DOWNLOAD COVERSHEET:

This is a basic statutory-compliant 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 ~

Health Care Advance Directive

For

Vermont Residents

Statutory Compliant
Advance Directive for
Health Care Choices

~ Lifecare Directives ~

Health Care Advance Directive

For

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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.

Health Care Advance Directive
For Vermont 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 Vermont 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." The version supplied here is basic statutory-compliant form, though it does not contain all of the optional information provided by available legislation and recommended by various advocacy groups. This version has been produced solely for those who want to make minimum designations only. Consider carefully whether or not you want to complete a longer, more detailed version, also available through Lifecare Directives, LLC.

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 treatment wishes. Or you may complete only ***Section II***, naming only 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:
HEALTH CARE INSTRUCTIONS

(Vermont Living Will)

(*VSA Title 18; Pt. 10; Ch.231: §9700 to §9720*)

1. INTRODUCTION: *On September 1, 2005 new advance directive legislation became effective in Vermont. The statutes provide for adults to leave specific instructions by which to guide their future health care, if they are ever unable to speak for themselves. Historically, instructions of this kind have been referred to as a "living will" – which is the term that will be used within this document. The following constitutes such instructions.*

*In the legislation, "**health care**" is defined as "any treatment, service or procedure to maintain, diagnose, or treat an individual's physical or mental condition..." (§9701(10)). "**Life sustaining treatment**" is defined as "any medical intervention, including nutrition and hydration administered by medical means and antibiotics, which is intended to extend life and without which the principal is likely to die" (§9701(17)). **Nutrition and hydration** by "medical means" is defined as "food and water [provided] by means other than...by eating or drinking" (§9701(18)). The statutes do not specify a written format that a living will must take, but specific rules for its content have been provided (§9703(a-e)). The essential structure is provided here, but you may add any information that is of significant importance to you.*

DECLARATION

2. ***Treatment Wishes***. Many people have strong feelings about situations in which they would, or would not, want to have their life artificially prolonged. Some common situations are included here, for your convenience and consideration:

A. *Terminal conditions*. If I am suffering with a condition which expected to end my life in a short time, and from which there can be no reasonable expectation of recovery, my treatment wishes are as follows:

(*initial only one*)

_____ I want no further treatment intended to sustain or prolong my life, and instead want the focus of my care to be on my comfort and easing other burdens related to the management my condition.

_____ I am unsure of my treatment wishes in a terminal condition, and defer to my agent (if appointed in Section II), or my family and my doctors (if no agent has been named).

_____ I want life-sustaining treatments to be continued, even if I am in a terminal condition. I recognize that this may result in significant burdens of continued treatment (pain, lingering dying, etc), and I accept these burdens.

B. *Permanently Unconscious Conditions*. If I am in condition which has left me in a permanent coma or similar vegetative state, and I have remained in this long enough for my doctors to properly diagnose the condition as being permanent and holding no reasonable expectation of recovery, then my treatment wishes are as follows: (*initial only one*)

_____ I want no further treatment intended to sustain or prolong my life, and instead want the focus of my care to be on my comfort and easing other burdens related to the management my condition.

_____ I am unsure of my treatment wishes in a terminal condition, and defer to my agent (if appointed in Section II), or my family and my doctors (if no agent has been named).

_____ I want life-sustaining treatments to be continued, even if I am in a terminal condition. I recognize that this may result in significant burdens of continued treatment (pain, lingering dying, etc), and I accept these burdens.

C. *Regarding Tube Feeding and Hydration*. The use of feeding tubes and other medical devices to artificially deliver food and water may be of special concern to you. Some people believe that food and water should always be provided, no matter what the situation. Others feel that if they are already actively dying, or if they are being kept alive by these and other artificial measures in a permanently unconscious condition, they would not want feeding tubes to be used to keep them alive longer than they would naturally live without these devices. You may wish to make your desires known here:

(1) In a terminal condition: If I am in a known terminal condition, and I am unable to eat or drink normally (or if I am simply unable to take in enough food and water to sustain my life) then:

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

_____ I ***do*** want feeding tubes and other medical devices to be used to sustain my life, even in a known terminal condition.

_____ I am ***unsure*** of my treatment wishes in a terminal condition, and defer to my agent (if appointed in Section II), or my family and my doctors (if no agent has been named).

_____ I do ***not*** want feeding tubes and other medical devices to be used to continue to sustain my life, even in a terminal condition.

(1) In a permanently unconscious condition: If I am in a permanently unconscious condition, and I am unable to eat or drink normally (or if I am simply unable to take in enough food and water to sustain my life) then:

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

_____ I ***do*** want feeding tubes and other medical devices to be used to sustain my life, even in comatose or vegetative condition.

_____ I am ***unsure*** of my treatment wishes in a terminal condition, and defer to my agent (if appointed in Section II), or my family and my doctors (if no agent has been named).

_____ I do ***not*** want feeding tubes and other medical devices to be used to continue to sustain my life, even in a terminal condition.

D. <u>Organ and Tissue Donation</u>. My wishes about the donation of any of my organs or tissues to others who may be in need of such are as follows:

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

_____ I wish to donate any needed organs (i.e., heart, lung, kidney, liver)

_____ I wish to donate any needed tissues (i.e., cornea, bone, skin, etc)

_____ I wish to donate ***only*** the following organs and/or tissues:

_____

_____ I do ***not*** wish to be an organ and tissue donor.

E. <u>Other Desires and Treatment Wishes</u>. (Here you may write out any other desires, special provisions, limitations, and other concerns you may have about your health, your medical treatment, and other values and goals you may want to share with those providing your medical care).

_____

_____

_____

_____

_____

_____

3. ***Statement and Signature of Principal and Witnesses***:

These directions express my legal right to accept or refuse treatment under the laws of Vermont. I intend my instructions to be carried out, unless I have rescinded them in a new writing or by clearly indicating that I have changed my mind.

By signing below, I indicate that I am fully aware of the contents of this document, and I understand its purpose, effect, 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, named below*)

4. Signed: _____

Date: _____

Address: _____

Statement of Witnesses

5. 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 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 understand the purpose and nature of this document, and 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 am not the a health care representative, agent, surrogate or proxy, nor a successor of such in this directive document. 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 deed, will or codicil now existing, nor by any other operation of law.

6. Witness: _____
Printed Name: _____
Address: _____

7. Witness: _____
Printed Name: _____
Address: _____

[***If you are in a hospital, or in a residential care setting or nursing facility, please see additional witnessing instructions on page 10***]

SECTION II:
APPOINTMENT OF HEALTH CARE AGENT
With Specific Instructions and Authorities
(*Pursuant to VSA Title 18: Part 10: Ch.231, §9700 to §9720*)

8. INTRODUCTION: *This section lets you name a person (called an "agent") 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 granted 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 further counsel and advice.*

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

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

~~ Intend by this document to appoint a health care agent. This appointment and its specific power and authorities 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 appointment is for the purpose of designating someone to act in my place to make medical decisions for me if I become unable to make them for myself . It also grants my agent the authority to make other related legal and personal care decisions as outlined in this document. This designation is effective when, in the opinion of my agent herein named and 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 health care agent designation or appointment.

10. I understand that I am <u>not</u> required to choose a health care agent, but recognize that by doing so I may more fully ensure that my wishes are represented and carried out. Therefore:

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

_____ I do <u>not</u> want to choose an agent at this time (*or I have no one appropriate to the task*). However, I instruct that Section I of this document be recognized by as a declaration of my wishes within this Advance Health Care Directive (*initial here, and skip forward to sign on page 8*);

***OR*,**

_____ I <u>do</u> wish to appoint a health care agent. I recognize that, by Vermont law, this person may ***<u>not</u>*** be my health care provider. Unless related to me by blood, marriage, civil union or adoption, my agent also may ***<u>not</u>*** be: an owner, operator, employee, agent, or contractor of a residential care facility, or of a health care or a correctional facility in which I reside; nor a funeral director or employee of such,

nor a crematory operator or employee, or a cemetery official or employee otherwise engaged by me for services. The person I have chosen to act as my agent and to whom I give **full** authority to make all medical, health care, and related decisions for me at any time I am unable to make them for myself, is:

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

12. If for any reason I revoke the authority of my agent, or this individual is unavailable, unable, 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:

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

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

15. Each alternate successor designated shall be vested with the same power and duties as if originally named as my health care agent. These persons, *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. My agent is also authorized to receive and release 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*. 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.

16. *Treatment Wishes (living will declaration) Incorporation (if completed)*: I intend for my agent to follow, incorporate and enforce as medical and health care directives, any and all wishes as outlined in the Health Care Instructions Declaration contained in this advance directive document.

17. *Other Wishes*: _____
_____
_____
_____
_____
_____
_____

Signature of Principal and Witnesses:

18. These instructions express my legal right to accept or refuse treatment under the laws of Vermont. I intend my instructions to be carried out, unless I have rescinded them in a new writing or by clearly indicating that I have changed my mind.

By signing below, I indicate that I am fully aware of the contents of this Directive, and I 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.

(*Do sign <u>in the presence</u> of <u>two</u> qualified witnesses; see below*)

19. Signed:_____ Date: _____

At: (City) _____ (State) _____

Qualified Witnesses

20. 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. Notarization is not required, but is recommend, as witnesses may become unavailable in the future. Your witnesses must qualify to sign the following statement:

Statement of Witnesses

21. 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 affixed (or caused to be affixed) his/her signature or mark in my presence. It appears that the individual understands the nature of this document, and that the principal appears to be 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, civil union or adoption, nor am I directly responsible for his or her medical care or costs. I am not the agent or an alternate or successor named in this document. Further, I am not the attending physician or other health care provider, nor an employee of the physician or other health care provider, nor that of a 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 he principal, and to the best of my knowledge I have no claim against nor am I entitled to any part of the principal's estate upon his or her death under a deed, will or codicil 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)

SPECIAL REQUIREMENTS FOR INDIVIDUALS WHO ARE HOSPITALIZED OR IN RESIDENTIAL CARE:

24. If you are a patient in a hospital or a residential care setting, your advance directive will not be valid unless *one* of the following persons also signs the statement below: 1) an "ombudsman," 2) a "recognized member of the clergy," 3) an "attorney licensed to practice in Vermont," or 4) a "probate court designee." The recommended statement is provided as follows:

25. The principal herein is a resident of/admitted at:

Facility Name_____ City:_____

"I declare under penalty of perjury that I am an individual recognized by Vermont statute §9703 to explain the nature and effect of this advance directive, and I have done so with the principal completing this directive."

Signature_____ Date: _____

Title: _____

Address: _____ Ph#: _____

CERTIFICATE OF ACKNOWLEDGMENT OF NOTARY PUBLIC (*notarization of your advance directive is not required, but it is recommended*):

26. State of Vermont,

County of_____ }

Place: _____

On this_____day of _____, in the year_____, before me (insert officer name/title): _____, personally appeared (insert name of Principal on line here):_____, personally known to me (or proved to me on the basis of satisfactory evidence* (describe:_____)) to be the person(s) whose name(s) is/are subscribed to this/these instrument(s) and acknowledged to me that he/she executed the same in his/her authorized capacity, and that by his/her signature on the instrument(s), executed the instrument(s). I declare that he/she appears of sound mind and not under or subject to duress, fraud, or undue influence, that he/she acknowledges the execution of the same to be his/her voluntary act and deed, and that I am not the agent (attorney-in-fact), proxy, surrogate, or a successor of any such, as designated within this document, nor do I hold any interest in his/her estate through a Will or by other operation of law.

WITNESS my hand and official seal.

_____ **Notary Seal:**

Signature of Notary Public

_____

Date Commission Expires

PHOTOCOPIES AND FACSIMILES:

27. A photocopy (photostatic copy) or electronic facsimile ("fax") of this document shall be deemed as valid as the original. I understand I should keep the original copy, and give copies of the original to 1) my agent and alternate agents, 2) my physician(s), 3) members of my family and others who might be called in the event of a medical emergency, and 4) any hospital or other health care facility where I receive treatment. My agent(s) and my family or friends should be directed to give a copy of this directive to my health care provider(s) or physician(s) upon request.

28. INDIVIDUALS AND INSTITUTIONS WHO HAVE BEEN GIVEN COPIES OF THIS ADVANCE DIRECTIVE

Name: ______________________________
Address ______________________________
____
Phone (_____) ______ - ______________
Fax: (_____) ______ - ______________
E-mail: ______________________________

Name: ______________________________
Address ______________________________
____
Phone (_____) ______ - ______________
Fax: (_____) ______ - ______________
E-mail: ______________________________

Name: ______________________________
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E-mail: ______________________________

Name: ______________________________
Address: ______________________________
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Phone (_____) ______ - ______________
Fax: (_____) ______ - ______________
E-mail: ______________________________

For additional copies of this directive, or other related materials, please contact Lifecare Directives, LLC, at:

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