DOWNLOAD COVERSHEET:

This is a "standard" advance directive for American Samoa, made available to you as a courtesy by Lifecare Directives, LLC. You should be aware that extensive research has demonstrated that there are significant drawbacks to using a very brief state-standard document. As one researcher has noted, "the development of statutory forms occurs in the legislative arena, [so] their content is the result of a political rather than a 'scientific' process." Therefore, "...many of the forms ultimately passed by the legislatures are not optimal from a consumer perspective" (see: Hoffmann, Diane E; Zimmerman, S; Tompkins, C. The dangers of directives, or the false security of forms. *Journal of Law, Medicine & Ethics*. 1996;24(1) (Spring):5-17).

American Bar Association concurs, noting that "The statutory advance directive is not necessarily the exclusive, or even the best, pathway for individuals to follow," and suggesting that revised and enhanced documents "may be especially helpful as a...replacement for statutory forms where restrictions in a statutory directive prevents the individual from fully expressing his or her wishes" (see: American Bar Association. (1991). *Patient Self Determination Act State Law Guide*. Government printing office, Washington, DC).

Lifecare Directives staff have reviewed more than 6,000 medical, legal, academic, and news media articles on advance directives, as well as reviewing hundreds of document forms. They have also conducted formal research with scores of medical, legal, and academic processionals along with more than 1,000 lay public participants. From this process, more than 30 additional key living will and medical power of attorney enhancements have been identified that should be included in any living will (or "health care instruction" or "declaration") and medical power of attorney (or "proxy") forms that you may use.

Please consider obtaining the *Lifecare Advance Healthcare Directive* to obtain these important additions and benefits. To better understand the important enhancements available through this combined living will and medical power of attorney, you may wish to obtain the booklet, "*Should I Use a Shorter Standard Directive?*" available through Lifecare Directives, LLC.

If you have any other questions about this document or other Lifecare resources, please do not hesitate to contact our staff who will make every effort to fully respond your inquiries and address any questions you may have. We can be reached at the following:

Lifecare Directives, LLC
5348 Vegas Drive
Las Vegas, NV 89108
www.lifecaredirectives.com
Toll Free: (877) 559-0527

~ Lifecare Directives ~

Statutory Advance Directive

For American Samoa Residents

Statutory Compliant Advance Directive for Health Care Choices

~ Lifecare Directives ~

Statutory Advance Directive

For American Samoa Residents

Statutory Compliant Advance Directive for Health Care Choices

Important Notice:

An advance directive is not a substitute for medical, legal or other necessary advice or direction. This document should not be construed as offering counseling, medical, legal, financial, or estate planning or advice, nor any other similar guidance or direction. Such counsel should be obtained from qualified, certified, and licensed professionals who are experienced in the specific area of concern. Completion of this document by the principal constitutes acceptance of its content both in whole and in part, as well as a determination of its utility for the purposes indicated. Lifecare Directives, LLC, and all involved in this document's design, publication, and distribution assume no liability for the use of the document, including that which may arise from omissions, technical inaccuracies, and typographical errors. Diligent efforts notwithstanding, this document is not warrantied to be in compliance with state and local laws. All warranties, including those of merchantability, fitness for a particular purpose, and non-infringement are expressly disclaimed. The principal agrees to seek appropriate outside review prior to completion. The principal and all heirs, assigns, designees, devisees, representatives, and all others involved, agree to assume all liability for its use and any subsequent outcomes, and to release and hold harmless all involved in its design, publication, advertising and distribution. The principal also agrees that any physician, health care provider, agent, proxy, surrogate, representative, mediator, court officer, and all others relying on its content are similarly free of all liability, when they act in good faith and with due diligence to follow the principal's wishes and directions.

Statutory Advance Directive For American Samoa Residents

_____ _____

Print Full Name *Date of Birth*

Your right *(when age 18 or older): To Document Your Personal Wishes, and to have these wishes followed ~~*

The American Samoa legislature has provided statutes guiding the creation of both a living will and an appointment of a Health Care Representative for medical decision-making . Collectively, these documents are known as "advance directives." Because the content of these documents was specified by the American Samoa Fono, each is in compliance with all applicable statutes and laws.

There is an introduction to each that summarizes the scope and purpose of the documents, as well as providing further directions for completion. Read them carefully to ensure that your advance directives are fully and properly filled out.

Understanding Your Directive:

To make the *best* choices for your medical care, your physician needs to know *your* wishes. In fact, doctors are required to seek your permission before giving you *any* treatment. However, if you are ever unable to speak due to severe illness or injury, this may not be possible. Completing this document will help your family and physicians know who should speak for you, and understand what you want, if you cannot speak for yourself.

You can **revoke** (cancel) this directive document at ***any*** time by: 1) writing "revoked" across the front of the directive, followed by your signature and date, and the signature of at least one witness aged 18 years or older ; or 2) by completing a Notice of Revocation; or 3) by *telling* an adult witness that you want it revoked (who must then sign and date a statement confirming that you requested this document revoked); or 4) *by simply completing a new directive* in which you state that any prior directive is no longer valid.

You can **limit** your directive and the authority of anyone named in it, but *only at the time of first completion*. Any scope-of-authority changes needed *after* your directive has been witnessed must be made by completing a new directive. Changes made when first completing this document can be made by lining out anything you do not wish and writing "deleted" beside that sentence, or section (or by initialing above any word(s) you have lined out), followed by your signature, and the signature of at least one of the persons serving as a witness to this document, placed in the margin immediately beside the change(s).

If you are **unable to write**, you may tell your directive witnesses what you want to have excluded, limited, or added to this directive. They must then sign and date a statement of the

limitations and exclusions as you have described them. Remember, unless you direct otherwise, this directive will **only** be used to guide your family and doctors if you are unable to make and communicate medical treatment decisions for yourself.

Instructions for Completing the Directive:

This directive is written in two parts. While it is best if you fill out the whole document, you may choose to complete only ***Section I***, leaving just a statement of your values and wishes. Or you may complete only ***Section II***, just naming someone to speak for you. However, only partly completing this document may leave your family and others without any evidence to support your wishes in the future, or leave them unsure who is to make decisions and speak for you. So, you are strongly encouraged to complete the entire document.

To complete the document, you should ***initial*** in the underlined spaces provided beside all the questions that are asked, and fill in any blank lines as directed. Feel free to write "No," "None," or "Does Not Apply" in areas that would otherwise be left blank.

SECTION I:
Health Care Advance Directives
Optional Living Will

(ASCA. Title:13, Ch.8: §13.0804 to §13.0808)

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1. INTRODUCTION: *The American Samoa Living Will is designed to assist you in writing out your wishes regarding the use of "life-prolonging procedures" if you are ever in a "terminal condition," an "end-stage" condition, or in a "persistent vegetative state" (§13.0804). The Fono did not specifically define these terms in the legislation. However, a review of all statutes in the United States and the three largest territories revealed workable definitions, provided here:*

*A **terminal** condition is typically defined as an incurable and irreversible condition that will result in death within approximately six (6) months.*

*An **end-stage condition** (a term used in only four states) has been defined as: "a condition which results in severe and permanent deterioration [as] indicated by incompetency and complete physical dependency for which...treatment would be medically ineffective"(see: OK §3101.3.4 – as well as Florida §765.303; MD §5-603; and TN Dept. Of Health forms).*

*A **persistent vegetative state** is commonly defined as: "an irreversible condition...in which [all] thought and awareness of self and [the] environment are absent"(see, for example: OK§3101.3.7).*

(*Cross through Part I if you do not want to complete this portion of the form. Otherwise, initial those statements you want to be included in the document and cross through those statements that do not apply.*)

Part I: Health Care Advance Directives

2. If my attending physician (and another physician, if there is any uncertainty *(§13.0802)*) determine that I am no longer able to make decisions regarding my health care, I direct my attending physician and other health care providers, to follow my instructions as set forth below. A determination about whether or not I have any of the following conditions shall be made by my "attending or treating physician and at least one other consulting physician" who "must separately examine" me and record their decision in my medical record *(§13.0807)*.

3. *If I have a terminal condition*:

If I have a terminal condition, that is, an incurable and irreversible condition that will, in the opinion of the attending physician and another physician, result in death within approximately six (6) months:

(*initial only <u>one</u> option*)

_____ I direct that my life not be extended by life-prolonging treatment, and that artificially administered nutrition and hydration shall be withheld or withdrawn.

_____ I direct that my life not be extended by life-prolonging treatment, except that if I am unable to take food and water by mouth, I wish to receive artificially administered nutrition and hydration.

_____ I direct that I still be given life-prolonging treatment, and, if I am unable to take food and water by mouth, I also wish to receive artificially administered nutrition and hydration.

4. *Regarding an "end-stage" condition*:

If I have an end-stage condition, that is, a condition caused by injury, disease, or illness, which results in severe and permanent deterioration as indicated by incompetency and complete physical dependency and where treatment of the irreversible condition would be medically ineffective, then:

(*initial only <u>one</u> option*)

_____ I direct that my life not be extended by life-prolonging treatment, and that artificially administered nutrition and hydration shall be withheld or withdrawn.

_____ I direct that my life not be extended by life-prolonging treatment, except that if I am unable to take food and water by mouth, I wish to receive artificially administered nutrition and hydration.

_____ I direct that I still be given life-prolonging treatment, and, if I am unable to take food and water by mouth, I also wish to receive artificially administered nutrition and hydration.

5. *Regarding a "persistent vegetative state"*:

If I am persistently unconscious, that is, I have an irreversible condition, as determined by the attending physician and another physician, in which thought and awareness of self and environment are absent:

(*initial only <u>one</u> option*)

_____ I direct that my life not be extended by life-prolonging treatment, and that artificially administered nutrition and hydration shall be withheld or withdrawn.

_____ I direct that my life not be extended by life-prolonging treatment, except that if I am unable to take food and water by mouth, I wish to receive artificially administered nutrition and hydration.

_____ I direct that I still be given life-prolonging treatment, and, if I am unable to take food and water by mouth, I also wish to receive artificially administered nutrition and hydration.

6. *Other Directives and Instructions*:

Other instructions regarding providing, withholding or withdrawing treatment (including artificially administered nutrition and hydration) in a terminal condition, an end-stage condition, or persistent vegetative state, and/or any other condition(s) you wish to note:

I also direct that: _____

_____

_____

_____

_____

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_____

7. Upon my death, I wish to **donate**:

_____ Any needed organs and tissues.

_____ Only the following organs and/or tissues:

_____

_____

_____

8. I **authorize** the use of my organs and tissues:

_____ For transplantation
_____ For therapy
_____ For research
_____ For medical education
_____ For any purpose authorized by law.

I understand that before any vital organ or tissue may be recovered for transplantation, I must be pronounced dead. After death, I direct that all support measures be continued to **maintain the viability** for transplantation of my organs and tissues until appropriate recovery has been completed.

I understand that **my estate will not be charged** for any costs associated with my decision to donate or for the actual disposition of my organs and/or tissues.

9. I also direct (*in the following space, indicate any other instructions regarding receiving or not receiving any other health care or treatments*):

_____
_____
_____
_____
_____

Your Signature
(*sign only in the presence of two qualified witnesses*)

By signing below (*or by having my signature entered by one of my witnesses in the presence of myself and my witnesses, and at my specific direction*), I indicate that I am emotionally and mentally competent to make this living will and that I understand the purpose and effect of this document.

10. Signed:_____ Date: _____

At: (City) _____ (County) _____

Statement and Signatures of Witnesses

We declare that we are at least eighteen (18) years of age or older, not related to the principal by blood, marriage, or adoption, and shall not inherit from him or her. This living will was signed in our presence (*if the principal's signature is entered above in behalf of a principal who is otherwise unable to sign, it must be entered by the first witness, who also signs below as first witness*):

11. 1st Witness: _____
(Signature)

_____ _____
(Name Printed) (Date)

_____
(Residence Address)

12. 2nd Witness: _____
(Signature)

_____ _____
(Name Printed) (Date)

_____
(Residence Address)

PART II: Optional Appointment of a
Health Care Representative

(ASCA. Title:13, Ch.8: §13.0801 to §13.0803)

13. INTRODUCTION: *This section lets you name a person to make health care and other related decisions for you, if you cannot make them for yourself. The person must be at least 18 years of age. Cross through this section of the directive if you do not want to appoint a health care representative to make health care decisions for you. Unless you indicate otherwise, the powers which you may grant through this document include the authority to make health care decisions, including life-prolonging treatment decisions, as well as other authorities regarding related affairs. If you have questions, you should seek further counsel and advice.*

(*Cross through Part II if you do not want to appoint a health care agent to make health care decisions for you. If you do want to appoint an agent, you may cross through any items in the form that you do not want to apply*.)

14. Be it known that I,
    Full Legal Name: _____
    Date of Birth: _____
    Street Address: _____
    City: _____ County: _____
    Territory: _____ Zip Code: _____

    ~~ appoint the following individual as my Health Care Representative to make health care decisions for me:

    Representative: _____
    Address: _____
    Telephone: Home:_____ Work:_____
    Cell Phone or Pager: _____ E-mail: _____

    ~~ (*Optional*): If this person is unavailable or is unable or unwilling to act as my agent, then I appoint the following person as successor to act in this capacity:

    Name of Alternate #1:_____
    Address: _____
    Telephone: Home:_____ Work:_____
    Cell Phone or Pager: _____ E-mail: _____

15. My representative (or subsequent alternate successor) has full power and authority to make health care decisions for me, including the power to *(see also: §13.0803)*:
    A. Request, receive, and review any information, oral or written, regarding my physical or mental health, including, but not limited to, medical and

hospital records, and consent to the disclosure of this information – including that covered by HIPAA regulations;

B. Authorize the release of information and medical records as necessary to ensure my proper continued care.

C. Consent to the provision, withholding, or withdrawal of health care, including, in appropriate circumstances, life-prolonging procedures.

D. Provide written consent in my behalf on any form as required, including a physician's order not to resuscitate.

E. Authorize my admission to or discharge from (including transfer to another facility) any hospital, nursing home, adult home, or other medical care facility or program licensed to provide long-term, tertiary, or hospice care.

F. Apply for public benefits, such as Medicare and Medicaid, in my behalf and have access to information regarding my income, assets, banking, and financial records to the extent required to complete the application process.

16. The authority of my representative is subject to the following provisions and limitations:

_____
_____
_____
_____
_____
_____
_____
_____

17. My representative's authority becomes operative:

(*initial the option that applies*)

_____ When my attending physician (and a second physician, if needed) determines that I am incapable of making an informed decision regarding my health care;

OR,

_____ When this document is signed.

18. This appointment shall remain in effect indefinitely unless a termination date is entered here:

(*initial the option that applies*)

_____ This appointment shall remain in effect indefinitely, unless I revoke it.

OR,

_____ This appointment shall end on the following date: _____

19. My representative is to make health care decisions for me based on: a) consultation with my doctor(s); b) the health care instructions I give in this document; and, c) my wishes as otherwise known to my representative. If my wishes are unknown or unclear, my representative is to make health care decisions for me in accordance with my best interest,

as determined by my representative after considering the benefits, burdens, and risks that might result from a given treatment or course of treatment, or from the withholding or withdrawal of a treatment or course of treatment *(see: §13.0803(2))*.

20. My agent shall not be liable for any costs of care based solely on this authorization.

Signature of Principal / Grantor

(*Do not sign until in the presence of two qualified witnesses*)

By signing below (*or causing my signature to be affixed in my presence and in the presence of my witnesses, at my direction*), I indicate that I am emotionally and mentally competent to make this Appointment of a Health Care Representative and that I understand its purpose and effect.

21. Signed:_____ Date: _____

At: (City) _____ (County) _____

Statement and Signature of Witnesses

We declare that the principal signed or acknowledged the signing this Appointment of a Health Care Representative in our presence. We further declare that we are at least 18 years of age or older, that we are not named as a Representative or Alternate Representative in this document, that we did not sign the principal's name in his or her behalf, and that we are not related to the principal by blood, marriage, or adoption, and shall not inherit from him or her.

22. 1st Witness: _____
(Signature)

_____ _____
(Name Printed) (Date)

_____
(Residence Address)

23. 2nd Witness: _____
(Signature)

_____ _____
(Name Printed) (Date)

_____
(Residence Address)