

Important Choices with Your Care

York Hospital Advance Care Planning

About Advance Care Planning

An advance care plan gives instructions about the healthcare you want as an adult 18 years of age or older if you become too hurt or ill to speak for yourself. It also allows you to name someone to make decisions on your behalf. Even if you're in good health, it's still important to make sure your health care team and loved ones know your wishes. Because your health status could change suddenly, often the most ideal time to make these decisions is when you are not in crisis, allowing time to talk with your loved ones about your values and beliefs.

We are here to help you and your loved ones in this process. For more information:

- Visit www.yorkhospital.com/care-management
- Call Care Management at (207) 351-2226
- Contact the HealthCare Help Center at (207) 351-2345
- The Center for Older Adults can be reached at (207) 351-2371
- Contact your primary care provider
- Contact Spiritual Care at (207) 361-3647

York Hospital Advance Care Planning Form

You may use this form now to tell your provider and others what medical care you want to receive if you become too sick in the future to tell them what you want. You may choose to fill out the whole form or any part of the form and then sign and date the form in Part 6.

These are the parts:

PART 1	Fill this out if you want to choose someone to make all your health care decisions for you, either right away or if you become too sick to tell others what you want. This person is called your agent.
PART 2	Fill this out if: (1) you did not name an agent in Part 1 and now want to choose whether you want certain treatments or, (2) you did name an agent in Part 1 and want to tell your agent your wishes about certain treatments, knowing that your agent must follow your directions.
PART 3	Fill this out if you want to give the name of your primary provider.
PART 4	Fill this out if you want to make decisions about donating your organs, body or tissues after your death.
PART 5	Fill this out if you want: (1) to choose someone to make all funeral and burial decisions after your death, or (2) to tell your family any wishes you have about funeral and burial decisions.
PART 6	You must sign and date your Advance care planning form on this page. Have two witnesses sign the form at the same time you sign it. Tell others about your decisions and give copies to your provider, family and hospital.
PART 7	If you do not wish to be revived by ambulance crews should your heart or breathing stop, then you and your provider need to sign this Do Not Resuscitate (DNR) form.

Note

You may change any part of this form except for Part 6 and Part 7. You may cross out any words, sentences, or paragraphs you do not want. You can also add your own words. If you make any changes to the form, it is best if you put your initials and the date next to each change so that everyone knows it was your decision to make the change. The form lets you choose different ways to handle your care by checking boxes or filling in blanks. You may initial each box and each blank you fill in to show that it was your decision to check the box or fill in the blank.

Before filling out this form, we suggest that you talk with your lawyer, family members, providers, and others close to you about your wishes. If you make changes or complete a new form, be sure to let everyone know.

My name (please print): _____

My address: _____

My birth date: _____

This is a list of all the people who have copies of my signed health care advance care planning:

1. _____

2. _____

3. _____

4. _____

5. _____

6. _____

7. _____

8. _____

9. _____

10. _____

Part 1 – Power of Attorney for Health Care

Instructions

This part lets you choose another person to make health care decisions for you, either right away or when you are too sick to choose your own care. The person you choose is called your agent. You may also name a second and third choice to be your agent, if your first choice is not willing, reasonably available or able to make decisions for you. If you choose an agent on this form, but do not fill out any other parts of the form, your agent will be able to:

- Make all health care decisions for you, including decisions regarding tests, surgery and medication;
- Decide whether or not to have food or fluids given to you through tubes or fed into your veins through an IV
- Decide whether or not to use treatments or machines to keep you alive or to restart your heart or breathing;
- Choose who will give you health care and where you will get it, such as hospitals, nursing homes, assisted living settings, home health, or hospice care; and
- Make any health decision he or she believes would be consistent with your values or in your best interest, even if it is not listed in the form.

Who can be your agent

You can name any adult you trust to be your agent, except your agent may not be the owner, operator or employee of a nursing home or residential long-term care facility where you are receiving care, unless that person is your relative.

How your agent must make decisions

If your agent does not know what you want, the agent must make decisions consistent with your personal values, if known, or based on your best interests. In Part 2, you can decide what you want in advance. If you make choices in Part 2, your agent must make decisions based on those choices.

Who can see your health care information

Once your agent has the right to make health care decisions for you, your agent can look at your medical records and consent to giving your medical information to others. The state and federal privacy laws let your agent see all of your health information so that he or she can make the right decision for you.

Choosing an agent

Fill in your name and the name of the person you choose to be your agent to make health care decisions for you here:

My name (please print): _____

My address: _____

My birth date: _____

My agent's name _____

Title or relationship to me _____

My agent's address _____

My agent's home phone (____) _____ My agent's work phone (____) _____

My agent's email address _____

If the agent I have named above is not willing, reasonably available or able to make decisions for me, I choose the following person to be my agent:

Choice #2 to be my agent

Name _____

Title or Relationship to Me: _____

Address: _____

Home phone (____) _____

Work phone (____) _____

Email Address: _____

If the person I have named as Choice # 2 is not willing, reasonably available or able to make decisions for me, I choose the following person to be my agent:

Choice #3 to be my agent

Name _____

Title or Relationship to Me: _____

Address: _____

Home phone (____) _____

Work phone (____) _____

Email Address: _____

You may change your mind later about who you want to be your agent. If you want to stop the agent you have named from making decisions for you, you must tell your primary provider or fill in these blanks

I do NOT want _____ to be my agent _____

My signature

Date you filled out this section _____

Any time you cancel, replace or change this form you should give copies of the changed or new form to everyone who has a copy of your original form.

Your Agent's Power:

When your agent can start making decisions for you: (Check only one box: A or B)

A. My agent can make decisions only when my primary provider or a judge decides that I am too sick to make my own health care decisions.

~OR~

B. My agent can start making health care decisions for me right away, but this does not mean I have given up the right to make my own decisions if I am still able and willing to make my own decisions. When my agent makes a health care decision for me, I will be told, if possible, about that decision before it is carried out unless I say I do not want to know. If I disagree with that decision and am still able to decide, I can make a different decision. As long as I am able, I can end my agent's right to make decisions for me, change my agent or make my own decisions. If I want to end my agent's right to make decisions for me, I must tell my primary provider or put my decision in writing and sign it with the date of my signature.

Nominating a guardian:

A guardian is a person chosen by a court to make decisions about your personal care. These decisions can include not only health care, but other decisions such as where you will live and how your personal needs will be met. If you wish, you may ask that a court assign your agent as your guardian, if appointment of a guardian should become necessary. Check the box below to nominate your agent to be your guardian, if a judge needs to appoint a guardian for you.

I nominate my agent to be my guardian if a judge needs to appoint a guardian for me.

If you want to nominate someone other than your agent to be your guardian, you may fill in the section below.

If a judge needs to appoint a guardian for me, I nominate the person named below as my guardian:

Name _____

Title or relationship to me _____

Address _____

Home phone (____) _____

Work phone (____) _____

Part 2 – Special Instructions

Instructions if you did **NOT** name an agent in Part 1:

If you did not name an agent in Part 1, you should fill out this Part to state what you want for care if you become too sick to make your choices known.

~OR~

Instructions if you did name an agent in Part 1:

If you named an agent in Part 1, you do not have to fill out this part of the form. If you want your agent to make all of your health care decisions, **DO NOT** fill out this part of the form. Your agent will make decisions in your best interests, including decisions to refuse treatment. However, you may fill out this part if you want to give special directions to your agent about your wishes, such as when you are near death, in a permanent coma or no longer able to make your own decisions. You may also cross out or add words. It is best if you put your initials and date next to any changes you make so everyone knows the changes were your decision. If you complete this part, your provider and others will follow these instructions and your agent cannot make a different decision. You may also write your wishes on another piece of paper, sign it, date it, and keep it with this form.

Life-Sustaining Treatment Choices:

You may also check one of the two boxes below to show your choice about treatment that would keep you alive:

Choice not to be kept alive

I do not want treatment to keep me alive if my provider decides that either of the following is true;

- (i) I have an illness that will not get better, cannot be cured, and will result in my death quite soon (sometimes referred to as a terminal condition),

~OR~

- (ii) I am no longer aware (unconscious) and it is very likely that I will never be conscious again (sometimes referred to as a persistent vegetative state).

Choice to be kept alive

I want to be kept alive as long as possible within the limits of generally accepted health care standards, even if my condition is terminal or I am in a persistent vegetative state.

Life-Sustaining Treatment Choices:

You may also check one of the two boxes below to show your choice about treatment that would keep you alive if, in the future, you have late stage Alzheimer's disease or other severe dementia. These choices will not limit the authority under state law for your agent, surrogate, guardian or provider to make treatment choices if you are unable to make your own decisions and are not in late stage Alzheimer's disease or other severe dementia:

<input type="checkbox"/> Choice not to be kept alive	<input type="checkbox"/> Choice to be kept alive
If my provider and a second provider decide that I am in the late stage of Alzheimer's disease* or other severe dementia, I do not want treatment to keep me alive.	I want treatment to keep me alive as long as possible within the limits of generally accepted health care standards, even if my provider and a second provider decide that I am in the late stage of Alzheimer's disease or other severe dementia.

*Only a provider can determine that someone is in the late stage of Alzheimer's disease. People in the late stages of Alzheimer's disease generally have a number of the following characteristics: loss of the ability to respond to their environment; loss of the ability to speak; loss of the ability to control movement; loss of the capacity for recognizable speech, although words or phrases may occasionally be uttered; needing help with eating and toileting; general incontinence of urine; loss of the ability to walk without assistance, then the ability to sit without support, then the ability to smile, and the ability to hold their head up; reflexes become abnormal; muscles grow rigid; and swallowing is impaired.

Tube Feeding:

You may check one of the two boxes below to show your choice about tube feeding or having water and nutrition fed into your body through an IV or tube (artificial nutrition and hydration):

<input type="checkbox"/> Artificial nutrition and hydration should not be given, or should be stopped, based on the other life-sustaining treatment choices I made about keeping me alive on Pages 6 and 7.	<input type="checkbox"/> Artificial nutrition and hydration should be given regardless of my condition.
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Relief from Pain:

You may check the box or fill in the blanks below to show your choice about relief of pain or discomfort.

<input type="checkbox"/> I want treatment for relief of pain or discomfort to be given at all times, even if it shortens the time until my death or makes me drowsy, unconscious or unable to do other things.

These are my wishes about relief of pain or discomfort:

Other Directions:

You may give more directions or add any other treatment choices in the space below:

Part 3 – Primary Provider

This section is optional. Fill out this part only if you wish to name your primary provider today. This may or may not be your established PCP.

Name of my primary provider: _____

Address _____

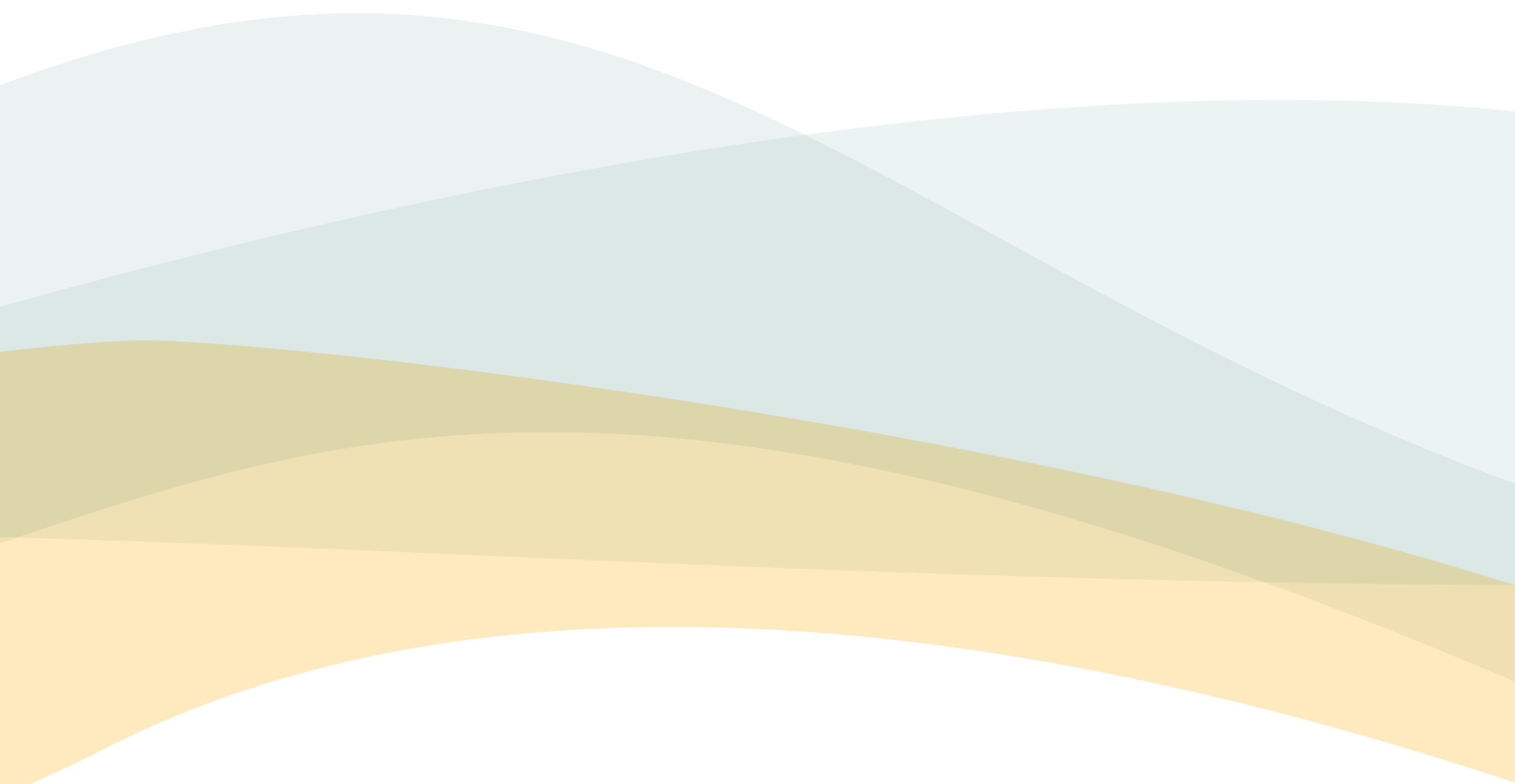
Phone _____

I want any agent I named in Part 1 to talk with this provider about my health care. If the provider I have named above is not willing, reasonably available or able to carry out my wishes, I want the agent I named in Part 1 to talk with the provider listed below:

Name of provider: _____

Address _____

Phone _____



Part 4 – Donation of Body, Organs or Tissues at Death

This section is optional. Fill out this part only if you want to give directions about donating your body, organs or tissues after your death.

I do NOT wish to donate any organs, tissues or parts.

I have checked below my choices about donating my body, organs or tissues after death. I have spoken with my family so that they will not object to my wishes after I die.

I give my body. **OR**

I give any needed organs, tissues or parts. **OR**

I give only the following organs, tissues, or parts:

My gift is for the following purposes (you may check any number of boxes):

My gift is for transplant or therapy for another person, to be chosen based on generally accepted health care standards.

My gift is for research and education. My preference, if any, is to give my body, organs, or tissues to the following hospital, medical school, or provider:

Name: _____

Address _____

I understand that I may need to contact the hospital, medical school, or provider before I die in order for them to accept my body, organs or tissues after my death.

Part 5 – Instructions About Funeral and Burial Arrangements

This section is optional. Fill out this part only if you wish to give special instructions about your funeral or burial arrangements here.

I hope that my family will follow my wishes after I die as noted below.

I choose _____ to have custody and control of my body after my death with the right to decide everything about my funeral and burial.

OR

I want my family to know these are my wishes about: burial, cremation, funeral, or memorial service. (Fill in)

If you plan to die at home, talk with your provider and funeral director about your plans. When you die, your family or agent should call your provider and the funeral home you have chosen. The funeral home staff will pick up your body from your home.

Part 6 – Signing the Form

If you have filled out any part of this form, you must sign and date the form on this page. You must also have two other adults sign as witnesses at the same time you sign the form. Your agent cannot sign as a witness. You do not need to have a Notary Public sign your Advance care planning form to make it legal in Maine. However, if you travel or live part of the year out-of-state, it would be wise to have it signed by a Notary. Some states require this. You can find this service under Notary Public in the phone book. Most banks also have Notaries Public and will usually notarize papers for bank customers when asked. The Notary Acknowledgment may be done at any time after you sign this form.

Sign and date the form here:

Sign your name: _____ Date: _____

Print your name: _____ Your address: _____

First Witness:

Sign your name: _____ Date: _____

Print your name: _____ Your address: _____

Second Witness:

Sign your name: _____ Date: _____

Print your name: _____ Your address: _____

Notary Acknowledgment.

Then personally appeared the above named _____, known to me or who presented satisfactory evidence of his/her identity, and acknowledged this Advance care planning as his/her free act and deed before me.

Notary signature: _____ Date: _____

Printed name: _____ Notary Public State of _____ Commission Exp.: _____

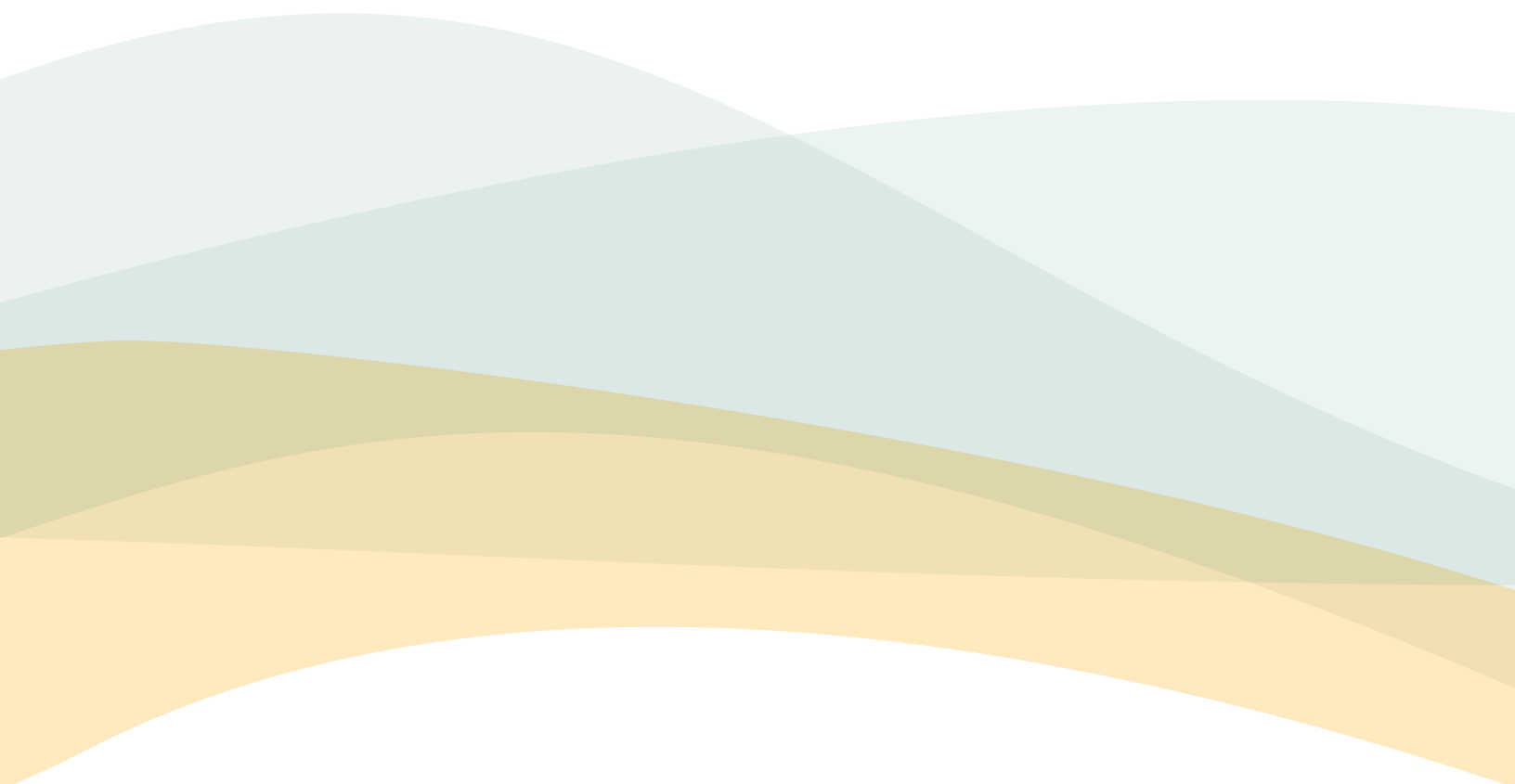
Make sure to tell people.

Tell your family members, providers and others close to you what you have decided. You should talk to the agent(s) you have chosen to make sure that they understand your wishes and are willing to carry them out. Give a copy of this form to your provider, to any place where you get health care, and to any **agent(s) you have chosen in Part 1. Please be sure to list the people who have copies of this form on the front page.**

Canceling or changing the form.

Part 1: You may end your agent's right to make decisions while you are still able to make those decisions by telling your primary provider or putting your decision in writing and attaching it to this form. If you want to name a new agent, you must put that instruction in writing and sign it in front of two witnesses who must also sign their names.

Parts 2–7: You may cancel any other part of this form, or change your instructions in the other parts of this form while you are still able to make those decisions. It is best to do so by (1) writing on this form, (2) writing on another piece of paper and attaching it to this form, or (3) completing a new form. Any of those written changes should be signed and dated by you.



Part 7 – Instructions to Emergency Medical Services (Ambulance Crews) About What to Do if Your Heart or Breathing Stops.

This section is optional. If you do not want ambulance crews to revive you if your heart or breathing stops, you and your provider must both complete and sign this part.

Instructions for Part 7:

- If I stop breathing or my heart stops, I do not want the Emergency Medical Services (ambulance crews) to try to revive me. My provider and I have discussed this and signed the special form on the next page. I understand that this decision will not prevent me from receiving other emergency care, or comfort care from health care workers before I die.
- I understand that the form goes into effect when I have signed it AND it is signed by my provider.
- I understand that this directive will not be followed unless my family, caretaker or I give the signed form on the next page to Emergency Medical Services (ambulance crews), and that it is solely my responsibility to make sure they see it.
- I understand that I should carry the signed form with me unless I wear health alert jewelry, such as MedicAlert, that also tells people that I do not want to be revived if my heart or breathing stops (Please call Maine Emergency Medical Services at 207-626-3860 to see if there are other Maine EMS approved health alert jewelry companies).
- I understand that if any health care provider has any doubts about what I want, they will try to restart my heart or breathing.
- I understand that I may revoke this directive at any time by destroying this form and removing any Maine EMS approved Do-Not-Resuscitate jewelry. I can also tell the ambulance crews that I have changed my mind.
- I understand that should I change my mind, it is my responsibility to tell my provider and other people who have copies of the signed form. If I want my agent to make this decision later, my agent should take the form available at: <http://www.maine.gov/dps/ems> to my provider when it is time to make the decision.

If you complete and sign this section, put the original in a safe place and be sure to give copies to ambulance crews, your family, your caregivers, and your provider.

DO-NOT-RESUSCITATE (DNR) DIRECTIVE

This section is optional. If you do not want ambulance crews to revive you if your heart or breathing stops, you and your provider must complete and sign this form.

FOR PATIENT TO COMPLETE after consultation with his or her health care provider:

In the event that my heart or breathing stops and I am unable to speak for myself, I, _____ (printed name) direct that no efforts be taken to restart my heart or breathing and that Emergency Medical Services (ambulance crews) if notified, honor my directive. I have come to this decision after considering my condition and prognosis and the potential risks, burdens and benefits of refusing efforts to restart my heart or breathing.

I understand that I may change my mind at any time by destroying this form and removing any Maine EMS approved Do-Not-Resuscitate jewelry, such as MedicAlert. I will also tell my provider and other caregivers if I change my mind.

I understand that this form is not valid until my provider and I have signed it.

I understand that in a hospital, nursing home, hospice or home health setting, federal law requires that my provider must include a specific DNR order in my medical record or plan of care, even if we have both signed this form.

No expiration date OR Expires on _____

Patient Signature _____ Date Signed _____

FOR PROVIDER TO COMPLETE:

By my signature I affirm that:

(i) After meeting with this patient and discussing this decision, I am satisfied that the patient understands the potential risks, burdens and benefits of refusing resuscitative interventions in light of the patient's medical condition; and (ii) I believe that the patient has made a voluntary informed decision about resuscitation and I agree to comply with that decision. I will tell any health care providers providing care under my authority to comply with this decision.

Signature and license level (MD, DO, PA or NP):

_____ Date Signed _____

Printed Name _____ Telephone Number _____

THIS FORM IS ENDORSED BY MAINE EMERGENCY MEDICAL SERVICES



York Hospital

Safe, Trusted, Quality Care

HealthCare Help Center • (207) 351-2345

The Center for Older Adults • (207) 351-2371

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