



WINDSOR
Medicare *Extra*

Advance Directives

H5698 EADB003 0107
CMS Approval 01-2007

ADVANCE DIRECTIVE INFORMATION

1. What are Advance Directives?

You have the right to make decisions about the care you want at the end of your life. If you are conscious and able to make your own decisions when the time comes, you will be able to decide and whether the doctor should withdraw treatment and when that should happen. It is when you do not have the ability to make or explain your own decisions that you need what is called an Advance Directive. An Advance Directive is a legal document in which you tell your choices for medical treatment or name someone to make medical decisions for you when you cannot. A “Living Will” is a type of Advance Directive. A “Durable Power of Attorney for Health Care” is another type of Advance Directive.

2. What is a Living Will?

A Living Will is a document which tells medical professionals and members of your family to what extent special means should or should not be used to keep your body alive if you are incurably ill or permanently unconscious. It allows you to tell others your health care choices in the event that you are unable to express your wishes.

3. Why Should I Have a Living Will?

A Living Will gives you a voice in decisions about your medical care when you are unconscious or too ill to communicate. As long as you are able to express your own wishes, your advance directive will not be used, and you can accept or refuse any medical treatment. But if you are unable to participate in decisions about your own treatment, a Living Will becomes important to ensure that your personal wishes are respected. Also, by preparing a Living Will, you can relieve those closest to you of the burden and stress of trying to guess what your wishes might be at a very emotional time.

4. When Does A Living Will Become Effective?

Your Living Will will become effective only when you are unable to make or communicate decisions about your care and are terminally ill with no hope of recovery or permanently unconscious.

5. Does A Living Will Mean I am Giving Up or Stopping Care?

No. Making a Living Will does not mean that you will be abandoned by your health care providers. A Living Will affects only measures which are deemed useless. Doctors and nurses will continue attending to your needs, and comfort care will continue.

6. How Do I Make a Living Will?

A Living Will must be in writing, signed by you or another person at your direction, and witnessed by two other adults. It is a good idea to discuss your health care wishes with your loved ones and your physician before signing a Living Will.

7. What is a Durable Power of Attorney for Health Care?

By signing a Durable Power of Attorney for Health Care, you can choose another person as your representative to make health care decisions for you if you should become temporarily or permanently unable to make decisions. Your health care representative must make treatment decisions based on your known wishes. A Durable Power of Attorney for Health Care must be in writing, signed by you or another person at your direction, and witnessed by two other adults.

8. What Do I Do With My Living Will and Durable Power of Attorney for Health Care?

Keep the original documents in a safe and easily accessible place, and make an extra copy for yourself in case the original is lost or accidentally destroyed. It is important that your doctor and family members know about your Living Will and have a copy of it. Take your Living Will and Durable Power of Attorney for Health Care with you if you are admitted to the hospital.

9. What If I Change My Mind?

Your Living Will and/or Durable Power of Attorney for Health Care can be revoked at any time by telling your doctor and family members that your wishes have changed. You should tear up and throw away all copies of the document you have revoked.

10. What if I Choose Not To Have a Living Will and Have Not Signed A Durable Power Of Attorney For Health Care?

If you do not have a Living Will or a Durable Power of Attorney for Health Care, then decisions about your care may be made by a “surrogate decision-maker,” such as certain relatives, a person appointed by a court, or a court itself. The surrogate decision-maker must make decisions based on what you would have wanted if you were able to express your decisions, but if you have not made your wishes known, then the surrogate decision-maker, together with your physician, will make treatment decisions for you based upon their opinions as to your best interest.

**DECLARATION OF LIVING WILL
OF**

[Name of Declarant]

If I should have an incurable or irreversible condition with no hope of recovery that will cause my death within a relatively short time, and I am no longer able to make decisions regarding my medical treatment, I direct my attending physician, pursuant to the Common Law and the Arkansas Rights of the Terminally Ill or Permanently Unconscious Act, to withhold or withdraw treatment that only prolongs the process of dying and is not necessary to my comfort or to alleviate pain.

Additionally, if I should become permanently unconscious, I direct my attending physician, pursuant to the Arkansas Rights of the Terminally Ill or Permanently Unconscious Act, to withhold or withdraw life-sustaining treatments that are no longer necessary to my comfort or to alleviate pain.

Section 1: Life-Sustaining Treatments

The life-sustaining treatments which **may be withheld or withdrawn** are (check all that apply):

- Cardiopulmonary Resuscitation.
- Mechanical Breathing.
- Major Surgery.
- Kidney Dialysis.
- Chemotherapy.
- Minor Surgery (unless necessary for my comfort or to alleviate pain).
- Invasive Diagnostic Tests.
- Antibiotics.
- Blood Products.
- Other Medications not Necessary for Alleviation of Pain.

Add other medical directives, if any below:

Section 2: Artificial Nutrition and Hydration

I understand that Arkansas law requires me to make my wishes regarding artificial nutrition and hydration known separately from the above directions. Therefore, by initialing the appropriate line(s) below, I specifically:

DIRECT that **artificial nutrition may be withheld** or withdrawn after consultation with my attending physician.

DIRECT that **artificial hydration may be withheld** or withdrawn after consultation with my attending physician.

SIGNED this _____ day of _____, 20__.

Signature

We, the undersigned, do hereby certify that the Declarant, _____ subscribed this Declaration of Living Will in our presence, and we, at his or her request, in his or her presence, and in the presence of each other, signed as attesting witnesses, and we do further certify that the Declarant appeared to be eighteen years of age or older, of sound mind, and acting without undue influence, fraud or restraint and that his or her signature was voluntary.

Witness

Witness

Address

Address

City, State and Zip Code

City, State and Zip Code

**DURABLE POWER OF ATTORNEY FOR HEALTH CARE
OF**

[Name of Declarant]

Pursuant to the Arkansas Durable Power of Attorney for Health Care Act (Ark. Code Ann. § 20-13-104) (the "Act"), I hereby designate and appoint _____ as my agent, or attorney in fact, to make decisions regarding my health care during periods when my health care provider has determined that I lack capacity to decide for myself. Specifically, and not to limit any other rights prescribed under the Act, my attorney-in-fact shall have the power to have access to my medical records for treatment or payment decisions; to disclose medical records to others for purposes of treatment, payment, or health care operations; to employ and discharge physicians; to consent to or refuse to consent to medical procedures, including the withholding or withdrawal of life-sustaining treatment, and nutrition and hydration, according to my wishes expressed in my Living Will, or, if my wishes are unclear under the then existing circumstances of my medical condition, then upon consideration of my best interests as determined by my physician in consultation with my agent; to admit me to hospitals, including psychiatric hospitals, nursing homes, or hospice care; and to sign all appropriate forms, consents and releases in connection with any of said matters.

If _____ resigns, or is not able or available to make health care decisions for me, or if an agent named by me is divorced from me or is my spouse and legally separated from me, I appoint _____ as successor, with all of the rights and powers and authority herein stated. The term "health care" shall have the meaning set forth in Ark. Code Ann. § 20-13-104(c). This Durable Power of Attorney for Health Care shall not be affected by my subsequent disability or incapacity.

SIGNED this _____ day of _____, 20__

Signature

We, the undersigned, do hereby certify that the Declarant, _____ subscribed this Durable Power of Attorney for Health Care in our presence, and we, at his or her request, in his or her presence, and in the presence of each other, signed as attesting witnesses, and we do further certify that the Declarant appeared to be eighteen years of age or older, of sound mind, and acting without undue influence, fraud or restraint and that his or her signature was voluntary.

Witness

Witness

Address

Address

City, State and Zip Code

City, State and Zip Code

