DISTRICT OF COLUMBIA
Advance Directive
Planning for Important Health Care 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.

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 health care providers
Engage in personal or community efforts to improve end-of-life care

Note: The following is not a substitute for legal advice. While Caring Connections updates the following information and form to keep them up-to-date, changes in the underlying law can affect how the form will operate in the event you lose the ability to make decisions for yourself. If you have any questions about how the form will help ensure your wishes are carried out, or if your wishes do not seem to fit with the form, you may wish to talk to your health care provider or an attorney with experience in drafting advance directives.

Using these Materials

BEFORE YOU BEGIN

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

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

1. You may want to photocopy or print a second set of these forms before you start so you will have a clean copy if you need to start over.

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

3. 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.

4. 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, health care providers and/or faith leaders so that the form is available in the event of an emergency.

5. You may also want to save a copy of your form in Google Health, or another online medical records management 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. You can read more about Google Health at http://www.caringinfo.org/googlehealth.

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:

The **District of Columbia Durable Power of Attorney for Health Care** lets you name someone to make decisions about your medical care — called an attorney-in-fact — if you can no longer speak for yourself. The durable power of attorney for health care is especially useful because your attorney-in-fact can speak for you any time you are unable to make your own medical decisions, not only at the end of life.

Your durable power of attorney for health care goes into effect when your doctor determines that you are no longer able to make or communicate your health-care decisions.

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.

Your declaration goes into effect if you have an incurable condition that will lead to your death, with or without the use of life-sustaining medical care, and life-sustaining procedures would serve only to postpone your death.

In addition to these advance directive documents, a **District of Columbia Organ Donation Form** is included in this packet.

These forms do not expressly address mental illness. If you would like to make advance care plans involving mental illness, you should talk to your physician and an attorney about a durable power of attorney.

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

COMPLETING YOUR DISTRICT OF COLUMBIA ADVANCE DIRECTIVE FORMS

Whom should I appoint as my attorney-in-fact?

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 may 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. Your attorney-in-fact does not have to be a lawyer.

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

How do I make my Advance Directive Forms legal?

Each of the three forms included in this packet must be signed in the presence of two adult witnesses. Each form has its own restrictions regarding who can witness your signature.

Your signature on your durable power of attorney for health care cannot be witnessed by your attorney-in-fact, your health-care provider, or your health-care provider's employees. 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 any part of your estate.

Your signature on your declaration cannot be witnessed by a person signing on your behalf, anyone related to you (by blood, marriage, or adoption), anyone who will inherit any part of your estate, anyone directly financially responsible for your medical care, your attending doctor or an employee of your attending doctor, or 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.

At least one of the witnesses to your signature on your organ donation form must be disinterested. This means that the witness should not be a person who could receive your organs or any portion of your estate.

Note: You do not need to notarize your Durable Power of Attorney for Health care, Declaration, or Organ Donation Form.

Should I add personal instructions to my Durable Power of Attorney for Health care or my Declaration?

One of the strongest reasons for naming an attorney-in-fact 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 your durable power of attorney or your declaration it may help your attorney-in-fact carry out your wishes, but be careful that you do not unintentionally restrict your attorney-in-fact's power to act in your best interest. In any event, be sure to talk with your attorney-in-fact about your future medical care and describe what you consider to be an acceptable "quality of life."

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, or
- executing a new durable Power of Attorney for Health care.

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

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;
- 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.

INTRODUCTION

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

PRINT YOUR NAME AND ADDRESS

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

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

DISTRICT OF COLUMBIA DURABLE POWER OF ATTORNEY FOR HEALTH CARE

I, _____, of
(name)
_____, hereby appoint:
(home address)

_____
(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:

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)

DISTRICT OF COLUMBIA DURABLE POWER OF ATTORNEY FOR HEALTH CARE — PAGE 3 OF 4

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

PRINT THE DATE AND YOUR LOCATION AND SIGN THE DOCUMENT

YOUR WITNESSES MUST SIGN THE DOCUMENT ON THE NEXT PAGE

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.

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

_____
_____
_____
_____
_____

Special provisions and limitations:

_____
_____
_____
_____
_____

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)

DISTRICT OF COLUMBIA DURABLE POWER OF ATTORNEY FOR HEALTH CARE — PAGE 4 OF 4

WITNESSING PROCEDURE

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

WITNESS #1

WITNESS #2

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

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.

First Witness' Signature: _____

Home Address: _____

Print Name: _____

Date: _____

Second Witness' Signature: _____

Home Address: _____

Print Name: _____

Date: _____

(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, adoption, or domestic partnership, and that 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: _____ Date _____

Signature: _____ Date _____

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

INSTRUCTIONS

PRINT THE DATE

PRINT YOUR NAME

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

DISTRICT OF COLUMBIA DECLARATION – PAGE 1 OF 2

Declaration made this _____ day of _____.
(date) (month, year)

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.

Other directions:

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

DISTRICT OF COLUMBIA DECLARATION — PAGE 2 OF 2

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.

SIGN AND DATE THE DOCUMENT AND PRINT YOUR ADDRESS

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

Signed _____ Date_____

Address _____

WITNESSING PROCEDURE

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, marriage, or domestic partnership, 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.

TWO WITNESSES MUST SIGN AND DATE HERE

Witness _____ Date_____

Witness _____ Date_____

ORGAN DONATION (OPTIONAL)

INITIAL THE OPTION THAT REFLECTS YOUR WISHES

ADD NAME OR INSTITUTION (IF ANY)

PRINT YOUR NAME, SIGN, AND DATE THE DOCUMENT

YOUR WITNESSES MUST SIGN AND PRINT THEIR ADDRESSES

AT LEAST ONE WITNESS MUST BE A DISINTERESTED PARTY

DISTRICT OF COLUMBIA ORGAN DONATION FORM

Initial the line next to the statement below that best reflects your wishes. You do not have to initial any of the statements. If you do not initial any of the statements, your attorney for health care, proxy, or other agent, or your family, may have the authority to make a gift of all or part of your body under District of Columbia law.

_____ I do not want to make an organ or tissue donation and I do not want my attorney for health care, proxy, or other agent or family to do so.
_____ I have already signed a written agreement or donor card regarding organ and tissue donation with the following individual or institution:

Name of individual/institution:_____

_____ Pursuant to District of Columbia law, I hereby give, effective on my death:

_____ Any needed organ or parts.
_____ The following part or organs listed below:

For (initial one):

_____ Any legally authorized purpose.
_____ Transplant or therapeutic purposes only.

Declarant name_____

Declarant signature_____Date_____

The declarant voluntarily signed or directed another person to sign this writing in my presence.

Witness _____Date_____

Address _____

_____

I am a disinterested party with regard to the declarant and his or her donation and estate. The declarant voluntarily signed or directed another person to sign this writing in my presence.

Witness _____Date_____

Address _____

_____

Courtesy of Caring Connections
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You Have Filled Out Your Health Care Directive, Now What?

1. Your durable 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 original to your attorney-in-fact and alternates, 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 attorney(s)-in-fact, 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 Google Health, or another online medical records management 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. You can read more about Google Health at http://www.caringinfo.org/googlehealth.

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 District of Columbia document.

7. Be aware that your District of Columbia 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” or “do not resuscitate orders” 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 jurisdictions have laws authorizing these orders. We suggest you speak to your physician if you are interested in obtaining one. **Caring Connections does not distribute these forms.**