RHODE ISLAND
Advance Directive
Planning for Important Healthcare Decisions

Caring Connections
1731 King St., Suite 100, Alexandria, VA 22314
www.caringinfo.org
800/658-8898

Caring Connections, a program of the National Hospice and Palliative Care Organization (NHPCO), is a national consumer engagement initiative to improve care at the end of life.

Caring Connections tracks and monitors all state and federal legislation and significant court cases related to end-of-life care to ensure that our advance directives are up to date.

It's About How You LIVE

It's About How You LIVE is a national community engagement campaign encouraging individuals to make informed decisions about end-of-life care and services. The campaign encourages people to:

Learn about options for end-of-life services and care
Implement plans to ensure wishes are honored
Voice decisions to family, friends and healthcare providers
Engage in personal or community efforts to improve end-of-life care

Using these Materials

BEFORE YOU BEGIN

1. Check to be sure that you have the materials for each state in which you may receive healthcare.

2. These materials include:
    - Instructions for preparing your advance directive, please read all the instructions.
    - Your state-specific advance directive forms, which are the pages with the gray instruction bar on the left side.

ACTION STEPS

3. You may want to photocopy these forms before you start so you will have a clean copy if you need to start over.

4. When you begin to fill out the forms, refer to the gray instruction bars - they will guide you through the process.

5. Talk with your family, friends, and physicians about your advance directive. Be sure the person you appoint to make decisions on your behalf understands your wishes.

6. Once the form is completed and signed, photocopy the form and give it to the person you have appointed to make decisions on your behalf, your family, friends, healthcare providers and/or faith leaders so that the form is available in the event of an emergency.

Introduction to Your Rhode Island 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 **Rhode Island Durable Power of Attorney for Healthcare** 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 Healthcare is especially useful because it appoints someone to speak for you any time you are incapacitated, not only at the end of life.

2. The **Rhode Island Declaration** is your state's living will. It lets you state your wishes about medical care in the event that you develop an incurable or irreversible condition and can no longer make your own medical decisions. The Declaration becomes effective if, in your doctor's opinion, your death would occur without the use of life-sustaining medical care.

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

Completing Your Rhode Island Durable Power of Attorney for Healthcare

Whom should I appoint as my agent?

Your agent is the person you appoint to make decisions about your medical care if you become unable to make those decisions yourself. The person you name as your agent should clearly understand your wishes and be willing to accept the responsibility of making medical decisions for you. Your agent may be a family member or a close friend whom you trust to make serious decisions. (An agent may also be called an "attorney-in-fact" or "proxy.")

The person you appoint as your agent **cannot** be:

- your treating healthcare provider,
- an employee of your treating healthcare provider who is not related to you,
- an operator of a community care facility, or
- an employee of an operator of a community care facility who is not related to you.

You can appoint a second and third person as alternate agents. The alternates will step in, by order of selection, if the first person you name as agent is unable, ineligible or unavailable to act for you. If you appoint your spouse as your agent, he or she will become ineligible to act as your agent if your marriage is dissolved.

How do I make my Rhode Island Durable Power of Attorney for Healthcare legal?

The law requires that you sign and date your Durable Power of Attorney for Healthcare in the presence of two witnesses or one notary public. The witnesses sign the document to show that they know you and believe you to be of sound mind and under no duress, fraud or undue influence that you signed or acknowledged the signature of the document in their presence, and that they do not fall into any of the categories of people who cannot be witnesses.

These witnesses **cannot** be:

- the person you name as your agent or alternate agent(s),
- a healthcare provider,
- an employee of a healthcare provider,
- the operator of a community care facility, or
- an employee of an operator of a community care facility.

At least one of your witnesses or the notary public cannot be related to you by blood, marriage or adoption, or be entitled to any part of your estate under an existing will or by operation of law.

Note: You do not need to notarize your Rhode Island Durable Power of Attorney for Healthcare if it is signed by two qualified witnesses.

Completing Your Rhode Island Durable Power of Attorney for Healthcare (continued)

Should I add personal instructions to my Rhode Island Durable Power of Attorney for Healthcare?

One of the strongest reasons for naming an agent is to have someone who can respond flexibly as your medical situation changes and deal with situations that you did not foresee. If you add instructions to this document, you might unintentionally restrict your agent's power to act in your best interest. A statement such as, "My agent knows my wishes concerning all forms of medical treatment" is sufficient. Talk with your agent 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 the Rhode Island Declaration (the living will).

What if I change my mind?

You may revoke your Rhode Island Durable Power of Attorney for Healthcare at any time and in any manner, regardless of your mental or physical condition. Your revocation becomes effective once you, or a witness to your revocation, communicate it to your doctor or any healthcare provider, who must then make it part of your medical record.

What other important facts should I know?

Due to restrictions in the state law, a pregnant patient's Rhode Island Durable Power of Attorney for Healthcare will not be honored if it is probable that the fetus could develop to the point of live birth with continued application of life-sustaining procedures.

Completing Your Rhode Island Declaration

How do I make my Declaration legal?

In order to make your Declaration legally binding, you must sign your Declaration in the presence of two witnesses, who must also sign the document to show that they personally know you, that you voluntarily signed the document in their presence, and that they are not related to you by blood or marriage.

Note: You do not need to notarize your Rhode Island Declaration.

The Declaration becomes effective when it is communicated to your doctor, the doctor determines that you are in a terminal condition and you are unable to make treatment decisions.

Can I add personal instructions to my Declaration?

Yes. You can add personal instructions in the part of the document called "Other directions."

If you have appointed an agent, 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 agent."

What if I change my mind?

You can revoke your Rhode Island Declaration at any time and in any manner, regardless of your physical or mental condition. Your revocation becomes effective once you, or a witness to your revocation, notify your doctor or healthcare provider, who must then make the revocation part of your medical record.

What other important facts should I know?

Due to restrictions in the state law, a pregnant patient's Rhode Island Declaration will not be honored if it is probable that the fetus could develop to the point of live birth with continued application of life-sustaining procedures.

RHODE ISLAND STATUTORY FORM
DURABLE POWER OF ATTORNEY FOR HEALTH CARE – PAGE 1 OF 7

WARNING TO PERSON EXECUTING THIS DOCUMENT
(R.I. Gen. Laws 23-4.10-1 to 23-4.10-2 [1989])

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.

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.

INSTRUCTIONS

PRINT YOUR NAME AND ADDRESS

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

RHODE ISLAND STATUTORY FORM DURABLE POWER OF ATTORNEY FOR HEALTH CARE

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:

a. Statement of desires concerning life-prolonging care, treatment, services, and procedures:

ADD PERSONAL INSTRUCTIONS (IF ANY)

b. Additional statements of desires, special provisions, and limitations regarding health care decisions:

ADD PERSONAL INSTRUCTIONS (IF ANY)

(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.)

ORGAN DONATION (INITIAL IF APPLICABLE)

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

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

____ 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.

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.

PRINT EXPIRATION DATE OF YOUR DURABLE POWER OF ATTORNEY (OPTIONAL)

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.)

ALTERNATE AGENTS

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.)*

PRINT THE NAME, ADDRESS AND TELEPHONE NUMBER OF TWO ALTERNATE AGENTS

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: _____
(name of first agent)

ALTERNATE #1

_____

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

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

ALTERNATE #2

_____

_ _
(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.

DATE YOUR DOCUMENT AND PRINT YOUR CITY AND STATE OF RESIDENCE

SIGN YOUR DOCUMENT HERE

WITNESSING PROCEDURE

YOUR WITNESSES MUST DATE AND SIGN YOUR DOCUMENT ON THE NEXT PAGE THEY MUST ALSO PRINT THEIR NAMES AND ADDRESSES

DATE AND SIGNATURE OF PRINCIPAL

(YOU MUST DATE AND SIGN THIS POWER OF ATTORNEY)

I sign my name to this Statutory Form Durable Power of Attorney For Health Care on _____ (date) at _____ (city), _____ (state).

_____
(you sign here)

(THIS POWER OF ATTORNEY WILL NOT BE VALID UNLESS IT IS SIGNED BY ONE NOTARY PUBLIC OR 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.)

STATEMENT OF WITNESSES

This document must be witnessed by two (2) qualified adult witnesses or one (1) notary public. None of the following may be used as a witness:

1. A person you designate as your agent or alternate agent,
2. A health care provider,
3. An employee of a health care provider,
4. The operator of a community care facility,
5. An employee of an operator of a community care facility.

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.

WITNESS #1

Signature: _____

Print Name: _____

Residence Address: _____

_____

Date: _____

WITNESS #2

Signature: _____

Print Name: _____

Residence Address: _____

_____

Date: _____

ONE WITNESS MUST AGREE WITH THIS STATEMENT AND SIGN AND PRINT HIS OR HER NAME BELOW

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

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: _____

Print Name: _____

Signature: _____

Print Name: _____

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

INSTRUCTIONS

PRINT YOUR NAME

ADD PERSONAL INSTRUCTIONS (IF ANY)

CHECK THE OPTION THAT REFLECTS YOUR WISHES

SIGN AND DATE THE DOCUMENT AND PRINT YOUR ADDRESS

RHODE ISLAND DECLARATION – PAGE 1 OF 2

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.

Other directions:

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

Signed this _____ day of _____, 20 _____.
(date) (month) (year)

Signature _

Address _

_ _

RHODE ISLAND DECLARATION - PAGE 2 OF 2

WITNESSING PROCEDURE

YOUR WITNESSES MUST SIGN AND PRINT THEIR ADDRESSES

The declarant is personally known to me and voluntarily signed this document in my presence. I am not related to the declarant by blood or marriage.

Witness _____

Address _____

_____

Witness _____

Address _____

_____

Courtesy of Caring Connections
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www.caringinfo.org, 800/658-8898

You Have Filled Out Your Advance Directive, Now What?

1. Your Rhode Island Durable Power of Attorney for Healthcare and Rhode Island 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 agent and alternate agent(s), doctor(s), family, close friends, clergy and anyone else who might become involved in your healthcare. 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 agent and alternates, 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 Rhode Island documents.

6. Be aware that your Rhode Island 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 "non-hospital 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 non-hospital do-not-resuscitate orders. We suggest you speak to your physician for more information. **Caring Connections does not distribute these forms.**