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:

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~ Lifecare Directives ~

Statutory Advance Directive

For

Rhode Island Residents

Statutory Compliant
Advance Directive for
Health Care Choices

~ Lifecare Directives ~

Statutory Advance Directive

For

Rhode Island Residents

Statutory Compliant
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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 Rhode Island 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 Rhode Island state legislature has provided statutes guiding the construction of both a Living Will as well as 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, they should be in full 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

(*Pursuant to RIC. Title 23: Ch.4.11: §23-4.11.1 to §23-4.11-14*)

1. INTRODUCTION. *The Rhode Island statutory Living Will was designed to assist those wishing to refuse life-sustaining treatment in a terminal condition (§23-4.11-1). Before completing the directive, you should be aware of key terms and definitions. A* ***terminal condition*** *is defined as, "an incurable or irreversible condition that, without the administration of life-sustaining procedures will, in the opinion of the attending physician, result in death within a relatively short time"(§23-4.11-3(13)).* ***Life-sustaining treatment*** *is defined as, "any medical procedure or intervention that, when administered to a qualified patient, will serve only to prolong the dying process"(§23-4.11-2(8)). It is specifically noted, however, that such treatment does not include "any medical procedure or intervention considered necessary by the attending physician to provide comfort and care or [to] alleviate pain"(§23-4.11-2(8)).*

DECLARATION

2. I, _____, being of sound mind, do willfully and voluntarily make known my desire that my dying shall not be artificially prolonged under the circumstances set forth below, do hereby declare:

3. _____ If I should have an incurable or irreversible condition that will cause my death and if I am unable to make decisions regarding my medical treatment, I direct my attending physician to withhold or withdraw procedures that merely prolong the dying process and are not necessary to my comfort, or to alleviate pain.

4. *Regarding Artificially Provided Food and Water*. I specifically declare that this authorization: (*initial only <u>one</u>, below*)

[_____] ***<u>includes</u>*** the withholding or withdrawal of artificial feeding.

OR,

[_____] does ***<u>not</u>*** include the withholding or withdrawal of artificial feeding.

5. Signed this _____ day of _____, 20_____.

6. Signed: _____

Date: _____

Address: _____

Statement of Witnesses

7. I am at least 18 years of age, and I know the principal personally. The principal has affixed (or caused to have affixed) 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 or marriage, 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 also not the employee of a life or health insurance provider for the principal, and to the best of my knowledge I have no claim against nor am I entitled to any part of the individual's estate upon his or her death under a will or codicil now existing, nor by any other operation of law.

8. Witness: _____

Printed Name:_____

Address: _____

9. Witness: _____

Printed Name:_____

Address: _____

SECTION II:
HEALTH CARE POWER OF ATTORNEY

Designation of Health Care Agent

(*Pursuant to RIGL, Title 23: Ch.4.10: §23-4.10.1 to §23-4.10-12*)

10. INTRODUCTION. *The following preface, "Warning to Person Executing This Document" is a required introduction to the statutory Power of Attorney for Health Care.*

WARNING TO PERSON EXECUTING THIS DOCUMENT

This is an important legal document which is authorized by the general laws of this state. Before executing this document, you should know these important facts:

You must be at least eighteen (18) years of age and a resident of the state for this document to be legally valid and binding.

This document gives the person you designate as your agent (the attorney in fact) the power to make health care decisions for you. Your agent must act consistently with your desires as stated in this document or otherwise made known.

Except as you otherwise specify in this document, this document gives your agent the power to consent to your doctor not giving treatment or stopping treatment necessary to keep you alive.

Notwithstanding this document, you have the right to make medical and other health care decisions for yourself so long as you can give informed consent with respect to the particular decision. In addition, no treatment may be given to you over your objection at the time, and health care necessary to keep you alive may not be stopped or withheld if you object at the time. This document gives your agent authority to consent, to refuse to consent, or to withdraw consent to any care, treatment, service, or procedure to maintain, diagnose, or treat a physical or mental condition. This power is subject to any statement of your desires and any limitation that you include in this document. You may state in this document any types of treatment that you do not desire. In addition, a court can take away the power of your agent to make health care decisions for you if your agent:

(a) Authorizes anything that is illegal,

(b) Acts contrary to your known desires, or

(c) Where your desires are not known, does anything that is clearly contrary to your best interests.

Unless you specify a specific period, this power will exist until you revoke it. Your agent's power and authority ceases upon your death except to inform your family or next of kin of your desire, if any, to be an organ and tissue owner.

You have the right to revoke the authority of your agent by notifying your agent or your treating doctor, hospital, or other health care provider orally or in writing of the revocation.

Your agent has the right to examine your medical records and to consent to their disclosure unless you limit this right in this document.

This document revokes any prior durable power of attorney for health care.

You should carefully read and follow the witnessing procedure described at the end of this form. This document will not be valid unless you comply with the witnessing procedure.

If there is anything in this document that you do not understand, you should ask a lawyer to explain it to you.

Your agent may need this document immediately in case of an emergency that requires a decision concerning your health care. Either keep this document where it is immediately available to your agent and alternate agents or give each of them an executed copy of this document. You may also want to give your doctor an executed copy of this document.

11. DESIGNATION OF HEALTH CARE AGENT

Be it Known that I:

Full Legal Name: _____

Date of Birth: _____

Street Address: _____

City: _____ County: _____

State: _____ Zip Code: _____

~~ do hereby designate and appoint: *Note: none of the following may be designated as your agent: (a) your treating health care provider, (b) a non-relative employee of your treating health care provider, (c) an operator of a community care facility, or (4) a non-relative employee of an operator of a community care facility*.)

12. **Name of Agent**: _____

Address: _____

Telephone: Home:_____ Work:_____

Cell Phone or Pager: _____ E-mail: _____

~~ as my attorney in fact (agent) to make health care decisions for me as authorized in this document. For the purposes of this document, "health care decision" means consent, refusal of consent, or withdrawal of consent to any care, treatment, service, or procedure to maintain, diagnose, or treat an individual's physical or mental condition.

13. CREATION OF DURABLE POWER OF ATTORNEY FOR HEALTH CARE

By this document I intend to create a durable power of attorney for health care.

14. GENERAL STATEMENT OF AUTHORITY GRANTED

Subject to any limitations in this document, I hereby grant to my agent full power and authority to make health care decisions for me to the same extent that I could make such decisions for myself if I had the capacity to do so. In exercising this authority, my agent shall make health care decisions that are consistent with my desires as stated in this document or otherwise made known to my agent, including, but not limited to, my desires concerning obtaining or refusing or withdrawing life-prolonging care, treatment, services, and procedures and informing my family or next of kin of my desire, if any, to be an organ or tissue donor.

(*If you want to limit the authority of your agent to make health care decisions for you, you can state the limitations in paragraph (15) ("Statement of Desires, Special Provisions, and Limitations") below. You can indicate your desires by including a statement of your desires in the same paragraph*.)

15. STATEMENT OF DESIRES, SPECIAL PROVISIONS, AND LIMITATIONS

(*Your agent must make health care decisions that are consistent with your known desires. You can, but are not required to, state your desires in the space provided below. You should consider whether you want to include a statement of your desires concerning life-prolonging care, treatment, services, and procedures. You can also include a statement of your desires concerning other matters relating to your health care. You can also make your desires known to your agent by discussing your desires with your agent or by some other means. If there are any types of treatment that you do not want to be used, you should state them in the space below. If you want to limit in any other way the authority given your agent by this document, you should state the limits in the space below. If you do not state any limits, your agent will have broad powers to make health care decisions for you, except to the extent that there are limits provided by law*.)

In exercising the authority under this durable power of attorney for health care, my agent shall act consistently with my desires as stated below and is subject to the special provisions and limitations stated below:

a) ***Statement of desires concerning life-prolonging care, treatment, services, and procedures***: _____
_____
_____

(b) ***Additional statement of desires, special provisions, and limitations regarding health care decisions***:

_____
_____
_____

(c) ***Statement of desire regarding organ and tissue donation***:

Initial if applicable:

[_____] In the event of my death, I request that my agent inform my family/next of kin of my desire to be an organ and tissue donor, if possible.

(*You may attach additional pages if you need more space to complete your statement(s). If you attach additional pages, you must date and sign EACH of the additional pages at the same time you date and sign this document*.)

16. INSPECTION AND DISCLOSURE OF INFORMATION RELATING TO MY PHYSICAL OR MENTAL HEALTH. Subject to any limitations in this document, my agent has the power and authority to do all of the following:

(a) Request, review, and receive any information, verbal or written, regarding my physical or mental health, including, but not limited to, medical and hospital records.

(b) Execute on my behalf any releases or other documents that may be required in order to obtain this information.

(c) Consent to the disclosure of this information.

(*If you want to limit the authority of your agent to receive and disclose information relating to your health, you must state the limitations in paragraph (15), "Statement of desires, special provisions, and limitations," above*.)

17. SIGNING DOCUMENTS, WAIVERS, AND RELEASES. Where necessary to implement the health care decisions that my agent is authorized by this document to make, my agent has the power and authority to execute on my behalf all of the following:

(a) Documents titled or purporting to be a "Refusal to Permit Treatment" and "Leaving Hospital Against Medical Advice."

(b) Any necessary waiver or release from liability required by a hospital or physician.

18. DURATION. (*Unless you specify a shorter period in the space below, this power of attorney will exist until it is revoked. Fill in the space below ONLY if you want the authority of your agent to end on a specific date*.)
This durable power of attorney for health care expires on: _____

19. DESIGNATION OF ALTERNATE AGENTS. (*You are not required to designate any alternate agents but you may do so. Any alternate agent you designate will be able to make the same health care decisions as the agent you designated in paragraph (1), above, in the event that agent is unable or ineligible to act as your agent. If the agent you designated is your spouse, he or she becomes ineligible to act as your agent if your marriage is dissolved*.)

If the person designated as my agent in paragraph (1) is not available or becomes ineligible to act as my agent to make a health care decision for me or loses the mental capacity to make health care decisions for me, or if I revoke that person's appointment or authority to act as my agent to make health care decisions for me, then I designate and appoint the following persons to serve as my agent to make health care decisions for me as authorized in this document, such persons to serve in the order listed below:

(A) ***First Alternate Agent***: _____
Address: _____
Telephone: Home:_____ Work:_____
Cell Phone or Pager: _____ E-mail: _____

(B) ***Second Alternate Agent***: _____
Address: _____
Telephone: Home:_____ Work:_____
Cell Phone or Pager: _____ E-mail: _____

20. PRIOR DESIGNATIONS REVOKED. I revoke any prior durable power of attorney for health care.

21. **DATE AND SIGNATURE OF PRINCIPAL:**
(***You must date and sign this power of attorney***)

22. I sign my name to this Statutory Form Durable Power of Attorney for Health Care on:

_____ _____ _____
(*Date*) (*City*) (*State*)

_____
(*You sign here*)

23. (*THIS POWER OF ATTORNEY WILL NOT BE VALID UNLESS IT IS SIGNED BY TWO (2) QUALIFIED WITNESSES WHO ARE PRESENT WHEN YOU SIGN OR ACKNOWLEDGE YOUR SIGNATURE. IF YOU HAVE ATTACHED ANY ADDITIONAL PAGES TO THIS FORM, YOU MUST DATE AND SIGN EACH OF THE ADDITIONAL PAGES AT THE SAME TIME YOU DATE AND SIGN THIS POWER OF ATTORNEY.*)

YOU ARE NOT REQUIRED TO HAVE THIS POWER OF ATTORNEY NOTARIZED

(*This document must be witnessed by two (2) qualified adult witnesses. None of the following may be used as a witness:*

A) A person you designate as your agent or alternate agent,
B) A health care provider,
C) An employee of a health care provider,
D) The operator of a community care facility,
E) An employee of an operator of a community care facility.

At least one of the witnesses must make the additional declaration set out following the place where the witnesses sign.)

Statement of Witnesses

24. "I declare under penalty of perjury that the person who signed or acknowledged this document is personally known to me to be the principal, that the principal signed or acknowledged this durable power of attorney in my presence, that the principal appears to be of sound mind and under no duress, fraud, or undue influence, that I am not the person appointed as attorney in fact by this document, and that I am not a health care provider, an employee of a health care provider, the operator of a community care facility, nor an employee of an operator of a community care facility."

25. 1st Witness: _____
(Signature)

_____ _____
(Name Printed) (Date)

_____
(Residence Address)

26. 2nd Witness: _____
(Signature)

_____ _____
(Name Printed) (Date)

_____
(Residence Address)

(*AT LEAST ONE OF THE ABOVE WITNESSES MUST ALSO SIGN THE FOLLOWING DECLARATION*)

27. I further declare under penalty of perjury that I am not related to the principal by blood, marriage, or adoption, and, to the best of my knowledge, I am not entitled to any part of the estate of the principal upon the death of the principal under a will now existing or by operation of law.

Signature: _____ Signature: _____

Print Name: _____ Print Name: _____