MAINE 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 healthcare 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 MAINE ADVANCE HEALTH-CARE DIRECTIVE

This packet contains a legal document, a **Maine 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. You may complete any or all of the first four parts, depending on your advance planning needs. You must complete part 5.

Part 1 is a **Power of Attorney for Health Care**. This part lets you name someone (an agent) to make decisions about your health care. The power of attorney for health care becomes effective when your doctor determines that you can no longer make or communicate your health care decisions.

Part 2 includes your **Individual Instructions**. 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, including end-of-life choices.

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.

Part 5 contains the signature and witnessing provisions so that your document will be effective.

This form does not expressly address mental illness. If you would like to make advance care plans regarding mental illness, you should talk to your physician and an attorney about an advance directive tailored to your needs.

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 MAINE ADVANCE HEALTH-CARE DIRECTIVE

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

You must sign and date your advance directive or direct someone to do so for you if you are unable to sign it yourself.

Your signature must be witnessed by two witnesses.

Whom should I appoint as my agent?

Your agent is the person you appoint to make decisions about your health 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 health care decisions for you.

Unless related to you by blood, marriage or adoption, your agent cannot be an owner, operator, or employee of a residential, long-term health-care institution where you receive care.

You can appoint a second and third person as your alternative agent(s). An alternative agent can 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 advance health-care directive?

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 health care and describe what you consider to be an acceptable "quality of life."

What if I change my mind?

Except for the appointment of your agent, you may revoke any portion or all of this advance directive at any time and in any way that communicates your intent to revoke. This could be by telling your agent or physician that you revoke your advance directive, by signing a revocation, or simply by tearing up your advance directive.

In order to revoke your agent's appointment, you must either tell your supervising health-care provider of your intent to revoke or revoke your agents appointment in a signed writing.

If you execute a new advance directive, it will revoke the old advance directive to the extent of any conflict between the two documents.

Unless you specify otherwise in Part 2, if you designate your spouse as your agent, that designation will automatically be revoked by divorce, legal separation, or annulment or dissolution of your marriage

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 donation of organs 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 or if you want someone else to make those decisions for you now even though you are still capable. 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, your agent may not be an owner, operator or employee of a residential long-term health-care institution at which you are receiving care.

Unless the form you sign limits the authority of your agent, your agent may make all health-care decisions for you. This form has a place for you to limit the authority of your agent. You need not limit the authority of your agent if you wish to rely on your agent for all health-care decisions that may have to be made. If you choose not to limit the authority of your agent, 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;

B) Select or discharge health-care providers and institutions;

C) Approve or disapprove diagnostic tests, surgical procedures, programs of medication, and orders not to resuscitate; and

D) Direct the provision, withholding, or withdrawal of artificial nutrition and hydration and all other forms of health care, including life-sustaining treatment.

EXPLANATION (CONTINUED)

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 wishes.

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.

Part 5 contains the signature and witnessing provisions so that your document will be effective.

After completing this form, sign and date the form at the end. You must have 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 he or she 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.

PART 1

Part 1: POWER OF ATTORNEY FOR HEALTH CARE

PRINT YOUR NAME

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

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

_____
(name of agent)

_____
(address)

_____
(city) (state) (zip code)

_____
(home phone) (work phone)

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

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 alternate agent:

_____
(name of first alternative agent)

_____
(address)

_____
(city) (state) (zip code)

_____
(home phone) (work phone)

PRINT THE NAME, ADDRESS, AND TELEPHONE NUMBERS OF YOUR SECOND ALTERNATIVE 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 alternative agent)

_____
(address)

_____
(city) (state) (zip code)

_____
(home phone) (work phone)

ADD INSTRUCTIONS HERE ONLY IF YOU WANT TO LIMIT THE POWER OF YOUR AGENT

(2) **AGENT'S AUTHORITY**: My agent is authorized to make all health care decisions for me, including decisions to provide, withhold or withdraw artificial nutrition and hydration and all other forms of health care to keep me alive, **except** as I state here:

_____

_____

_____

_____

_____

_____

_____

CROSS OUT AND INITIAL ANY STATEMENTS WITHIN THE FOLLOWING PARAGRAPHS THAT DO NOT REFLECT YOUR WISHES

(3) **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 BOX IN PARAGRAPH (4) ONLY IF YOU WANT YOUR AGENT'S AUTHORITY TO TAKE EFFECT IMMEDIATELY

(4) **WHEN AGENT'S AUTHORITY BECOMES EFFECTIVE**: My agent's authority becomes effective when my primary physician determines that I am unable to make my own health-care decisions unless I mark the following box. If I mark this box [ ], my agent's authority to make health-care decisions for me takes effect immediately.

(5) **NOMINATION OF GUARDIAN**: If a guardian of my person needs to be appointed for me by a court, I nominate the agent designated in this form. If that agent is not willing or reasonably available to act as guardian, I nominate the alternate agents whom I have named, in the order designated.

PART 2

Part 2: INSTRUCTIONS FOR HEALTH CARE

(6) **END-OF-LIFE DECISIONS**: 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:

INITIAL THE PARAGRAPH THAT BEST REFLECTS YOUR WISHES REGARDING LIFE-SUPPORT MEASURES (INITIAL ONLY ONE)

____I Choose NOT To Prolong Life: I do not want my life to be prolonged if (i) I have an incurable or irreversible condition that will result in my death within a relatively short time; (ii) I become unconscious and, to a reasonable degree of medical certainty, I will not regain consciousness; or (iii) the likely risks and burdens of treatment would outweigh the expected benefits;

OR

____I Choose To Prolong Life: I want my life to be prolonged as long as possible within the limits of generally accepted health-care standards.

(7) **ARTIFICIAL NUTRITION AND HYDRATION**: I also specify that under the conditions mentioned in the above paragraph:

INITIAL YOUR PREFERENCE REGARDING ARTIFICIAL NUTRITION AND HYDRATION (INITIAL ONLY ONE)

____ I **do not** want artificial nutrition and hydration provided to me in order to prolong my life.

____ I **do** want artificial nutrition and hydration provided to me in order to prolong my life.

(8) **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 INSTRUCTIONS HERE ONLY IF YOU WANT TO LIMIT PAIN RELIEF OR COMFORT CARE

_____

_____

_____

_____

(Add additional pages, if needed.)

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

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

(9) **OTHER HEALTH CARE INSTRUCTIONS OR WISHES**:

(Add additional pages, if needed.)

PART 3

ORGAN DONATION (OPTIONAL)

INITIAL THE STATEMENT THAT AGREES WITH YOUR WISHES ABOUT ORGAN DONATION (INITIAL ONLY ONE)

STRIKE THROUGH ANY USES YOU DO NOT AGREE TO

Part 3: DONATION OF ORGANS AT DEATH

(10) Upon my death: (initial applicable box)

____ (a) I do not give any of my organs, tissues, or parts and do not want my agent, conservator, or family to make a donation on my behalf,

____ (b) I give any needed organs, tissues, or parts,

OR

____ (c) I give the following organs, tissues, or parts only:

_____

_____

_____

My gift is for the following purposes:
(strike any of the following you do not want)

(1) Transplant

(2) Therapy

(3) Research

(4) Education

PART 4

DESIGNATION OF PRIMARY PHYSICIAN (OPTIONAL)

PRINT THE NAME, ADDRESS, AND TELEPHONE NUMBER OF YOUR PRIMARY PHYSICIAN

PRINT THE NAME, ADDRESS, AND TELEPHONE NUMBER OF YOUR ALTERNATE PRIMARY PHYSICIAN

Part 4: DESIGNATION OF PRIMARY PHYSICIAN

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

_____
(name of physician)

_____
(address)

_____
(city) (state) (zip code)

_____
(phone)

If the physician I have designated is not willing, able, or reasonably available to act as my primary physician, I designate the following physician as my primary physician:

_____
(name of physician)

_____
(address)

_____
(city) (state) (zip code)

_____
(phone)

PART 5

Part 5: EXECUTION

Sign and date the form here:

SIGN YOUR DOCUMENT PRINT THE DATE, YOUR NAME, AND YOUR ADDRESS

_____
(signature) (date)

_____
(name)

_____
(address)

WITNESSES

Witness 1:

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

_____
(signature) (date)

_____
(name)

_____
(address)

Witness 2:

_____
(signature) (date)

_____
(name)

_____
(address)

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 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 healthcare. 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 Maine document.

7. Be aware that your Maine 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 these orders. We suggest you speak to your physician if you are interested in obtaining one. **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
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$100	helps us maintain our free InfoLine
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OR donate online today: www.NationalHospiceFoundation.org/donate