Introduction to your District of Columbia Advance Directive

This packet contains two legal documents that protect your right to refuse medical treatment you do not want, or to request treatment you do want, in the event you lose the ability to make decisions yourself:

1. The **District of Columbia Power of Attorney for Health Care** lets you name someone to make decisions about your medical care—including decisions about life support—if you can no longer speak for yourself. The Durable Power of Attorney for Health Care is especially useful because it appoints someone to speak for you any time you are unable to make your own medical decisions, not only at the end of life. Before the Durable Power of Attorney for Health Care can go into effect, two physicians, including one psychiatrist, must certify in writing that you are mentally unable to make health care decisions.

2. The **District of Columbia Declaration** is the District of Columbia's living will. It lets you state your wishes about medical care in the event that you develop a terminal condition and can no longer make your own medical decisions. The Declaration goes into effect if your death would occur with or without the use of life-sustaining medical care. One other doctor must agree with your attending physician's opinion of your medical condition, and both must certify your diagnosis in writing.

Partnership for Caring recommends that you complete both of these documents to best ensure that you receive the medical care you want when you can no longer speak for yourself.

Note: These documents will be legally binding only if the person completing them is a competent adult (at least 18 years old).

Whom should I appoint as my attorney-in-fact?
"Attorney-in-fact" does not refer to a lawyer. Your attorney-in-fact is the person you appoint to make decisions about your medical care if you become unable to make those decisions yourself. Your attorney-in-fact can be a family member or a close friend whom you trust to make serious decisions. The person you name as your attorney-in-fact should clearly understand your wishes and be willing to accept the responsibility of making medical decisions for you. (An attorney-in-fact may also be called an "agent" or "proxy.") You cannot appoint your doctor or other health care provider as your attorney-in-fact.

You can appoint a second and third person as your alternate attorney(s)-in-fact. The alternate will step in if the first person you name as attorney-in-fact is unable, unwilling or unavailable to act for you.

How do I make my Power of Attorney for Health Care legal?
The law requires that you sign your Power of Attorney for Health Care in the presence of two adult witnesses, who must also sign to show that they personally know you and believe you to be of sound mind and under no duress, fraud, or undue influence, that you signed or acknowledged the Power of Attorney for Health Care in their presence and that they do not fall into any of the categories of people who cannot serve as witnesses.

These witnesses **cannot** be:

- the person you appointed as your attorney-in-fact;
- your health care provider; or
- an employee of your health care provider.

At least one of your witnesses must be a person who is not related to you (by blood, marriage or adoption) and who will not inherit from you under any existing will, codicil or by operation of law.

Note: You do not need to notarize your Durable Power of Attorney for Health Care.

Should I add personal instructions to my Power of Attorney for Health Care?
Partnership for Caring advises you not

to add instructions to this document. One of the strongest reasons for naming an attorney-in-fact is to have someone who can respond flexibly as your medical condition changes and deal with situations that you did not foresee. If you add instructions to this document, you might unintentionally restrict your attorney-in-fact's power to act in your best interest.

Instead, we urge you to talk with your attorney-in-fact about your future medical care and describe what you consider to be an acceptable "quality of life." If you want to record your wishes about specific treatments or conditions, you should use your District of Columbia Declaration (the living will).

What if I change my mind?

You may revoke your Durable Power of Attorney for Health Care by:

- notifying your attorney-in-fact orally or in writing,
- notifying your health care provider orally or in writing so that your revocation can be noted in your medical records and your attorney-in-fact can be contacted, **or**
- executing a new District of Columbia Durable Power of Attorney for Health Care.

If you named your spouse as your attorney-in-fact and your marriage ends, your spouse's power to act on your behalf will automatically be revoked.

How do I make my Declaration legal?

The law requires that you sign your District of Columbia Declaration, or direct another to sign it, in the presence of two adult witnesses, who must also sign the document to show that they are at least 18 years of age, that they believe you to be of sound mind, that they did not sign the document on your behalf, and that they do not fall into any of the categories of people who cannot serve as witnesses.

These witnesses **cannot:**

- be related to you by blood or marriage,
- stand to inherit from your estate upon your death,
- be financially responsible for your medical care,
- be your doctor or an employee of your doctor, **or**
- be an employee of a health care facility in which you are a patient.

If you are a patient in an intermediate care or skilled care facility, one of your witnesses must be a patient advocate or ombudsman.

Note: You do not need to notarize your District of Columbia Declaration.

Can I add personal instructions to my Declaration?

Yes. You can add personal instructions in the part of the document called "Other directions." For example, you may want to refuse specific treatments by a statement such as, "I especially do not want cardiopulmonary resuscitation, a respirator, artificial feeding, or antibiotics." You may also want to emphasize pain control by adding instructions such as, "I want to receive as much pain medication as necessary to ensure my comfort, even if it may hasten my death."

If you have appointed an attorney-in-fact and you want to add personal instructions to your Declaration, it is a good idea to write a statement such as "Any questions about how to interpret or when to apply my Declaration are to be decided by my attorney-in-fact."

It is important to learn about the kinds of life-sustaining treatment you might receive. Consult your doctor or order the Partnership for Caring booklet, "Advance Directives and End-of-Life Decisions."

What if I change my mind?

You may revoke your Declaration at any time, regardless of your mental condition, by:

- obliterating, burning, tearing, or otherwise destroying or defacing the document, or directing another person to do so in your presence;
- executing, or directing another person to execute, a dated and signed written revocation which becomes effective when it is given to your doctor, who will then make it part of your medical record;
- orally revoking your Declaration in the presence of a witness, 18 years or older, who must sign and date a written confirmation of your oral revocation. An oral revocation becomes effective once it is communicated to your doctor, who will then make it part of your medical record.

1. Your District of Columbia Power of Attorney for Health Care and Declaration are important legal documents. Keep the original signed documents in a secure but accessible place. Do not put the original documents in a safe deposit box or any other security box that would keep others from having access to them.

2. Give photocopies of the signed originals to your attorney-in-fact and alternate attorney-in-fact, 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 documents placed in your medical records.

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

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

5. Remember, you can always revoke one or both of your District of Columbia documents.

6. Be aware that your District of Columbia documents will not be effective in the event of a medical emergency. Ambulance personnel are required to provide cardiopulmonary resuscitation (CPR) unless they are given a separate order that states otherwise. These orders, commonly called "nonhospital do-not-resuscitate orders," are designed for people whose poor health gives them little chance of benefiting from CPR. These orders must be signed by your physician and instruct ambulance personnel not to attempt CPR if your heart or breathing should stop. Currently not all states have laws authorizing nonhospital do-not-resuscitate orders. Partnership for Caring does not distribute these forms. We suggest you speak to your physician.

If you would like more information about this topic contact Partnership for Caring or consult the Partnership for Caring booklet "Cardiopulmonary Resuscitation, Do-Not-Resuscitate Orders and End-Of-Life Decisions."

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DISTRICT OF COLUMBIA POWER OF ATTORNEY FOR HEALTH CARE

INFORMATION ABOUT THIS DOCUMENT

This is an important legal document. Before signing this document, it is vital for you to know and understand these facts:

This document gives the person you name as your attorney in fact the power to make health-care decisions for you if you cannot make the decisions for yourself.

After you have signed this document, you have the right to make health care decisions for yourself if you are mentally competent to do so. In addition, after you have signed this document, no treatment may be given to you or stopped over your objection if you are mentally competent to make that decision.

You may state in this document any type of treatment that you do not desire and any that you want to make sure you receive.

You have the right to take away the authority of your attorney in fact, unless you have been adjudicated incompetent, by notifying your attorney in fact or health-care provider either orally or in writing. Should you revoke the authority of your attorney in fact, it is advisable to revoke in writing and to place copies of the revocation wherever this document is located.

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

You should keep a copy of this document after you have signed it. Give a copy to the person you name as your attorney in fact. If you are in a health-care facility, a copy of this document should be included in your medical record.

INSTRUCTIONS

DISTRICT OF COLUMBIA POWER OF ATTORNEY FOR HEALTH CARE

PRINT YOUR NAME AND ADDRESS

I, ____, of
(name)

____,hereby appoint:
(home address)

PRINT THE NAME, HOME ADDRESS AND HOME AND WORK TELEPHONE NUMBERS OF YOUR ATTORNEY IN FACT

____
(name of attorney-in-fact)

____
(home address)

____
(work telephone number) *(home telephone number)*

as my attorney in fact to make health-care decisions for me if I become unable to make my own health-care decisions. This gives my attorney in fact the power to grant, refuse, or withdraw consent on my behalf for any health-care service, treatment or procedure. My attorney in fact also has the authority to talk to health-care personnel, get information and sign forms necessary to carry out these decisions.

If the person named as my attorney in fact is not available or is unable to act as my attorney in fact, I appoint the following person(s) to serve in the order listed below:

PRINT THE NAME, HOME ADDRESS AND HOME AND WORK TELEPHONE NUMBERS OF YOUR FIRST AND SECOND ALTERNATE ATTORNEY IN FACT

1. ____
(name of first alternate attorney in fact)

____
(home address)

____
(work telephone number) *(home telephone number)*

2. ____
(name of second alternate attorney in fact)

____
(home address)

____
(work telephone number) *(home telephone number)*

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With this document, I intend to create a power of attorney for health care, which shall take effect if I become incapable of making my own health-care decisions and shall continue during that incapacity.

My attorney in fact shall make health-care decisions as I direct below or as I make known to my attorney in fact in some other way.

ADD PERSONAL INSTRUCTIONS (IF ANY)

Statement of directives concerning life-prolonging care, treatment, services and procedures:

ADD LIMITATIONS ON YOUR ATTORNEY IN FACT'S POWER (IF ANY)

Special provisions and limitations:

PRINT THE DATE AND YOUR LOCATION AND SIGN THE DOCUMENT

By my signature I indicate that I understand the purpose and effect of this document.

I sign my name to this form on ______________________________
(date)

at: ______________________________
(address of location)

____
(signature)

YOUR WITNESSES MUST SIGN THE DOCUMENT ON THE NEXT PAGE

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WITNESSING PROCEDURE

WITNESSES MUST SIGN AND DATE THE DOCUMENT AND PRINT THEIR NAMES AND ADDRESSES

WITNESSES

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

WITNESS #1

First Witness' Signature: ______________________________

Home Address: ______________________________

Print Name: ______________________________

Date: ______________________________

WITNESS #2

Second Witness' Signature: ______________________________

Home Address: ______________________________

Print Name: ______________________________

Date: ______________________________

ONE OF YOUR WITNESSES MUST ALSO AGREE WITH THIS STATEMENT AND SIGN BELOW

(AT LEAST 1 OF THE WITNESSES LISTED ABOVE SHALL ALSO SIGN THE FOLLOWING DECLARATION.)

I further declare 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 under a currently existing will or by operation of law.

Signature: ______________________________

Signature: ______________________________

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INSTRUCTIONS

DISTRICT OF COLUMBIA DECLARATION

PRINT THE DATE

Declaration made this _________ day of _____________________________.
(date) *(month, year)*

PRINT YOUR NAME

I, ____,
(name)

being of sound mind, willfully and voluntarily make known my desires that my dying shall not be artificially prolonged under the circumstances set forth below, do declare:

If at any time I should have an incurable injury, disease or illness certified to be a terminal condition by two physicians who have personally examined me, one of whom shall be my attending physician, and the physicians have determined that my death will occur whether or not life-sustaining procedures are utilized and where the application of life-sustaining procedures would serve only to artificially prolong the dying process, I direct that such procedures be withheld or withdrawn, and that I be permitted to die naturally with only the administration of medication or the performance of any medical procedure deemed necessary to provide me with comfort care or to alleviate pain.

ADD PERSONAL INSTRUCTIONS (IF ANY)

Other directions:

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In the absence of my ability to give directions regarding the use of such life-sustaining procedures, it is my intention that this declaration shall be honored by my family and physician(s) as the final expression of my legal right to refuse medical or surgical treatment and accept the consequences from such refusal.

I understand the full import of this declaration and I am emotionally and mentally competent to make this declaration.

SIGN THE DOCUMENT AND PRINT YOUR ADDRESS

Signed ____

Address ____

____

WITNESSING PROCEDURE

WITNESSES MUST SIGN BELOW

I believe the declarant to be of sound mind. I did not sign the declarant's signature above for or at the direction of the declarant. I am at least eighteen years of age and am not related to the declarant by blood or marriage, entitled to any portion of the estate of the declarant according to the laws of intestate succession of the District of Columbia or under any will of the declarant or codicil thereto, or directly financially responsible for declarant's medical care. I am not the declarant's attending physician, an employee of the attending physician, or an employee of the health facility in which the declarant is a patient.

WITNESS #1

Witness ____

WITNESS #2

Witness ____

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