DOWNLOAD COVERSHEET:

This is a standard advance directive for your state, 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." Because of "political compromise, ...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 Colorado Residents

Statutory Compliant Advance Directive for Health Care Choices

~ Lifecare Directives ~

Statutory Advance Directive

For Colorado 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 in your locale who are experienced in the specific areas of concern. Completion of this document 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 its use, 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 utilizer agrees to seek appropriate outside review prior to completion. The utilizer 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 utilizer also agrees that any physician, health care provider, agent, proxy, surrogate, representative, mediator, court officer, and all others relying on the document's content are similarly free of all liability, when they act in good faith and with due diligence to follow the recorded wishes and directions.

Statutory Advance Directive For Colorado 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 Colorado state legislature has provided statutes guiding the construction of both a living will and a Power of Attorney for Health Care for use by the public. Collectively, these documents are known as "advance directives." As the content of these documents was designed by your state government, 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, the law requires doctors to seek your permission before giving you *any* treatment. However, if you are ever unable to make decisions due to severe illness or injury, this may not be possible. Completing this Directive will help your family and physicians know who should speak for you, and understand what you want if you cannot make this known yourself.

You can **revoke** (cancel) this directive 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, which becomes effective only when given to your doctor or health care provider); or **4**) *by simply completing a new directive* in which you state that any prior directive is no longer valid (as is already stated in this directive).

You can **limit** your directive and the authority of anyone named in it, but *no changes are recommended after the document is witnessed*. Any scope-of-authority or content changes needed *after* your directive has been witnessed should be made by completing a new directive. First-time changes can be made by lining out anything in the directive and writing "deleted" beside that clause or section (or 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.

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, date, witness and/or notarize

the 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, this 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. Thus, omitting either section may cause your loved ones difficulty if they must eventually make medical choices in your behalf. So, you are strongly encouraged to complete the entire directive.

To complete each 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:

LIVING WILL DECLARATION

and Personal Instructions

(CRS. Title 15: Art.18: §15-18101 to §15-18-113)

---

1. Introduction: *The Colorado Living Will was designed to assist those wishing to refuse life-sustaining treatment in a terminal condition, if they also are in an incompetent or unconscious state (§15-18-104(1)). A terminal condition is defined in the Medical Treatment Decision Act as, "an incurable or irreversible condition for which the administration of life-sustaining procedures will serve only to postpone the moment of death"(§15-18-103(10)).*

   Life-sustaining treatment is defined as, "any medical procedure or intervention that...would serve only to prolong the dying process"(§15-18-103(7)). It is specifically noted that such treatment "shall not include any medical procedure or intervention for nourishment of the qualified patient considered necessary by the attending physician to provide comfort or alleviate pain." However, "artificial nourishment may be withdrawn or withheld pursuant to section §15-18-104(2.5). Even so, this section restricts the removal of artificial nutrition and hydration (through the declaration of a Living Will alone), to that situation where "the only procedure being provided is artificial nourishment"(§15-18-104(2.5)).

DECLARATION AS TO
MEDICAL OR SURGICAL TREATMENT

2. I, _____, being of sound mind, and at least eighteen years of age, direct that my life shall not be artificially prolonged under the circumstances set forth below and hereby declare that:

3. If at any time my attending physician and one other qualified physician certify in writing that:

a. I have an injury, disease, or illness which is not curable or reversible and which, in their judgment, is a terminal condition, and

b. For a period of seven consecutive days or more, I have been unconscious, comatose, or otherwise incompetent so as to be unable to make or communicate responsible decisions concerning my person, then

~~ I direct that, in accordance with Colorado law, life-sustaining procedures shall be withdrawn and withheld pursuant to the terms of this declaration, it being understood that life-sustaining procedures shall not include any medical procedure or intervention for nourishment considered necessary by the attending physician to provide comfort or alleviate pain. However, I may specifically direct, in accordance with Colorado law, that artificial nourishment be withdrawn or withheld pursuant to the terms of this declaration.

4. In the event that the only procedure I am being provided is artificial nourishment, I direct that one of the following actions be taken:

_____ a. Artificial nourishment shall not be continued when it is the only procedure being provided; or

_____ b. Artificial nourishment shall be continued for _____ days when it is the only procedure being provided; or

_____ c. Artificial nourishment shall be continued when it is the only procedure being provided.

5. I execute this declaration, as my free and voluntary act, on the date indicated below:
Signed this _____ day of _____, 20_____

6. By _____
(*Signature of Declarant*)

Wishes Regarding Organ and Tissue Donation

7. I hereby make an anatomical gift, to be effective upon my death, of:
   a._____ Any needed organs/tissues
   b._____ Only the following organs/tissues:
   _____
   _____

8. Donor/Declarant signature: _____

Statement of Witnesses

The foregoing Declaration as to Medical or Surgical Treatment was signed and declared by: _____, to be his or her Declaration, in the presence of us, who, in his or her presence, and in the presence of each other, and at his or her request, have signed our names below as witnesses. We declare that, at the time of the execution of this instrument, the declarant, according to our best knowledge and belief, was of sound mind and under no constraint or undue influence.

9. Dated at (*city*) _____, Colorado,

this _____ day of _____, 20_____

10. Witness: _____
    Printed Name:_____
    Address: _____

11. Witness: _____
    Printed Name:_____
    Address: _____

Certificate of Notary Public

State of Colorado)
) SS.
County of _____)

SUBSCRIBED and sworn to before me by _____, the declarant, and _____ and _____, witnesses, as the voluntary act and deed of the declarant this _____ day of _____, 20_____.

WITNESS my hand and official seal.

12. _____ **Notary Seal:**
    Signature of Notary Public

    _____
    Date Commission Expires

SECTION II:
MEDICAL POWER OF ATTORNEY
FOR HEALTH CARE DECISIONS
(CRS. Title 15:Art.14: Pt 5: §15-14-503 to §15-14-509)

13. Introduction: *This section lets you name a person (called an "agent" or "attorney-in-fact") to make health care decisions for you, if you cannot make them for yourself. The person you name must be at least 18 years of age. Unless you indicate otherwise, the powers which you may grant through this document include the authority to make health care decisions, including life-sustaining treatment decisions, as well as other authorities regarding related affairs. If you have questions, you should seek counsel and advice.*

14. ***Be it known that I***:

Full Legal Name: _____
Date of Birth: _____
Street Address: _____
City: _____ County: _____
State: _____ Zip Code: _____

~~ Intend by this document to create a medical durable power of attorney. This power of attorney shall not be affected by my later disability, incompetency, or incapacity (as the "principal" herein). I am of sound mind, and state that execution of this document is voluntary and without duress. Creation of this power of attorney is for the purpose of designating someone to act as my health care agent (also known as my attorney-in-fact), to act in my place to make medical and other health care decisions for me if I become unable to make them for myself . This designation is effective when, in the opinion of at least one licensed medical doctor who has personally examined me, I am no longer able make personal medical treatment decisions for myself. By creating this document I revoke any prior medical durable power of attorney.

I recognize that the person I appoint as my agent should ***not*** be my health care provider nor an employer of my health care provider, unless related to me by blood, marriage or adoption. Therefore, the person I have chosen to act as my agent and to whom I give **full** authority to make all medical and health care decisions for me at any time I am unable to make them for myself, is:

15. **Name of Agent**: _____
Address: _____
Telephone: Home:_____ Work:_____
Cell Phone or Pager: _____ E-mail: _____

If for any reason I revoke the authority of my agent, or this individual is unavailable, unwilling, or otherwise ineligible to make decisions for me, the following individuals (*to act alone and successively, in order of priority as listed*) are authorized to serve as alternate agents:

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

17. **Name of Alternate #2:** _____
Address: _____
Telephone: Home:_____ Work:_____
Cell Phone or Pager: _____ E-mail: _____

My health care agent and each alternate successor, *in priority of the order presented*, are to have binding authority over any and all other persons to make my personal and health care decisions. In making decisions in my behalf *if my wishes are not clear*, I direct my agent to act in his/her best understanding of what my wishes would have been. And, where not reasonably sure of what I would have wanted, to act according to his/her belief in my interests as determined from his/her knowledge of my personal and family affairs, and other goals and values in life. The authority of my agent shall not be terminated *unless* it appears that he or she is clearly and obviously not acting in accordance with my known wishes, or is overwhelmingly ignoring my best interests if my wishes are not otherwise known.

SPECIFIC AGENT AUTHORITY AND GENERAL INTENT:

18. My agent shall have the same authority to make health care decisions for me as I would, if I had the capacity to make them myself, subject to any limitations imposed through this document. Below are listed specific authorities given to my agent as named in this document.

This appointment shall extend to (but not be limited to) the following powers and authorities (*initial beside any power or authority you wish to include*):

a. _____ Consent, refuse consent, renew or withdraw consent to any treatment, tests, medications, care, services, surgery, procedures, or therapies used to diagnose or treat any physical or mental condition. This authorization includes the authority to consent to the provision, withholding or withdrawal of any life-sustaining treatment or procedure *even* if the consent or refusal of such will result in my death; **and** to legally act in *every* other matter related to my health and personal care with that same authority I would have, without incurring any personal, legal or financial liability for such.

b. _____ Make decisions about whether artificial feeding (tube feeding) and hydration (IV lines placed in my veins to give me nutrition or water) can be used, limited (e.g., for delivery of medications only), withheld or withdrawn.

c. _____ Consent to organ and/or tissue donation (or to donate my entire remains for medical or scientific research if I have indicated this is my wish).

d. _____ Sign, execute, deliver, and acknowledge any contract or other document that may be necessary, desirable, convenient, or proper in order to exercise and carry out any of the powers described in this document.

e. _____ Select, contract, or terminate any physician(s), health care provider, or other personnel involved in my care.

f. _____ Arrange for my admission to or discharge from any health care facility, even if against medical advice, and to sign any release, waiver, or authorizations required to accomplish a change in care my agent deems necessary.

g. _____ Interpret and apply the meaning and intent of my wishes, whether previously written or spoken to others, at any time I am unable to clarify my wishes myself.

h. _____ Request, review, receive, and disclose any medical information, verbal or written, needed to follow and manage my physical or mental health treatment and general care. This authority also applies to any information governed by the *Health Insurance Portability and Accountability Act of 1996 (HIPPA), 42 U.S.C. 1320d and 45 CFR 160 through 164*.

OTHER AGENT AUTHORITIES AND DIRECTIVES. *The following are additional authorities granted to my agent, and any other directions and instructions which shall be adhered to by may agent*:

19. _____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

LIMITS TO AGENT AUTHORITY. *The following conditions and limitations to my agent(s) authority should also be noted*:

20. _____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

STATEMENT AND SIGNATURE OF PRINCIPAL/GRANTOR:

This document is governed by Colorado law, although I request that it be honored in any state in which I may be found. By signing below, I indicate that I am fully aware of the contents of this document, and understand its purpose, effect, consequences, and full import. Further, I am of legal age, and I am emotionally and mentally competent to complete this document. I am acting voluntarily and without fraud, duress or undue influence.

(*Sign in the presence of two qualified witnesses; see below*)

21 Signed:_____ Date: _____

At: (City) _____ (State) _____

Qualified Witnesses

This Advance Directive for Health Care may <u>not</u> be upheld unless it is: (1) signed by two adult witnesses who are personally present when you sign or to whom you personally acknowledge your signature. Notarization is not required, but Lifecare staff recommend notarization as well, as witnesses may become unavailable in the future. Your witnesses must qualify to sign the following statement:

Statement of Witnesses

I am at least 18 years of age. I know the principal personally, or I have been provided convincing evidence of identity. The principal has read this document, and has signed or acknowledged his/her signature or mark in my presence. This document is being executed voluntarily, and the principal appears to be of sound mind and under no duress, fraud, or undue influence. I have not signed the principal's signature (above) for or at the direction of the principal. I declare under penalty of perjury that I am not related to the principal by blood, marriage, or adoption, nor am I directly responsible for his or her medical care or costs. Further, I am not the attending physician, nor an employee of the physician or other health care provider or current care facility, nor a party to any parent organization thereof. I am not a resident of the same facility in which the principal is receiving treatment. I am also not the employee of a life or health insurance provider for he principal, nor am I involved in directly physically caring for the principal, and to the best of my knowledge I am not entitled to any part of the principal's estate upon his or her death under a will now existing nor by any other operation of law.

22. 1st Witness: _____

(Signature)

_____ _____

(Name Printed) (Date)

_____

(Residence Address)

23. 2nd Witness: _____
(Signature)

_____ _____
(Name Printed) (Date)

_____
(Residence Address)

Certificate of Notary Public

State of Colorado)
) SS.
County of _____)

SUBSCRIBED and sworn to before me by _____, the declarant, and _____ and _____, witnesses, as the voluntary act and deed of the declarant this _____ day of _____, 20_____.

WITNESS my hand and official seal.

24. _____ **Notary Seal:**
Signature of Notary Public

_____
Date Commission Expires