PART I

PART I: DURABLE POWER OF ATTORNEY FOR HEALTH CARE

NOTICE

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 of Rhode Island 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:

(1) Authorizes anything that is illegal,
(2) Acts contrary to your known desires, or
(3) 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 next of kin of your desire to be an organ and tissue donor.

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.

NOTICE
(CONTINUED)

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.

PRINT YOUR NAME AND ADDRESS

PRINT THE NAME, ADDRESS, AND TELEPHONE NUMBERS OF YOUR AGENT

1. DESIGNATION OF HEALTH CARE AGENT.

I, _____,
(name)

_____
(address)

do hereby designate and appoint: _____
(name of agent)

_____
(address)

_____
(home telephone number) (work telephone number)

(insert name, address, and telephone number of one individual only as your agent to make health care decisions for you. None of the following may be designated as your agent: (1) your treating health care provider, (2) a non-relative employee of your treating health care provider, (3) an operator of a community care facility, or (4) a non-relative employee of an operator of a community care facility.) 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.

2. CREATION OF DURABLE POWER OF ATTORNEY FOR HEALTH CARE. By this document I intend to create a durable power of attorney for health care.

3. 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 4 ["Statement of Desires, Special Provisions, and Limitations"] below. You can indicate your desires by including a statement of your desires in the same paragraph.)

4. 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:

(You may attach additional pages if you need more space to complete your statement. 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.)

ADD OTHER INSTRUCTIONS, IF ANY, REGARDING YOUR ADVANCE CARE PLANS

THESE INSTRUCTIONS CAN FURTHER ADDRESS YOUR HEALTH CARE PLANS, SUCH AS YOUR WISHES REGARDING HOSPICE TREATMENT, BUT CAN ALSO ADDRESS OTHER ADVANCE PLANNING ISSUES, SUCH AS YOUR BURIAL WISHES

ATTACH ADDITIONAL PAGES IF NEEDED

If you wish to make a gift of any bodily organ you may do so pursuant to the Uniform Anatomical Gift Act.

INITIAL ONLY ONE

____ I do not want to be an organ donor.

____ I want to be an organ donor. In the event of my death I request that my agent inform my family/next of kin of my desires to be an organ and tissue donor if possible. My wishes are indicated below.

YOU MAY SPECIFY HERE ANY ADDITIONAL DESIRES REGARDING THE PERMITTED USES FOR YOUR ORGANS/TISSUES (E.G., TRANSPLANT, RESEARCH, ANY USE)

I wish to give:

____ any needed organs/ tissues: or

____ only the following organs/tissues:_____

_____

Additional Desires:_____

_____

5. 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 4 ["Statement of desires, special provisions, and limitations"])

6. 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.

FILL IN THIS SPACE ONLY IF YOU WANT THE AUTHORITY OF YOUR AGENT TO END ON A SPECIFIC DATE

7. DURATION. (Unless you specify a shorter period in the space below, this power of attorney will exist until it is revoked.)
This durable power of attorney for health care expires on

_____

(Fill in this space ONLY if you want the authority of your agent to end on a specific date.)

8. 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:

IF YOU WANT TO APPOINT ALTERNATE AGENTS, PRINT THEIR NAMES, ADDRESSES AND TELEPHONE NUMBERS HERE

A. First Alternate Agent: _____
(name of first agent)

_____

_____
(Insert address, and telephone number of first alternate agent.)

B. Second Alternate Agent: _____
(name of second alternate agent)

_____

_____
(Insert name, address, and telephone number of second alternate agent.)

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

PART II

PRINT YOUR NAME

INITIAL ONLY ONE CHOICE REGARDING ARTIFICIAL FEEDING

ADD OTHER INSTRUCTIONS, IF ANY, REGARDING YOUR ADVANCE CARE PLANS

THESE INSTRUCTIONS CAN FURTHER ADDRESS YOUR HEALTH CARE PLANS, SUCH AS YOUR WISHES REGARDING HOSPICE TREATMENT, BUT CAN ALSO ADDRESS OTHER ADVANCE PLANNING ISSUES, SUCH AS YOUR BURIAL WISHES

ATTACH ADDITIONAL PAGES IF NEEDED

PART II: DECLARATION (LIVING WILL)

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

If I should have an incurable or irreversible condition that, without the administration of life-sustaining procedures, 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.

This authorization (initial only one option)
_____ includes the withholding or withdrawal of artificial feeding.
_____ does not include the withholding or withdrawal of artificial feeding.

Other directions:

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(You may attach additional pages if you need more space to complete your statement. 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.)

If you complete Part I, this document must be either

IF YOU HAVE YOUR SIGNATURE WITNESSED, USE ALTERNATIVE NO. 1 (P. 9)

1. Witnessed by two (2) qualified adult witnesses. None of the following may be used as a witness:
    6. A person you designate as your agent or alternate agent,
    7. A health care provider,
    8. An employee of a health care provider,
    9. The operator of a community care facility,
    10. An employee of an operator of a community care facility.

In addition, one of your witnesses must be unrelated to you and not entitled to any portion of your estate.

OR

IF YOU HAVE YOUR SIGNATURE NOTARIZED USE ALTERNATIVE NO. 2 (P. 10)

2. Witnessed by a notary public.

If you complete Part II, you must have your advance directive witnessed by two (2) qualified adult witnesses, both of whom must be unrelated to you and not entitled to any portion of your estate. If you completed ONLY Part II, your witnesses are subject only to the restriction that they must be unrelated to you and not entitled to any portion of your estate.

IF YOU COMPLETE PART II, YOU MUST HAVE YOUR ADVANCE DIRECTIVE WITNESSED BY TWO (2) QUALIFIED ADULT WITNESSES

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 ADVANCE DIRECTIVE.

Alternative No. 1. Sign Before Witnesses.

PRINT YOUR NAME, THE DATE AND LOCATION

I _____(print name),

sign my name to this advance directive on

_____at _____, _____

(date) (city) (state)

SIGN HERE

_____

(Principal/Declarant Signature)

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/declarant signed or acknowledged this advance directive in my presence, and that the principal/declarant appears to be of sound mind and under no duress, fraud, or undue influence.

YOUR WITNESSES MUST SIGN, DATE AND PRINT THEIR NAMES AND ADDRESSES HERE

Signature: _____Date_____

Print Name: _____

Residence Address: _____

Signature: _____Date_____

Print Name: _____

Residence Address: _____

IF YOU COMPLETED PART I, YOUR WITNESSES MUST SIGN HERE

I further attest 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.

Signature: _____Date_____

IF YOU COMPLETED PART I, AT LEAST ONE OF YOUR WITNESSES MUST SIGN HERE

Signature: _____Date_____

IF YOU COMPLETED PART II, BOTH OF YOUR WITNESSES MUST SIGN HERE

I further attest 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: _____Date_____

Signature: _____Date_____

Alternative No. 2. Sign Before a Notary Public

PRINT YOUR NAME, THE DATE AND LOCATION

I _____(print name),

sign my name to this advance directive on

_____ at _____,_____.
(date) (city) (state)

SIGN HERE

_____
(Principal/Declarant Signature)

Notary Public

_____ COUNTY,

A NOTARY PUBLIC MUST FILL OUT THIS PORTION OF YOUR FORM

In the City/Town of _____ and County and State aforesaid, on the

_____ day of _____ , 20 _____, personally came

_____ ,

IF YOU COMPLETE PART II, YOU MUST HAVE YOUR ADVANCE DIRECTIVE WITNESSED BY TWO (2) QUALIFIED ADULT WITNESSES

that the principal/declarant signed or acknowledged this advance directive in my presence, and that the principal appears to be of sound mind and under no duress, fraud, or undue influence. I further attest 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.

_____
NOTARY PUBLIC

Commission expiration date: _____

_____Personally know by me

_____Produced identification

Courtesy of CaringInfo
1731 King St., Suite 100, Alexandria, VA 22314
www.caringinfo.org, 800/658-8898

You Have Filled Out Your Health Care Directive, Now What?

1. Your Rhode Island Advance Directive is an important legal document. Keep the original signed document in a secure but accessible place. Do not put the original document in a safe deposit box or any other security box that would keep others from having access to it.

2. Give photocopies of the signed original to your agent and alternate agent, doctor(s), family, close friends, clergy, and anyone else who might become involved in your health care. If you enter a nursing home or hospital, have photocopies of your document placed in your medical records.

3. Be sure to talk to your agent(s), doctor(s), clergy, family, and friends about your wishes concerning medical treatment. Discuss your wishes with them often, particularly if your medical condition changes.

4. You may also want to save a copy of your form in an online personal health records application, program, or service that allows you to share your medical documents with your physicians, family, and others who you want to take an active role in your advance care planning.

5. If you want to make changes to your documents after they have been signed and witnessed, you must complete a new document.

6. Remember, you can always revoke your Rhode Island document.

7. Be aware that your Rhode Island document will not be effective in the event of a medical emergency. Ambulance and hospital emergency department personnel are required to provide cardiopulmonary resuscitation (CPR) unless they are given a separate directive that states otherwise. These directives called "prehospital medical care directives," "do not resuscitate orders," or "medical orders for life sustaining treatment (MOLST)" are designed for people whose poor health gives them little chance of benefiting from CPR. These directives instruct ambulance and hospital emergency personnel not to attempt CPR if your heart or breathing should stop.

   Currently not all states have laws authorizing these orders. We suggest you speak to your physician if you are interested in obtaining one. **CaringInfo does not distribute these forms.**

Congratulations!

You've downloaded **your free, state specific advance directive.**

You are taking important steps to make sure your wishes are known. Help us keep this free.

Your generous support of the National Hospice Foundation and CaringInfo allows us to continue to provide these FREE resources, tools, and information to educate and empower individuals to access advance care planning, caregiving, hospice and grief services, and information.

I hope you will show your support for our mission and make a tax-deductible gift today.

Since 1992, the National Hospice Foundation has been dedicated to creating FREE resources for individuals and families facing a life-limiting illness, raising awareness for the need for hospice care, and providing ongoing professional education and skills development to hospice professionals across the nation.

Your gift strengthens the Foundation's ability to provide FREE caregiver and family resources.

Support your National Hospice Foundation by returning a **generous tax-deductible gift of $23, $47, $64,** or the most generous amount you can send.

You can help us provide resources like this advance directive FREE by sending in your gift to help others.

Please help to make this possible with your contribution! Cut along the dotted line and use the coupon below to return a check contribution of the most generous amount you can send. Thank you.

YES! I want to support the important work of the National Hospice Foundation.

$23	helps us provide free advance directives
$47	helps us maintain our free InfoLine
$64	helps us provide webinars to hospice

Return to:
National Hospice Foundation
PO Box 824401
Philadelphia, PA 19182-4401

AD_2018

OR donate online today: www.caringinfo.org/donate