DELAWARE
Advance Directive
Planning for Important Health-Care Decisions

CaringInfo
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CaringInfo, 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.

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:

Learn about options for end-of-life services and care
Implement plans to ensure wishes are honored
Voice decisions to family, friends and health-care providers
Engage in personal or community efforts to improve end-of-life care

Note: The following is not a substitute for legal advice. While CaringInfo updates the following information and form to keep them up-to-date, changes in the underlying law can affect how the form will operate in the event you lose the ability to make decisions for yourself. If you have any questions about how the form will help ensure your wishes are carried out, or if your wishes do not seem to fit with the form, you may wish to talk to your health-care provider or an attorney with experience in drafting advance directives. **If you have other questions regarding these documents, we recommend contacting your state attorney general's office.**

Using these Materials

BEFORE YOU BEGIN

1. Check to be sure that you have the materials for each state in which you may receive health-care.

2. These materials include:
    - Instructions for preparing your advance directive, please read all the instructions.
    - Your state-specific advance directive forms, which are the pages with the gray instruction bar on the left side.

ACTION STEPS

1. You may want to photocopy or print a second set of these forms before you start so you will have a clean copy if you need to start over.

2. When you begin to fill out the forms, refer to the gray instruction bars — they will guide you through the process.

3. 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.

4. 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.

5. You may also want to save a copy of your form in an online personal health records application, program, or service that allows you to share your medical documents with your physicians, family, and others who you want to take an active role in your advance care planning.

INTRODUCTION TO YOUR DELAWARE ADVANCE HEALTH-CARE DIRECTIVE

This packet contains a legal document, the **Delaware Advance Health-Care Directive** that protects 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.

Part 1 is a **Power of Attorney for Health Care**. This part lets you name someone (an agent) to make decisions about your medical care. The Power of Attorney for Health Care becomes effective when your doctor determines that you lack the ability to understand the significant benefits, risks, and alternatives to proposed health care and to make and communicate a health-care decision. Your agent may only make decisions regarding life-sustaining treatment if your doctor and at least one other doctor certify in your medical record that you are also terminally ill or permanently unconscious.

Part 2 includes your **Instructions for Health Care**. This is your state's living will. It lets you state your wishes about health care in the event that you can no longer speak for yourself and you are terminally ill or you are permanently unconscious.

Part 3 allows you to express your wishes regarding organ donation.

Part 4 of this form lets you designate a physician to have primary responsibility for your health care.

This form does not expressly address mental illness. If you would like to make advance care plans involving mental illness, you should talk to your physician and an attorney about a durable power of attorney.

Note: These documents will be legally binding only if the person completing them is a competent adult, who is 18 years of age or older, or an emancipated minor.

INSTRUCTIONS FOR YOUR DELAWARE ADVANCE HEALTH-CARE DIRECTIVE

How do I make my advance health-care directive legal?

Delaware law requires that you sign and date your written advance health-care directive in the presence of two witnesses who are 18 years of age or older. If you are unable to sign the document, another person may sign the document for you in your presence and at your direction. Your witnesses **cannot**:

- be related to you by blood, marriage, or adoption,
- be entitled to any portion of your estate,
- have a claim against any portion of your estate,
- be directly financially responsible for your health care, or
- be an operator or employee of — or have a controlling interest in — a health-care institution where you are a patient or in which you reside.

If you are a resident of a sanitarium, rest home, nursing home, boarding home, or related institution, then one of your witnesses must be a designated patient advocate or ombudsman.

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. Your agent may be a family member or a close friend whom you trust to make serious decisions. 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.

If you are a resident at a long-term health-care institution, your agent cannot be an operator or employee of or have a controlling interest in the residential long-term health-care institution where you are receiving care, unless that person is related to you by blood, marriage, or adoption.

You can appoint a second and third person as your alternate agents. An alternate agent will step in if the person(s) you name as agent is/are unable, unwilling or unavailable to act for you.

Should I add personal instructions to my Power of Attorney?

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 it may help your agent carry out your wishes, but be careful that you do not unintentionally restrict your agent's power to act in your best interest. In any event, be sure to talk with your agent about your future medical care and describe what you consider to be an acceptable "quality of life."

INSTRUCTIONS FOR YOUR DELAWARE ADVANCE HEALTH-CARE DIRECTIVE (CONTINUED)

What if I change my mind?

You can revoke all or part of your advance health-care directive:

- through a signed writing,
- by completing a new advance health-care directive, or
- in any other manner that communicates your intent to revoke your directive in front of two competent persons, one of whom is a health-care provider.

If your revocation is not in writing, someone must put it in writing and must sign and date it in front of two witnesses.

Unless you specify otherwise, if you designate your spouse as your agent, that designation will automatically be revoked by divorce, annulment, or dissolution of your marriage or by a filing of a petition for divorce.

Are there any important facts I should know?

Under Delaware law, a life-sustaining procedure may not be withheld or withdrawn from a patient known to be pregnant, if it is probable that the fetus will survive with the continued application of life-sustaining procedures.

EXPLANATION

EXPLANATION

You have the right to give instructions about your own health care. You also have the right to name someone else to make health-care decisions for you. This form lets you do either or both of these things. It also lets you express your wishes regarding anatomical gifts and the designation of your primary physician. If you use this form, you may complete or modify all or any part of it. You are free to use a different form.

Part 1 of this form is a power of attorney for health care. Part 1 lets you name another individual as agent to make health-care decisions for you if you become incapable of making your own decisions. You may also name an alternate agent to act for you if your first choice is not willing, able, or reasonably available to make decisions for you. Unless related to you, an agent may not have a controlling interest in or be an operator or employee of a residential long-term health-care institution at which you are receiving care. If you are not terminally ill or permanently unconsciousness, your agent may make all health-care decisions for you except for decisions providing, withholding, or withdrawing of a life-sustaining procedure. Unless you limit the agent's authority, your agent will have the right to:

(a) Consent or refuse consent to any care, treatment, service, or procedure to maintain, diagnose or otherwise affect a physical or mental condition unless it's a life-sustaining procedure or otherwise required by law.

(b) Select or discharge health-care providers and health-care institutions;

If you are terminally ill or permanently unconsciousness, your agent may make all health-care decisions for you, including, but not limited to:

(c) The decisions listed in (a) and (b).

(d) Consent or refuse consent to life-sustaining procedures, such as, but not limited to, cardiopulmonary resuscitation and orders not to resuscitate.

(e) Direct the providing, withholding, or withdrawal of artificial nutrition and hydration and all other forms of health care.

EXPLANATION

Part 2 of this form lets you give specific instructions about any aspect of your health care. Choices are provided for you to express your wishes regarding the provision, withholding, or withdrawal of treatment to keep you alive, including the provision of artificial nutrition and hydration as well as the provision of pain relief. Space is also provided for you to add to the choices you have made or for you to write out any additional instructions for other than end-of-life decisions.

Part 3 of this form lets you express an intention to donate your bodily organs and tissues following your death.

Part 4 of this form lets you designate a physician to have primary responsibility for your health care.

After completing this form, sign and date the form at the end. It is required that 2 other individuals sign as witnesses. Give a copy of the signed and completed form to your physician, to any other health-care providers you may have, to any health-care institution at which you are receiving care and to any health-care agents you have named. You should talk to the person you have named as agent to make sure that the person understands your wishes and is willing to take the responsibility.

You have the right to revoke this advance health-care directive or replace this form at any time.

INSTRUCTIONS

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

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

PART 1
POWER OF ATTORNEY FOR HEALTH CARE

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

_____
(name of agent)

_____
(address)

_____
(city) (state) (zip code)

_____
(home phone) (work phone)

If I revoke the authority of my agent or if my agent is not willing, able, or reasonably available to make health-care decisions for me, I designate as my first alternate agent:

_____
(name of first alternate agent)

_____
(address)

_____
(city) (state) (zip code)

_____
(home phone) (work phone)

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

If I revoke the authority of my agent and first alternate agent or if neither is willing, able or reasonably available to make a health-care decision for me, I designate as my second alternate:

_____
(name of second alternate agent)

_____
(address)

_____
(city) (state) (zip code)

_____
(home phone) (work phone)

ADD PERSONAL INSTRUCTIONS UNDER PARAGRAPH (2) ONLY IF YOU WANT TO LIMIT THE POWER OF YOUR AGENT

(2) AGENT'S AUTHORITY: If I am NOT terminally ill or permanently unconsciousness, my agent is authorized to make all health-care decisions for me, except decisions about life-sustaining procedures and as I state here:

_____
_____
_____
_____
_____
_____

and if I am terminally ill or permanently unconsciousness, my agent is authorized to make all health-care decisions for me, except as I state here:

_____
_____
_____
_____
_____
_____

(3) WHEN AGENT'S AUTHORITY BECOMES EFFECTIVE: My agent's authority becomes effective when my primary physician determines that I lack the capacity to make my own health-care decisions. As to decisions concerning providing, withholding, and withdrawal of life-sustaining procedures, my agent's authority becomes effective when my primary physician determines I lack the capacity to make my own health-care decisions and my primary physician and another physician determine I am in a terminal condition or permanently unconscious.

(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 known to my agent. To the extent 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.

INITIAL THE STATEMENT THAT BEST REFLECTS YOUR WISHES REGARDING NOMINATION OF A GUARDIAN

(5) NOMINATION OF GUARDIAN: If a guardian of my person needs to be appointed for me by a court:

_____I nominate the agent(s) whom I named in this form in the order designated to act as guardian.

_____ I nominate the following to be guardians in the order designated:

_____

_____

_____ I do not nominate anyone to be guardian.

PART 2
INSTRUCTIONS FOR HEALTH CARE

(6) END-OF-LIFE DECISIONS: If I can no longer make my own decisions and I have a qualifying condition, I direct that my health-care providers and others involved in my care provide, withhold or withdraw treatment in accordance with the choice I have marked below:

IF PARAGRAPH (A) REFLECTS YOUR WISHES, INITIAL ONLY THAT STATEMENT

A. Choice To Prolong Life:

_____ I want my life to be prolonged as long as possible within the limits of generally accepted health-care standards.

IF PARAGRAPH (B) REFLECTS YOUR WISHES, INITIAL THAT STATEMENT AND ALL OF THE STATEMENTS THAT REFLECT YOUR WISHES, INCLUDING YOUR WISHES ABOUT ARTIFICIAL NUTRITION AND HYDRATION

B. Choice NOT To Prolong Life:

_____ I do not want my life to be prolonged if I have a terminal condition (an incurable condition caused by injury, disease or illness which to a reasonable degree of medical certainty, makes death imminent and from which, despite the application of life sustaining procedures, there can be no recovery.) I make the following instructions regarding artificial nutrition and hydration if I have a terminal condition:

Artificial Nutrition through a conduit:
_____ I want _____ I do not want

Artificial Hydration through a conduit:
_____ I want _____ I do not want

ARTIFICIAL NUTRITION OR HYDRATION TROUGH A CONDUIT MEANS NUTRITION OR HYDRATION PROVIDED BY MEANS OF A FEEDING TUBE OR INTRAVENOUS LINE

_____ I do not want my life to be prolonged if I become permanently unconscious (a medical condition that has been diagnosed in accordance with currently accepted medical standards that has lasted at least 4 weeks and with reasonable medical certainty as total irreversible loss of consciousness and capacity for interaction with the environment. The term includes, without limitation, a persistent vegetative state or irreversible coma.) I make the following instructions regarding artificial nutrition and hydration if I become permanently unconscious:

Artificial Nutrition through a conduit:
_____ I want _____ I do not want

Artificial Hydration through a conduit:
_____ I want _____ I do not want

ADD PERSONAL INSTRUCTIONS UNDER PARAGRAPH (7) ONLY IF YOU WANT TO LIMIT PAIN OR COMFORT TREATMENT

(7) RELIEF FROM PAIN OR DISCOMFORT: Except as I state in the following space, I direct that treatment for alleviation of pain or discomfort be provided at all times, even if it hastens my death.

ADD OTHER INSTRUCTIONS, IF ANY, REGARDING YOUR ADVANCE CARE PLANS

(8) OTHER HEALTH-CARE INSTRUCTIONS OR WISHES:

THESE INSTRUCTIONS CAN FURTHER ADDRESS YOUR HEALTH CARE PLANS, SUCH AS YOUR WISHES REGARDING HOSPICE TREATMENT, BUT CAN ALSO ADDRESS OTHER ADVANCE PLANNING ISSUES, SUCH AS YOUR BURIAL WISHES

ATTACH ADDITIONAL PAGES IF NEEDED

(add additional pages if needed)

INITIAL THE STATEMENT(S) THAT REFLECT YOUR WISHES REGARDING ORGAN DONATION (OPTIONAL)

PART 3
ANATOMICAL GIFTS AT DEATH (OPTIONAL)

(9) I am mentally competent and 18 years or more of age. I hereby make this anatomical gift to take effect upon my death. The marks in the appropriate lines and words filled into the blanks below indicate my desires.

I give:

_____ My body

_____ any needed organs or parts

_____ the following organ parts:_____

To the following person or institutions:

_____ the physician in attendance at my death

_____ the hospital at which I die

_____ the following named physician, hospital storage bank or medical institution:_____

_____ the following individual for treatment:_____

For the following purposes:

_____ any purpose authorized by law

_____ transplantation

_____ therapy

_____ research

_____ medical education

PROVIDE THE NAME, ADDRESS, AND PHONE NUMBER OF A PHYSICIAN, IF ANY, YOU WOULD LIKE TO HAVE PRIMARY RESPONSIBILITY FOR YOUR HEALTH CARE (OPTIONAL)

PART 4
DESIGNATION OF PRIMARY PHYSICIAN (OPTIONAL)

(10) I designate the following physician as my primary physician:

_____
(name of physician)

_____
(address)

_____
(city) (state) (zip code)

_____
(phone)

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

DATE AND SIGN THE DOCUMENT

PRINT YOUR NAME AND ADDRESS

YOUR WITNESSES MUST READ THIS STATEMENT AND SIGN ON THE NEXT PAGE

(12) SIGNATURE: Sign and date the form here:

I understand the purpose and effect of this document.

_____

(Date) (Sign your name)

_____

(Print your name)

_____

(Address)

_____

(City) (State) (Zip code)

(13) STATEMENT OF WITNESSES

SIGNED AND DECLARED by the above named-declarant as and for his/her written declaration under 16 Del.C. §§2502 and 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. That the declarant is mentally competent.

B. That 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 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 direct financial responsibility for the declarant's medical care;
5. Has a controlling interest in or is an operator or employee of a health-care institution in which the declarant is a resident or patient; or
6. Is under eighteen years of age.

(IF YOU ARE A RESIDENT OF A NURSING HOME, A REGISTERED PATIENT ADVOCATE OR OMBUDSMAN MUST SERVE AS ONE OF YOUR WITNESSES AND PRINT HIS/HER NAME IN PARAGRAPH C)

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.

HAVE YOUR WITNESSES SIGN AND DATE THE DOCUMENT, AND THEN PRINT THEIR NAMES AND ADDRESS

Witness 1:

_____
(Date) (Sign your name)

_____
(Print your name)

_____
(Address)

_____
(City) (State) (Zip code)

Witness 2:

_____
(Date) (Sign your name)

_____
(Print your name)

_____
(Address)

_____
(City) (State) (Zip code)

Courtesy of CaringInfo
1731 King St., Suite 100, Alexandria, VA 22314
www.caringinfo.org, 800/658-8898

You Have Filled Out Your Advance Health-care Directive, Now What?

1. Your Delaware Advance Health-Care Directive is an important legal document. Keep the original signed document in a secure but accessible place. Do not put the original document in a safe deposit box or any other security box that would keep others from having access to it.

2. Give photocopies of the signed original to your agent and alternate agent, 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 document placed in your medical records.

3. Be sure to talk to your agent(s), doctor(s), clergy, family and friends about your wishes concerning medical treatment. Discuss your wishes with them often, particularly if your medical condition changes.

4. You may also want to save a copy of your form in an online personal health records application, program, or service that allows you to share your medical documents with your physicians, family, and others who you want to take an active role in your advance care planning.

5. If you want to make changes to your documents after they have been signed and witnessed, you must complete a new document.

6. Remember, you can always revoke your Delaware document.

7. Be aware that your Delaware document will not be effective in the event of a medical emergency. Ambulance and hospital emergency department personnel are required to provide cardiopulmonary resuscitation (CPR) unless they are given a separate directive that states otherwise. These directives called "prehospital medical care directives" or "do not resuscitate orders" are designed for people whose poor health gives them little chance of benefiting from CPR. These directives instruct ambulance and hospital emergency 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. We suggest you speak to your physician if you are interested in obtaining this form. **CaringInfo does not distribute these forms.**

Congratulations!

You've downloaded **your free, state specific advance directive.**

You are taking important steps to make sure your wishes are known. Please consider helping us keep this resource free.

Your generous support to the National Hospice Foundation allows us to continue to provide FREE resources, tools, and information to educate and empower individuals to access advance care planning, caregiving, hospice and grief services.

Please show your support for our mission and consider making a tax-deductible gift to the National Hospice Foundation today.

Since 1992, the National Hospice Foundation has been dedicated to creating FREE resources for individuals and families facing a life-limiting illness, raising awareness for the need for hospice and palliative care, and providing ongoing professional education and skills development to hospice and palliative care professionals across the nation. To learn more, please visit www.NationalHospiceFoundation.org

You may wonder if a gift of $35, $50 or $100 to the National Hospice Foundation would make a difference, but it is only because of the generosity of others like you that these FREE resources are made available.

Please consider supporting our mission by returning a **generous tax-deductible donation**. Every gift makes a difference! Your gift strengthens the Foundation's ability to provide FREE caregiver and family resources.

Cut along the dotted line and use the coupon below to return a check contribution of the most generous amount you can send. Thank you.

YES! I want to support the important work of the National Hospice Foundation.

$35	helps us provide webinars to hospice professionals
$50	helps us provide free advance directives
$100	helps us maintain our free InfoLine
$_____	to support the mission of the National Hospice Foundation.

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