

DELAWARE Advance Directive Planning for Important Healthcare Decisions

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Caring Connections, 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.

Caring Connections tracks and monitors all state and federal legislation and significant court cases related to end-of-life care to ensure that our advance directives are up to date.

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:

- L**earn about options for end-of-life services and care
- I**mplement plans to ensure wishes are honored
- V**oice decisions to family, friends and healthcare providers
- E**ngage in personal or community efforts to improve end-of-life care

Using these Materials

BEFORE YOU BEGIN

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

3. You may want to photocopy these forms before you start so you will have a clean copy if you need to start over.
4. When you begin to fill out the forms, refer to the gray instruction bars - they will guide you through the process.
5. 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.
6. 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, healthcare providers and/or faith leaders so that the form is available in the event of an emergency.

INTRODUCTION TO YOUR DELAWARE ADVANCE HEALTHCARE DIRECTIVE

This packet contains a legal document, the **Delaware Advance Healthcare 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.

1. **Section I, Power of Attorney for Healthcare**, lets you name someone (an agent) to make decisions about your medical care. The Power of Attorney for Healthcare becomes effective when it is determined that you can no longer understand the benefits or risks of or alternatives to proposed healthcare, or you can no longer make and communicate your healthcare decisions. However, your agent may only make decisions regarding the providing, withholding or withdrawal of life-sustaining treatment if you also have a qualifying condition.

2. **Section II, Instructions for Healthcare**, is your state's living will. It lets you state your wishes about medical care in the event that you can no longer speak for yourself and you have a qualifying condition.

Under Delaware law you have a qualifying condition when your attending physician and one other physician determine, in writing, that you have one or more of the following conditions:

- a) *terminal condition*: you have an illness or condition for which there is no reasonable medical expectation of recovery which will result in death regardless of the use or discontinuance of life-sustaining procedures.
- b) *permanent unconsciousness*: you have been diagnosed as having a total and irreversible loss of consciousness and capacity for interaction with your environment for at least 4 weeks. This includes a persistent vegetative state or irreversible coma.

Note: These documents will be legally binding only if the person completing them is a competent adult or an emancipated minor.

INTRODUCTION TO YOUR DELAWARE ADVANCE HEALTHCARE DIRECTIVE (CONTINUED)

How do I make my advance healthcare directive legal?

The law requires that you sign and date your advance healthcare directive in the presence of two witnesses who are eighteen 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 healthcare, or
- be an operator or employee of, or have a controlling interest in, a healthcare institution in which you are a patient or 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 person designated as a patient advocate or ombudsman. The patient advocate or ombudsman must have the qualifications required of other witnesses. In addition to signing as a witness, the patient advocate or ombudsman must print his/her name in paragraph 13(C).

Are there any important facts that I should know?

Section III of your Delaware Advance Healthcare Directive is an optional section that allows you to designate a physician to have primary responsibility for your healthcare.

Section IV of your Delaware Advance Healthcare Directive is an optional section that allows you to record your wishes regarding organ donation.

A copy of your Delaware Advance Directive has the same effect as the original.

COMPLETING SECTION I: POWER OF ATTORNEY FOR HEALTHCARE

Whom should I appoint as my agent?

A healthcare agent is the person you appoint to make decisions about your medical care if you become unable to make and communicate these decisions yourself. Your agent can 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.

The person you appoint as your agent **cannot be** an operator or employee of, or have a controlling interest in, a residential long-term healthcare institution at which you receive care unless he or she is related to you by blood, marriage or adoption.

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

Should I add personal instructions to my Power of Attorney?

You can use the space provided under paragraph (2) to **limit** your agent's authority. Unless the form you sign limits the authority of your agent, your agent may make all healthcare decisions for you including:

- (a) selecting or discharging healthcare providers and institutions; and
- (b) consenting or refusing consent to any care, treatment, service or procedure to maintain, diagnose or otherwise affect your physical or mental condition, unless it is a life-sustaining procedure. Your agent may make decisions regarding the providing, withholding or withdrawal life-sustaining treatment only if you have a qualifying condition (as defined above). If you also have a qualifying condition, your agent may make all healthcare decisions for you, including the following:
- (c) the decisions listed in (a) and (b) above;
- (d) consenting or refusing consent to life-sustaining procedures such as cardiopulmonary resuscitation and orders not to resuscitate;
- (e) direction the provision, withholding or withdrawal of artificial nutrition and hydration and all other forms of healthcare.

One of the strongest reasons for naming a healthcare agent is to have someone who can respond effectively as your medical condition changes and can deal with situations that you did not foresee.

COMPLETING SECTION I: POWER OF ATTORNEY FOR HEALTHCARE (CONTINUED)

What if I change my mind?

If you wish to cancel your Power of Attorney for Healthcare you may do so (1) through a signed writing, (2) by completing a new Advance Healthcare Directive, or (3) in any other manner that communicates your intent to revoke in front of two competent persons, one of whom is a healthcare provider. If your revocation is not in writing, someone must put it in writing and both witnesses must sign and date it.

Are there any important facts I should know?

If you designate your spouse as your agent, that designation will automatically be revoked if a petition for divorce is filed or your marriage is annulled, unless you specify otherwise in the divorce or annulment decree or in your Power of Attorney for Healthcare.

Paragraphs (3) and (4) contain various statements about your agent's authority. Cross out and initial any portion of these statements that do not reflect your wishes.

Paragraph (5) nominates your agent, alternate agents or another person to be your court-appointed guardian should one become necessary.

COMPLETING SECTION II: INSTRUCTIONS FOR HEALTHCARE

Can I add personal instructions to my Instructions for Healthcare?

Yes. Paragraphs (6) and (7) allow you to include instructions about certain care and treatment. If there are any specific instructions that you would like to include that are not already listed on the document, you may list them in paragraph (8).

If you have appointed an agent, it is a good idea to write a statement such as, "Any questions about how to interpret or when to apply my Instructions for Healthcare are to be decided by my agent."

What if I change my mind?

If you wish to revoke all or part of your Advance Healthcare Directive, you may do so (1) through a signed writing, (2) by completing a new Advance Healthcare Directive, or (3) in any other manner that communicates your intent to revoke the Advance Healthcare Directive as long as it is done in the presence of two competent persons, one of whom is a healthcare provider. If your revocation is not in writing, someone must put it in writing and both witnesses must sign and date it.

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, so long as it is probable that the fetus will develop to be viable outside the uterus with the continued application of life-sustaining procedures.

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.

INSTRUCTIONS

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

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

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SECTION I
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)

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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:

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

(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 do not have a qualifying condition 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 have a qualifying condition, my agent is authorized to make all health care decisions for me, except as I state here:

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

(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 healthcare, any instructions I give in Section II 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.

(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.

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

SECTION II
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:

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.

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 _____ I want _____ I do not want
Artificial Hydration _____ I want _____ I do not want

_____ 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 _____ I want _____ I do not want
Artificial Hydration _____ I want _____ I do not want

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

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

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ADD PERSONAL INSTRUCTIONS ONLY IF YOU DISAGREE WITH THE STATEMENT IN PARAGRAPH (7)

(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 ANY ADDITIONAL INSTRUCTIONS THAT WILL GUIDE YOUR HEALTH CARE PROVIDER(S) AND AGENT (OPTIONAL)

(8) OTHER HEALTH CARE INSTRUCTIONS OR WISHES:
(add additional pages if needed)

SECTION III
DESIGNATION OF PRIMARY PHYSICIAN

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

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

(name of physician)

(address)

(city) (state) (zip code)

(phone)

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SECTION IV
ANATOMICAL GIFTS AT DEATH

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

(10) 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

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

PRINT YOUR NAME
AND ADDRESS

(12) SIGNATURE OF DECLARANT

(name)

(address)

(city)

(state)

(zip code)

(date)

(signature)

DATE AND SIGN
THE DOCUMENT

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

(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 PATIENT ADVOCATE MUST SERVE AS ONE OF YOUR WITNESSES AND PRINT HIS/HER NAME IN PARAGRAPH C)

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

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 Division of Services for Aging and Adults with Physical Disabilities or the Public Guardian.

Signature of First Witness:

(print name of first witness)

(address of first witness)

(signature of first witness)

(date)

Signature of Second Witness

(print name of second witness)

(address of second witness)

(signature of second witness)

(date)

You Have Filled Out Your Advance Directive, Now What?

- 1.** Your Delaware Advance Healthcare 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 originals to your agent and alternate 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 and alternate, 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.** If you want to make changes to your documents after they have been signed and witnessed, you must complete a new document.
- 5.** Remember, you can always revoke one or both sections of your Delaware Advance Healthcare Directive.
- 6.** Be aware that your Delaware documents will not be effective in the event of a medical emergency. Ambulance personnel are required to provide cardiopulmonary resuscitation (CPR) unless they are given a separate order that states otherwise. These orders, commonly called "non-hospital do-not-resuscitate orders," are designed for people whose poor health gives them little chance of benefiting from CPR. These orders must be signed by your physician and instruct ambulance 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 for more information. **Caring Connections does not distribute these forms.**