

CATHOLIC ADVANCE HEALTH CARE DIRECTIVE FOR DELAWARE

Authorized by the Catholic Diocese of Wilmington, September 2005

Instructions for Making this Catholic Advance Health Care Directive with Power of Attorney for Health Care (the "ADVANCE DIRECTIVE"):

- 1) *Before completing your ADVANCE DIRECTIVE, you should discuss instructions you will include in it with your agent (if any), your doctor, priest, deacon, family members, or others who might become responsible for your care.*
- 2) *It is recommended that you periodically review this ADVANCE DIRECTIVE with the same people to insure that this directive continues to reflect your intentions.*
- 3) *If you decide to revoke this ADVANCE DIRECTIVE, make sure that your doctor and any agent you appoint will receive notice of the revocation. Revocation can be by any means, whether orally to someone, by a written revocation or by destroying the original of this ADVANCE DIRECTIVE.*

PREAMBLE

As a Catholic, I believe that life is a precious gift from God, and that He alone has dominion over human life. God has made us stewards of life. Our stewardship requires the use of every reasonable means to protect and preserve life and forbids any action intended to end our own lives or those of other innocent human beings. I believe that euthanasia and all forms of suicide are never morally permissible. For purposes of this ADVANCE DIRECTIVE, euthanasia is defined as an action or omission which of itself or by intention will cause my death for the purpose of eliminating suffering.

PART I. INSTRUCTIONS FOR HEALTH CARE DECISIONS

I understand that I have the right to make my own decisions about my health care. There may come a time when I am unable due to physical or mental incapacity, to express my own health care decisions. In these circumstances, those caring for me will need to turn to someone who knows my values and health care intentions. I am, therefore, signing the attached ADVANCE DIRECTIVE, to provide the guidance and authority needed to implement my wishes.

This ADVANCE DIRECTIVE shall take effect in the event that my attending physician determines that I lack sufficient capacity to make or communicate decisions about my health care. The determination of my medical condition must be confirmed by a second physician with appropriate expertise. To inform those responsible for my care of my specific intentions, I direct that the following health care decisions be implemented.

Medical Treatment Decisions

I desire that all *ordinary* medical interventions (those that are useful and offer a reasonable hope of benefit without causing excessive burdens) be used in my treatment and care. Unless there is a particular reason for doing otherwise, I wish to forgo all *extraordinary* means (those that are futile or that are likely to cause burdens that are disproportionate to any expected benefits). In all circumstances, I oppose any act or omission that of itself or by intention will cause my death,

even for the purpose of eliminating suffering. I direct that all decisions regarding my medical treatment and care be made in accord with Catholic moral teachings as contained in such documents as the following: Pope John Paul II, *Care for Patients in a "Permanent" Vegetative State* (March 20, 2004); Congregation for the Doctrine of the Faith, *Declaration on Euthanasia* (1980); United States Conference of Catholic Bishops, *Ethical and Religious Directives for Catholic Health Care Services* (edition current at the time decisions are being made).

Food and Fluids (Nutrition and Hydration)

I wish to receive nutrition and hydration, even if its supply is medically assisted, as long as it effectively sustains my life. If my death is truly imminent, or if my body is unable to assimilate foods and fluids, or if there is some other serious medical problem preventing nourishment, the medically assisted supply of nutrition and hydration may be considered unnecessary and discontinued.

Pain Relieving Medication

If my condition includes physical pain, I wish to receive pain-relieving medication in dosages sufficient to manage the pain. If I am dying and pain management should require increasingly greater dosages of medication, I direct that they be increased in increments sufficient to manage the pain, even if this increase should hasten my death. However, pain medication should not be given to me for the purpose of hastening my death.

Pregnancy

If I am pregnant, I wish that, regardless of my physical or mental condition, every means be taken to sustain and nurture my life and the life of my unborn child until birth, or at least until the child's viability, including medically assisted nutrition and hydration and all other life sustaining procedures.

End of Life

I ask that if I fall terminally ill, I be told of this so that I might prepare myself for death. I request that I be attended by a Catholic priest and be given the opportunity to receive the Sacraments of Penance, the Anointing of the Sick and the Eucharist. If I should be unconscious or otherwise incompetent, I wish the priest to offer the prayers for the dying, and, if appropriate, to administer the Sacrament of the Anointing of the Sick, including Viaticum.

PART II. POWER OF ATTORNEY FOR HEALTH CARE

Your agent may make any health care decision that you could have made while you had the capacity to make health care decisions. You may appoint an alternate agent to make health care decisions if the first agent is not willing, able or reasonably available to make health care decisions for you. Unless the persons you name as agent and alternate agent are related to you by blood, neither may own, operate or be employed by any residential long-term care institution where you are receiving care.

If you wish to appoint an agent to make health care decisions for you under these circumstances and conditions, you must fill out the section below. You may cross out any wording you do not want.

A. DESIGNATION OF AGENT: I hereby designate the following person as my agent to make health care decisions for me. If he/she is not living, willing or able, or reasonably available to

make health care decisions for me, then I designate the next listed person as my alternate agent to make health care decisions for me.

(name of individual you choose as agent)
(address) _____
(city) _____ (state) _____ (zip code) _____
(home phone) _____ (work phone) _____

(name of individual you choose as alternate agent)
(address) _____
(city) _____ (state) _____ (zip code) _____
(home phone) _____ (work phone) _____

B. AGENT'S AUTHORITY: If I am not in a condition to make decisions regarding my health care, I grant to my agent full authority to make such decisions for me; provided that, in exercising this authority, my agent shall follow my intentions as stated in this document or otherwise known to my agent. Accordingly, my agent is authorized as follows:

1. To consent to, refuse, or withdraw consent to any and all types of medical treatment, surgical procedures, diagnostic procedures, medication, and the use of mechanical or other procedures that affect any bodily function that have become useless or extraordinary;
2. To have access to medical records and information to the same extent that I am entitled to, including the right to disclose the contents to others;
3. To authorize my admission to or discharge from any hospital, nursing home, residential care, assisted living or similar facility or service;
4. To contract for any health care related service or facility on my behalf, without my agent incurring personal financial liability for such contracts;
5. To hire and fire medical, social service, and other support personnel responsible for my care; and
6. To authorize, or refuse to authorize, any medication or procedure intended to relieve pain directly (even though such use may lead to physical damage, addiction, or hasten the moment of my death as unintended possible side-effects).

C. WHEN AGENT'S AUTHORITY BECOMES EFFECTIVE: My agent's authority becomes effective when my attending physician determines I lack the capacity to make my own health care decisions.

D. AGENT'S OBLIGATION: My agent shall make health care decisions for me in accordance with the instructions I give in Part I of this form and my other intentions to the extent known to my agent. To the extent my intentions are unknown, health care decisions by my agent shall conform as closely as possible to what I would have done or intended under the circumstances. If my agent is unable to determine what I would have done or intended under the circumstances, my agent will make health care decisions for me in accordance with what my agent determines to be my best interest. In determining my best interest my agent shall at all times consider my Catholic religious values.

E. AUTHORIZATION AND CONSENT UNDER HIPAA: This ADVANCE DIRECTIVE shall constitute my direct authorization and consent under the Health Insurance Portability and Accountability Act of 1996, as amended, and the regulations thereunder ("HIPAA"). In addition, I hereby waive all rights to privacy under all federal and state laws and designate my agent as my personal representative, within the meaning of HIPAA, for the purpose of requesting, receiving, using, disclosing, amending or otherwise having access to my personal, individually identifiable health information.

I hereby authorize any health care provider to release to my agent or to any person designated by my agent, all medical records of whatever nature, mental health records, billing statements, radiological films, pathology material, photographs, videos, and other information concerning me. This ADVANCE DIRECTIVE also authorizes any health care provider to speak to and disclose orally, to my agent and any person designated by my agent, any information relating to my diagnosis, care, treatment, prognosis, and opinions with respect to me. It is my express intention that, to the greatest extent permitted by law, the authorization and consent provided herein shall be effective for so long as this ADVANCE DIRECTIVE is effective.

F. EFFECT OF COPY: A copy of this form has the same effect as the original.

STATEMENT OF WITNESSES

SIGNED and DECLARED by the above-named declarant as and for his/her written declaration under 16 *Del.C.* §§2502, 2503, in our presence, who in his/her presence, at his/her request, and in the presence of each other, have hereunto subscribed our names as witnesses, and state:

- A. The Declarant is mentally competent.
- B. That neither of us is prohibited by §2503 of Title 16 of the Delaware Code from being a witness. Neither of us:
 - 1. Is related to the declarant by blood, marriage or adoption;
 - 2. Is entitled to any portion of the estate of the declarant under any will of the declarant or codicil thereto then existing nor, at the time of the

executing of the advance health care directive, is so entitled by operation of law then existing;

3. Has, at the time of the execution of the advance health care directive, a present or inchoate claim against any portion of the estate of the declarant;
4. Has a direct financial responsibility for the declarant's medical care;
5. Has a controlling interest in or is an operator or an employee of a health care institution in which the declarant is a patient or resident; or is under eighteen years of age.

C. That if the declarant is a resident of a sanitarium, rest home, nursing home, boarding home or related institution, one of the witnesses, _____, is at the time of the execution of the advance health care directive, a patient advocate or ombudsman designated by the Division of Services for Aging and Adults with Physical Disabilities or the Public Guardian.

Signed this _____ day of _____, 20__.

(Signature of Declarant)

(Print Name)

(Address)

(City) (State) (Zip Code)

WITNESS:

(Print Name)

(Address)

(City, State, Zip Code)

(Signature of Witness) (Date)

WITNESS:

(Print Name)

(Address)

(City, State Zip Code)

(Signature of Witness) (Date)

NOTARIZATION

(Notarization is recommended, especially for those who might travel to other states, but it is not required by Delaware)

Sworn and subscribed to me this _____ day of _____, 20__

My term expires: _____

(Notary)