

**MAINE**  
**Advance Directive**  
**Planning for Important Healthcare Decisions**

*Caring Connections*  
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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

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## 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 MAINE ADVANCE DIRECTIVE

This packet contains a legal document, The Maine Advance 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. The document is divided into two sections:

1. Section I, **Power of Attorney for Healthcare**, lets you name someone to make decisions about your medical care—including decisions about life support—if you can no longer speak for yourself. The Power of Attorney for Healthcare is especially useful because it appoints someone to speak for you any time you are unable to make your own medical decisions, not only at the end of life.

2. Section II, **Instructions for Healthcare**, functions as your state's living will. It lets you state your wishes about the withholding or withdrawal of medical care in the event that you can no longer speak for yourself and:

- a) you have an incurable and irreversible condition that will result in death within a relatively short time, or
- b) you become unconscious and, to a reasonable medical certainty, will not regain consciousness, or
- c) the likely risks and burdens of treatment would outweigh the expected benefits.

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

## **COMPLETING YOUR MAINE ADVANCE DIRECTIVE**

### **How do I make my advance directive legal?**

The law requires that you sign your Advance Directive in front of two witnesses. Although the law does not restrict who can serve as a witness, we suggest that your witnesses be at least 18 years of age and that your healthcare agent not act as a witness.

### **Are there any important facts that I should know?**

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

Section IV of your Maine Advance Directive is an optional section that allows you to state your wishes regarding organ donation.

A copy of your Maine 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 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 responsibility of making medical decisions for you.

The person you appoint as your agent **cannot** be an owner, operator or employee of a 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 for Healthcare?

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) consenting to or refusing consent to any care, treatment, service, or procedure to maintain, diagnose or otherwise affect a physical or mental condition;
- b) selecting or discharging healthcare providers and institutions;
- c) approving or disapproving diagnostic tests, surgical procedures, programs of medications and orders not to resuscitate; and
- d) directing the provision, withholding and 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 deal with situations that you did not foresee.

Talk with your healthcare agent about your future medical care and describe what you consider to be an acceptable "quality of life". If you want to record your wishes about specific treatments or conditions, you can use Section II of this document ("Instructions for Healthcare").

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

### **What if I change my mind?**

You may cancel your designation of an agent only through a signed writing or by personally informing your supervising healthcare provider.

You can also cancel your advance directive if you execute a new advance directive that conflicts with the previous one. In addition, if you designate your spouse as your agent and you are later divorced, legally separated, or your marriage is dissolved or annulled, it will effectively revoke your designation of your spouse as your agent unless you specify otherwise.

### **Are there any important facts I should know?**

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

Check the box in paragraph (4) only if you want your agent's authority to take effect immediately. Paragraph (5) nominates your agent or alternate agents to be your court appointed guardian should one become necessary. If this is not your intention, cross out and initial this section.

## **COMPLETING SECTION II: INSTRUCTIONS FOR HEALTHCARE**

### **Can I add personal instructions to my Instructions for Healthcare?**

Yes. Paragraphs (6), (7), and (8) 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 (9).

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?**

You may cancel your Instructions for Healthcare at any time in any manner that communicates your intent to do so.

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. You may complete or modify all or any part of the following form or use a different form.

A copy of this form has the same effect as the original.

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SECTION I  
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)

**MAINE ADVANCE HEALTH CARE DIRECTIVE — PAGE 2 OF 6**

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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 PERSONAL  
INSTRUCTIONS  
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:

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

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

INITIAL THE PARAGRAPH THAT BEST REFLECTS YOUR WISHES REGARDING LIFE-SUPPORT

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(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 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.

(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.

## SECTION II 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:

[  ] **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.

INITIAL YOUR  
PREFERENCE  
REGARDING  
ARTIFICIAL  
NUTRITION AND  
HYDRATION

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

\_\_\_\_\_ 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.

ADD PERSONAL  
INSTRUCTIONS  
ONLY IF YOU  
DISAGREE WITH  
THE STATEMENT  
IN PARAGRAPH (8)

(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.

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

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

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

(OPTIONAL)  
INITIAL THE  
SENTENCE THAT  
BEST REFLECTS  
YOUR WISHES

INITIAL THE  
PURPOSES THAT  
REFLECT YOUR  
WISHES

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**SECTION III  
DESIGNATION OF PRIMARY PHYSICIAN**

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

-----  
(name of physician)

-----  
(address)

-----  
(city) (state) (zip code)

-----  
(phone)

**SECTION IV  
DONATION OF ORGANS AT DEATH**

(11) **UPON MY DEATH:**

\_\_\_ I give any needed organs, tissues or parts, or

\_\_\_ I give **only** the following organs, tissues or part:

(12) **MY GIFT IS FOR THE FOLLOWING PURPOSES:**

\_\_\_ (i) Transplant

\_\_\_ (ii) Therapy

\_\_\_ (iii) Research

\_\_\_ (iv) Education

PRINT YOUR NAME,  
ADDRESS, AND  
SOCIAL  
SECURITY NUMBER,  
AND THEN SIGN  
AND DATE THE  
DOCUMENT

**SIGNATURE**

-----  
*(name)*

-----  
*(address)*

-----  
*(social security number - optional)*

-----  
*(date)*

-----  
*(signature)*

**WITNESSES**

-----  
*(signature of first witness)*

-----  
*(date)*

-----  
*(printed name of first witness)*

-----  
*(address of first witness)*

-----  
*(signature of second witness)*

-----  
*(date)*

-----  
*(printed name of second witness)*

-----  
*(address of second witness)*

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

## **You Have Filled Out Your Advance Directive, Now What?**

1. Your Maine Advance 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, 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 copies of your document placed in your medical records.
3. Be sure to talk to your agent and alternate, doctor(s), clergy, and 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 document after it has been signed and witnessed, you should complete a new document.
5. Remember, you can always revoke one or both sections of your Maine Advance Directive.
6. Be aware that your Maine document 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.**