIDANCE

This part lets you give your Agent additional powers, and to provide more guidance about your wishes. You may mark or initial each choice. You may also leave any choice blank.

1. OPTIONAL SPECIAL POWERS

My Agent can do the following things ONLY if I marked or initialed below:

_____ Admit me as a voluntary patient to a facility for mental health treatment for up to _____ days (write in the number of days you want like 7, 14 or any number you want).

(If I do not mark or initial this choice my Agent MAY NOT admit me as a voluntary patient to this type of facility.)

_____ Place me in a nursing home for more than 100 days even if my needs can be met somewhere else, I am not terminally ill, and I object.

(If I do not mark or initial this choice, my Agent MAY NOT do this).

2. ACCESS TO MY HEATH INFORMATION

My Agent may obtain, examine, and share information about my health needs and health care if I am not able to make decisions for myself. If I mark or initial below, my Agent may also do that at any time my Agent thinks it will help me.

_____ I give my Agent permission to obtain, examine, and share information about my health needs and health care whenever my Agent thinks it will help.

FLEXIBILITY FOR MY AGENT

Mark or initial below if you want to give your Agent flexibility in following instructions you provide on this form. **If you do not**, your Agent must follow the instructions even if you Agent thinks something else would be better for you.

_____ I give my Agent flexibility in following instructions I provided if they think something else is better.

3. NOMINATION OF A GUARDIAN

You can say who you would want as your guardian if you needed one. A guardian is a person appointed by a court to make decisions for someone who cannot make decisions. Filling this out does NOT mean you want or need a guardian. There is no guarantee that the court will appoint the person you want as guardian.

If a court appoints a guardian to make personal decisions for me, I want the court to choose:

_____ My Agent named on this form. If my agent cannot be a guardian, I want the Alternate Agent named in this form.

_____ Other (provide contact info):

_____

_____

_____

PART D: ORGAN DONATION

This part lets you donate your organs after you die. You may have already indicated a decision on your driver's license, identification card, or in another registry. You can leave any item blank.

1. DONATION

You may mark or initial only one choice. Leave this donation section blank if you do not want to include your decision here.

_____ I donate my organs, tissues and other body parts after I die even if it requires maintaining treatments that conflict with other instructions I have put on this form, EXCEPT for those I list below (list any body part you do NOT want to donate): _____

_____

_____ I do not want my organs, tissues, or other body parts donated to anybody for any reason. (If you mark or initial this choice, you should skip the “purpose of donation” section.)

2. PURPOSE OF DONATION

You may mark or initial all that apply. (If you do not mark or initial any of the purposes below, your donation can be used for all of them.)

Organs, tissues, or other body parts that I donate may be used for:

_____ Transplant

_____ Therapy

_____ Research

_____ Education

_____ All the above

PART E: SIGNATURES

YOUR SIGNATURE

Sign here: _____

Date: _____

Optional City, State: _____

_____

_____

SIGNATURE OF WITNESS

You need a witness if you are using this form to name an Agent. The witness must be an adult and cannot be the person you are naming as an Agent or the Agent's spouse, domestic partner, or someone the Agent lives with as a couple. If you are receiving care in a nursing home or long-term care facility, the witness cannot be an employee or contractor of the home or someone who owns or runs the home.

Name of witness (please print): _____

Signature of Witness: _____

(Only sign as a witness if you think the person signing above is doing it voluntarily.)

Date witness signed: _____

PART F: INFORMATION FOR AGENT

1. If this form names you as an Agent, you can make decisions about health care for the person who named you when the person cannot make their own.
2. If you make a decision for the person, follow any instructions the person gave, including any in this form.
3. If you do not know what the person would want, make the decision that you think is in the person's best interest. To figure out what is in the best interest, Consider the person's values, preferences, and goals if you know them or can learn them. Some of these preferences may be in this form. You should also consider any behavior or communication from the person that indicates what the person currently wants.
4. If this form names you as an Agent, you can also get and share the person's health information. But in less the person said so in this form, you can get and share if information only when the person cannot make decisions about the person's health care.

Revised 9/30/2025.