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DURABLE POWER OF ATTORNEY FOR HEALTH CARE
(Rhode Island Version)

THE DURABLE POWER OF ATTORNEY FOR HEALTH CARE DOCUMENT lets you appoint someone to make health care decisions for you when you cannot actively participate in healthcare decision-making. The person you appoint to make health care decisions for you when you cannot participate in healthcare decision-making is called your agent. The agent must act consistent with your desires as stated in this document or otherwise known. Your agent must act in your best interest. Your agent stands in your place, and can make any health care decision that you have the right to make.

You may use the '**Durable Power of Attorney for Health Care'** form that is supplied in this document, make your own Durable Power of Attorney for Health Care form, or resort to the many resources available on-line.

If you use the form found in this document, please read and follow the instructions included in that form carefully. Follow the witnessing section as required. To have your wishes honored, this Durable Power of Attorney for Health Care must be properly validated.

AND REMEMBER

- You must be at least eighteen (18) years of age.
- You must be a Rhode Island resident.
- You should follow the instructions highlighted in the left column of the 'Durable Power of Attorney for Health Care' form which follows this page.
- You must voluntarily sign this Durable Power of Attorney for Health Care.
- You must have this Durable Power of Attorney for Health Care witnessed properly
- No special form must be used, but if you use this form, it will be recognized by health care providers.
- Make copies of your Durable Power of Attorney for Health Care for your agent, alternative agent, physicians, hospital and family.
- Do not put your Durable Power of Attorney for Health Care in a safe deposit box – you will be denying access to those whom you're relying on to oversee your wishes.
- Although you are not required to update your Durable Power of Attorney for Health Care, you may want to review it periodically.

Durable Power of Attorney for Health Care

[RHODE ISLAND HEALTH CARE ADVANCE DIRECTIVE]

You may not appoint the following individuals as your Health Care Agent:

- *Your treating health care provider, such as a doctor, nurse, hospital, or nursing home.*
- *A non-related employee of your treating health care provider*
- *An operator of a community care facility*
- *A non-relative employee of an operator of a community care facility.*

I _____ ,

who presently resides at _____ , am at least 18 years of age, a resident of the State of Rhode Island, and understand this document allows me to name another person (called the Health Care Agent) to make health care decisions for me if I can no longer make decisions for myself, and I cannot inform my health care providers and Agent about my wishes for medical treatment.

PART I: APPOINTMENT OF HEALTH CARE AGENT

This is who I want to make health care decisions for me if I can no longer do so myself

You should discuss this health care directive with your Health Care Agent of choice, and give them a copy of this document.

I am hereby appointing _____ as my Health Care Agent. In so doing he/she will serve on my behalf, if and when I am no longer able to make decisions for myself.

My Health Care Agent's Phone _____ Secondary Phone _____

My Health Care Agent's Address _____

_____

You are not required to name alternative health care agents.

An alternative health care agent will be able to make the same decisions as the agent named above, if that person is unable or ineligible to make health care decisions for you. For example, if you name your spouse as your health care agent, and your marriage dissolved, then your former spouse is ineligible to be your health care agent.

APPOINTMENT OF ALTERNATIVE HEALTH CARE AGENTS:

When I am no longer able to make decisions for myself—and should my Health Care Agent not be available, not able, loses the mental capacity to make health care decisions for me, becomes ineligible to act as my Agent, is not willing to make health care decisions for me, or I if revoke the person appointed as my Agent to make health care decisions for me, I name and appoint the following persons as my Agent to make health care decisions for me, as authorized by this document, in the order listed below:

Name of My First Alternate Health Care Agent _____

Agent's Phone _____ Secondary Phone _____

Agent's Address _____

_____

Name of My First Alternate Health Care Agent _____

Agent's Phone _____ Secondary Phone _____

Agent's Address _____

_____

PART I: Continued

My Health Care Agent is automatically given the powers I would have to make health care decisions for me if I were able to make such decisions. Some typical powers for a Health Care Agent are listed below in **A** through **H**. My Health Care Agent must convey my wishes for medical treatment as stated in this document, or any other instructions I have given to my Agent. If I have not given health care instructions, then my Agent must act in my best interest.

I understand that a court can take away the power of my Agent to make health care decisions on my behalf if they ever:

1. Authorize anything illegal
2. Act contrary to my known wishes, or
3. Where my desires are not known, does anything that is clearly contrary to my best interest.

Whenever I can no longer make decisions about my medical treatment, my Health Care Agent has the power to:

A. Make any health care decisions for me. This includes the power to give, refuse, or withdraw consent to any care, treatments, services, test, or procedures. This includes deciding whether to stop or not start health care that is keeping me or might keep me alive, and deciding about mental health treatment.

B. Advocate for pain management for me.

C. Choose my health care providers, including hospitals, physicians, and hospice.

D. Choose where I live and receive health care which may include residential care, assisted living a nursing home, a hospice and a hospital.

E. Review my medical records, and disclose my health care information as needed.

F. Sign releases or other documents concerning my medical treatment.

G. Sign waivers or releases from liability for hospitals or physicians.

H. Make decisions concerning participation in research.

IF I DO NOT want to grant my Health Care Agent power for any item(s) listed in items A-H above, OR if I want to LIMIT a power in A-H, I hereby state those limitations as such:

_____

_____

_____

_____

_____

_____

_____

_____

PART II: Health Care Instructions

this is what i want and do not want for my health care

In certain circumstances, many medical treatments may be used to try and improve my medical condition, or to prolong my life in other circumstances. Many medical treatments can be started and then stopped if they do not help. Examples include artificial breathing by a machine connected to a tube in the lungs, artificial feeding of fluids through tubes, attempts to start the heart, surgeries, dialysis, antibiotics, and blood transfusions (the last page of this document elaborates upon life-support measures).

Discussing these items with your Health Care Agent may greatly help him/her in making decisions which are in alignment with your wishes.

Note: Toward the end of this document, there is a full page for adding any additional statement(s) of desires, special provisions, and limitations regarding your health care decisions.

These are my views which may help my Agent make health care decisions on my behalf:

1. Do I think my life should be preserved for as long as possible? Why or why not?

2. Would I want my pain managed, even if it makes me less alert - or if it shortens my life?

3. Do my religious beliefs affect the way I feel about death? Would I prefer to be buried or cremated?

4. Should financial considerations be important when making a decision about medical care?

5. Have I talked with others about these issues?

PART II: Continued

Here are my desires about my health care to guide my Agent and health care providers:

1. If I am close to death, and life support would only prolong my dying:
   - ☐ I want to receive a feeding tube
   - ☐ I want all life support that may apply
   - ☐ I I want no life support
2. If I am unconscious and it is very unlikely that I will ever become conscious again:
   - ☐ I want to receive a feeding tube
   - ☐ I want all life support that may apply
   - ☐ I I want no life support
3. If I have a progressive illness that will be fatal, and is in an advanced stage, and I am consistently and permanently unable to communicate by any means, swallow food and water safely, care for myself and recognize my family and other people, and it is very unlikely that my condition will substantially improve
   - ☐ I want to receive a feeding tube
   - ☐ I want all life support that may apply
   - ☐ I I want no life support

ORGAN DONATION

(INITIAL THE APPLICABLE ITEM(S) - CROSS OUT THE NON-APPLICABLE ITEM(S)

_____ In the event of my death, I request that my Agent inform my family or next of kin of my desire to be an organ and tissue donor for transplant.

_____ In the event of my death, I request that my Agent inform my family or next of kin of my desire to be an organ and tissue donor for research.

RELIGIOUS AND SPIRITUAL REQUESTS

Should I become incapacitated, I request the following spiritual advisor:

My Spiritual Advisor's Name _____

Their Contact Information _____

Should my select spiritual advisor be unavailable, please provide me with an alternative:

☐ Rabbi ☐ Priest ☐ Clergy ☐ Minister ☐ Imam ☐ Monk ☐ Other (see below)

_____

DURATION

Unless you specify a shorter period in the space below, this power of attorney will exist until it is revoked. Fill in the following entry if your want the authority of you Agent to end on a specific date.

I do not want this durable power of attorney to exist until revoked. I want this durable power of attorney for health care to expire on:

Month and Day _____ Year of _____

REVOCATION

I can revoke this Durable Power of Attorney for Health Care at any time and for any reason – either in writing or orally spoken. If I change my Agent or alternative Agents, or make any other changes, I need to complete a new Durable Power of Attorney for Health Care that reflect those changes.

PART III: Making This Document Legal

I revoke any prior designations, advance directives, or Durable Power of Attorney for Health Care.

My Signature _____ Date _____

I am thinking clearly, I agree with everything that is written in this document, and I have made this document willingly.

My Signature _____ Date _____

Two qualified witnesses, or one notary public must sign the Durable Power of Attorney for Health Care format the same time the Principle signs the document. The witnesses must be adults, and must not be any of the following:

1. *A person you designate as your Agent or alternate Agent*
2. *A health care provider*
3. *The operator of a community care facility, or*
4. *And employee of an operator of a community care facility*

DATES & SIGNATURES

(OPTION ONE: TWO QUALIFIED WITNESSES, OR OPTION TWO: A SINGLE NOTARY PUBLIC)

I declare under penalty of perjury the person who signed or acknowledged this document is personally known to me to be the Principal, that the Principal signed or acknowledged this Durable Power of Attorney for Health Care in my presence, that the Principal appears to be of sound mind, and under no duress, fraud, or undue influence, that I am not the person appointed as attorney in fact by this document, and that I am not a health care provider, an employee of a health care provider, the operator of a community care facility, or the employee of an operator of a community care facility.

OPTION ONE

Name of My First Qualified Witness (printed) _____

Signature _____ Date _____

Address of My First Qualified Witness _____

_____

Name of My Second Qualified Witness (printed) _____

Signature _____ Date _____

Address of My Second Qualified Witness _____

_____

OPTION TWO

Name Notary Public (printed) _____

Signature _____ Date _____

Commission Expiration _____

Business Address _____

_____

PART III: Continued

PUBLIC DECLARATION

At least one of the qualified witnesses, or the Notary Public must make this additional declaration.

I further declare under penalty of perjury that I am not related to the Principal by blood, marriage, or adoption, and, to the best of my knowledge, I am not entitled to any part of the estate of the Principal upon the death of the Principal under a will now existing or by operation of law.

Witness Name (printed) _____

Signature _____ Date _____

Witness Name (printed) _____

Signature _____ Date _____

PART IV: Distributing This Document

You are not required to give anyone your Durable Power of Attorney for Health Care document, but if it cannot be found at the time you need it, the document cannot help you. For example, you are unable to participate in making health care decisions, and your Durable Power of Attorney for Health Care is in a safe deposit box, the Agent, physician and other health care providers will not have access to it, and they will not be able to carry out your wishes for medical treatment. You may want to give a copy of your Durable Power of Attorney for Health Care to some or all of the persons listed below, so that it can be available when you need it.

The following individuals have received a copy of this document:

Health Care Agent _____

Phone _____ Address _____

First Alternative Health Care Agent _____

Phone _____ Address _____

Second Alternative Health Care Agent _____

Phone _____ Address _____

Physician _____

Phone _____ Address _____

Family Member _____

Phone _____ Address _____

Lawyer _____

Phone _____ Address _____

Other _____

Phone _____ Address _____

PART V: Additional Provisions

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UNDERSTANDING LIFE SUPPORT MEASURES

Life support replaces or supports a failing bodily function.

UNDERSTANDING LIFE SUPPORT MEASURES

When patients have curable or treatable conditions, life support is used temporarily until the illness or disease can be stabilized and the body can resume normal functioning. Sometimes, the body never regains the ability to function without life support.

When making decisions about specific forms of life support, gather the facts you need to make informed decisions. In particular, understand the benefit as well as the burden the treatment will offer you or your loved one. A treatment may be beneficial if it relieves suffering, restores functioning, or enhances the quality of life. The same treatment can be considered burdensome if it causes pain, prolongs the dying process without offering benefit, or adds to the perception of a diminished quality of life. A person's decision to forgo life support is deeply personal. When gathering information about specific treatments, understand why the treatment is being offered and how it will benefit your care.

COMMONLY USED LIFE SUPPORT MEASURES

Artificial nutrition and hydration: Artificial nutrition and hydration (or tube feeding) supplements or replaces ordinary eating and drinking by giving a chemically balanced mix of nutrients and fluids through a tube placed directly into the stomach, the upper intestine, or a vein. Artificial nutrition and hydration can save lives when used until the body heals. Long-term artificial nutrition and hydration may be given to people with serious intestinal disorders that impair their ability to digest food, thereby helping them to enjoy a quality of life that is important to them. Long-term use of tube feeding frequently is given to people with irreversible and end-stage conditions. Often, the treatment will not reverse the course of the disease itself or improve the quality of life. Some health care facilities and physicians may not agree with stopping or withdrawing tube feeding. Therefore, explore this issue with your loved ones and physician and clearly state your wishes about artificial nutrition and hydration in your advance directive.

Cardiopulmonary resuscitation: Cardiopulmonary resuscitation (CPR) is a group of treatments used when someone's heart and/or breathing stops. CPR is used in an attempt to restart the heart and breathing. Electric shock and drugs also are used frequently to stimulate the heart. When used quickly in response to a sudden event like a heart attack or drowning, CPR can be life saving. But the success rate is extremely low for people who are at the end of a terminal disease process. Critically ill patients who receive CPR have a small chance of recovering and leaving the hospital. If you do not wish to receive CPR under certain circumstances, and you are in the hospital, your doctor must write a separate do-not-resuscitate (DNR) order in your medical record. If you are at home, some states including Ohio allow for a non-hospital or portable DNR order. This order is written by a physician and directs emergency workers not to start CPR.

Mechanical ventilation: Mechanical ventilation is used to support or replace the function of the lungs. A machine called a ventilator (or respirator) forces air into the lungs. The ventilator is attached to a tube inserted in the nose or mouth and down into the windpipe (or trachea). Mechanical ventilation often is used to assist a person through a short-term problem or for prolonged periods in which irreversible respiratory failure exists due to injuries to the upper spinal cord or a progressive neurological disease. Some people on long-term mechanical ventilation are able to live a quality of life that is important to them. For a dying patient, however, mechanical ventilation often merely prolongs the dying process until some other body system fails. It may supply oxygen, but it cannot improve the underlying condition. When discussing end-of-life wishes, make clear to loved ones and your physician whether you would want mechanical ventilation if you would never regain the ability to breathe on your own or return to a quality of life acceptable to you.

Kidney dialysis: Kidney dialysis is a life-support treatment that uses a special machine to filter harmful wastes, salt and excess fluid from your blood. This restores the blood to a normal, healthy balance. Dialysis replaces many of the kidneys' important functions for people whose kidneys have stopped working properly. Dialysis is not a cure for kidney failure. If your kidneys do not work and you stop dialysis, your kidneys will continue to fail. You cannot live without at least one functioning kidney, unless you get a kidney transplant. For many people, the benefits of dialysis and the quality of life they experience as a result, outweigh the burdens of dialysis. But for some people, the opposite is true – the burdens of dialysis outweigh the benefits, especially if they have a terminal condition in addition to kidney failure. When discussing end-of-life issues, make clear to your loved ones and your physician whether you would want kidney dialysis, especially if it would not provide you with a quality of life acceptable to you or if it would only prolonging your dying.

STOPPING AND STARTING TREATMENT:

The distinction often is made between not starting treatment and stopping treatment. However, no legal or ethical difference exists between withholding and withdrawing a medical treatment in accord with a patient's wishes. If such a distinction existed in the clinical setting, a patient might forgo treatment that could be beneficial out of fear that once started it could not be stopped. It is legally and ethically appropriate to discontinue medical treatments that no longer are beneficial. It is the underlying disease--not the act of withdrawing treatment--that causes death.