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, supported by a grant from The Robert Wood Johnson Foundation.

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

Please call the HelpLine at 800/658-8898 to learn more about the LIVE campaign, obtain free resources, or join the effort to improve community, state and national end-of-life care.

If you would like to make a contribution to help support our work, please visit [www.nationalhospicefoundation.org/donate](http://www.nationalhospicefoundation.org/donate). Contributions to national hospice programs can also be made through the Combined Health Charities or the Combined Federal Campaign by choosing #0544.

**Support for this program is provided by a grant from The Robert Wood Johnson Foundation, Princeton, New Jersey.**
Your Advance Care Planning Packet

Using these Materials 3

Summary of the HIPAA Privacy Rule 4

Introduction to Your State Advance Directive 6

Instructions for Completing Your State Advance Directive for Health Care 7


Glossary of Terms about End-of-Life Decision-making Appendix A

Legal & End-Of-Life Care Resources Pertaining to Health Care Advance Directives Appendix B
Using These Materials

BEFORE YOU BEGIN
1. Check to be sure that you have the materials for each state in which you could receive health care.

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

PREPARING TO COMPLETE YOUR ADVANCED DIRECTIVE
3. Read the HIPAA Privacy Rule Summary on page 4.

4. Read all the instructions, on pages 7 through 10, as they will give you specific information about the requirements in your state.

5. Refer to the Glossary of Terms About End-of-Life Decision-making if any of the terms are unclear, located in Appendix A.

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

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

8. 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.

9. 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.

If you have questions or need guidance in preparing your advance directive or about what you should do with it after you have completed it, please refer to the list of state-specific contacts for Legal Assistance for Questions Pertaining to Health Care Advance Directives located in Appendix B.
Summary of the HIPAA Privacy Rule

HIPAA is a federal law that gives you rights over your health information and sets rules and limits on who can look at and receive your health information.

Your Rights

You have the right to:
• Ask to see and get a copy of your health records.
• Have corrections added to your health information.
• Receive a notice that tells you how your health information may be used and shared.
• Decide if you want to give your permission before your health information can be used or shared for certain purposes, such as marketing.
• Get a report on when and why your health information was shared for certain purposes.
• If you believe your rights are being denied or your health information isn't being protected, you can
  File a complaint with your provider or health insurer
  File a complaint with the U.S. Government

You also have the right to ask your provider or health insurer questions about your rights. You also can learn more about your rights, including how to file a complaint from the Web site at www.hhs.gov/ocr/hipaa/ or by calling 1-866-627-7748.

Who Must Follow this Law?

• Doctors, nurses, pharmacies, hospitals, clinics, nursing homes, and many other health care providers.
• Health insurance companies, HMOs, most employer group health plans.
• Certain government programs that pay for health care, such as Medicare and Medicaid.

What Information is Protected?

• Information your doctors, nurses, and other health care providers put in your medical record.
• Conversations your doctor has about your care or treatment with nurses and others.
• Information about you in your health insurer's computer system.
• Billing information about you by your clinic / health care provider.
• Most other health information about you held by those who must follow this law.
Providers and health insurers who are required to follow this law must keep your information private by:

- Teaching the people who work for them how your information may and may not be used and shared.
- Taking appropriate and reasonable steps to keep your health information secure.

To make sure that your information is protected in a way that does not interfere with your health care, your information can be used and shared:

- For your treatment and care coordination.
- To pay doctors and hospitals for your health care and help run their businesses.
- With your family, relatives, friends or others you identify who are involved with your health care or your health care bills, unless you object.
- To make sure doctors give good care and nursing homes are clean and safe.
- To protect the public's health, such as by reporting when the flu is in your area.
- To make required reports to the police, such as reporting gunshot wounds.

Your health information cannot be used or shared without your written permission unless this law allows it. For example, without your authorization, your provider generally cannot:

- Give your information to your employer.
- Use or share your information for marketing or advertising purposes.
- Share private notes about your mental health counseling sessions.
INTRODUCTION TO YOUR DELAWARE ADVANCE HEALTH CARE DIRECTIVE

This packet contains a legal document, the **Delaware Advance Health Care Directive**, that protects 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. **Section I, Power of Attorney for Health Care**, lets you name someone (an agent) to make decisions about your medical care. The Power of Attorney for Health Care becomes effective when it is determined that you can no longer understand the benefits or risks of or alternatives to proposed health care, or you can no longer make and communicate your health care decisions. However, your agent may only make decisions regarding the providing, withholding or withdrawal of life-sustaining treatment if you also have a qualifying condition.

2. **Section II, Instructions for Health Care**, is your state’s living will. It lets you state your wishes about medical care in the event that you can no longer speak for yourself and you have a qualifying condition.

Under Delaware law you have a qualifying condition when your attending physician and one other physician determine, in writing, that you have one or more of the following conditions:

   a) *terminal condition*: you have an illness or condition for which there is no reasonable medical expectation of recovery which will result in death regardless of the use or discontinuance of life-sustaining procedures.

   b) *permanent unconsciousness*: you have been diagnosed as having a total and irreversible loss of consciousness and capacity for interaction with your environment for at least 4 weeks. This includes a persistent vegetative state or irreversible coma.

Although you have the option to complete only one part of this document, Caring Connections suggests that you complete Section I and Section II 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 or an emancipated minor.*
INTRODUCTION TO YOUR DELAWARE ADVANCE HEALTH CARE DIRECTIVE
(CONTINUED)

How do I make my advance health care directive legal?

The law requires that you sign and date your advance health care directive in the presence of two witnesses who are eighteen years of age or older. If you are unable to sign the document, another person may sign the document for you in your presence and at your direction. Your witnesses cannot:

- be related to you by blood, marriage or adoption,
- be entitled to any portion of your estate,
- have a claim against any portion of your estate,
- be directly financially responsible for your health care, or
- be an operator or employee of, or have a controlling interest in, a health-care institution in which you are a patient or reside.

If you are a resident of a sanitarium, rest home, nursing home, boarding home or related institution, then one of your witnesses must be a person designated as a patient advocate or ombudsman. The patient advocate or ombudsman must have the qualifications required of other witnesses. In addition to signing as a witness, the patient advocate or ombudsman must print his/her name in paragraph 13(C).

Are there any important facts that I should know?

Section III of your Delaware Advance Health Care Directive is an optional section that allows you to designate a physician to have primary responsibility for your health care.

Section IV of your Delaware Advance Health Care Directive is an optional section that allows you to record your wishes regarding organ donation.

A copy of your Delaware Advance Directive has the same effect as the original.
COMPLETING SECTION I: POWER OF ATTORNEY FOR HEALTH CARE

Whom should I appoint as my agent?

A health care agent is the person you appoint to make decisions about your medical care if you become unable to make and communicate these decisions yourself. Your agent can be a family member or a close friend whom you trust to make serious decisions. 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.

The person you appoint as your agent cannot be an operator or employee of, or have a controlling interest in, a residential long-term health-care institution at which you receive care unless he or she is related to you by blood, marriage or adoption.

You can appoint a second and third person as your alternative agents. An alternative agent will step in if the person you name as agent is unable, unwilling or unavailable to act for you.

Should I add personal instructions to my Power of Attorney?

You can use the space provided under paragraph (2) to limit your agent’s authority. Unless the form you sign limits the authority of your agent, your agent may make all health care decisions for you including:

(a) selecting or discharging health-care providers and institutions; and
(b) consenting or refusing consent to any care, treatment, service or procedure to maintain, diagnose or otherwise affect your physical or mental condition, unless it is a life-sustaining procedure. Your agent may make decisions regarding the providing, withholding or withdrawal life-sustaining treatment only if you have a qualifying condition (as defined above). If you also have a qualifying condition, your agent may make all health care decisions for you, including the following:
(c) the decisions listed in (a) and (b) above;
(d) consenting or refusing consent to life-sustaining procedures such as cardiopulmonary resuscitation and orders not to resuscitate;
(e) direction the provision, withholding or withdrawal of artificial nutrition and hydration and all other forms of health care.

One of the strongest reasons for naming a health care agent is to have someone who can respond effectively as your medical condition changes and can deal with situations that you did not foresee.

We urge you to talk with your health care 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 can use Section II of this document, Instructions for Health Care.
What if I change my mind?

If you wish to cancel your Power of Attorney for Health Care you may do so (1) through a signed writing, (2) by completing a new Advance Health Care Directive, or (3) in any other manner that communicates your intent to revoke in front of two competent persons, one of whom is a health care provider. If your revocation is not in writing, someone must put it in writing and both witnesses must sign and date it.

Are there any important facts I should know?

If you designate your spouse as your agent, that designation will automatically be revoked if a petition for divorce is filed or your marriage is annulled, unless you specify otherwise in the divorce or annulment decree or in your Power of Attorney for Health Care.

Paragraphs (3) and (4) contain various statements about your agent’s authority. Cross out and initial any portion of these statements that do not reflect your wishes.

Paragraph (5) nominates your agent, alternate agents or another person to be your court-appointed guardian should one become necessary. To avoid confusion, Caring Connections suggests that you nominate your health care agent.
COMPLETING SECTION II: INSTRUCTIONS FOR HEALTH CARE

Can I add personal instructions to my Instructions for Health Care?

Yes. Paragraphs (6) and (7) allow you to include instructions about certain care and treatment. If there are any specific instructions that you would like to include that are not already listed on the document, you may list them in paragraph (8). For example, you may want to include a sentence such as, “I especially do not want cardiopulmonary resuscitation, a respirator or antibiotics.”

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 Instructions for Health Care are to be decided by my agent.”

What if I change my mind?

If you wish to revoke all or part of your advance health care directives, you may do so (1) through a signed writing, (2) by completing a new Advance Health Care Directive, or (3) in any other manner that communicates your intent to revoke the advance health care directive as long as it is done in the presence of two competent persons, one of whom is a health cadre providers. If you revocation is not in writing, someone must put it in writing and both witnesses must sign and date it.

Are there any important facts I should know?

Under Delaware law, a life-sustaining procedure may not be withheld or withdrawn from a patient known to be pregnant, so long as it is probable that the fetus will develop to be viable outside the uterus with the continued application of life-sustaining procedures.

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

If you have questions about filling out your advance directive, please consult the list of state-based resources located in Appendix B.
You Have Filled Out Your Advance Directive, Now What?

Your Delaware Advance Health Care 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.

1. Give photocopies of the signed originals to your agent and alternate 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.

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

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

4. Remember, you can always revoke one or both sections of your Delaware Advance Health Care Directive.

5. Be aware that your Delaware 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. Caring Connections does not distribute these forms.

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. Caring Connections does not distribute these forms. We suggest you speak to your physician.

If you would like more information about this topic contact Caring Connections and ask about the booklet “Cardiopulmonary Resuscitation, Do-Not-Resuscitate Orders and End-Of-Life Decisions.”
EXPLANATION

You have the right to give instructions about your own health care. You also have the right to name someone else to make health-care decisions for you. This form lets you do either or both of these things. It also lets you express your wishes regarding anatomical gifts and the designation of your primary physician. If you use this form, you may complete or modify all or any part of it. You are free to use a different form.

SECTION I
POWER OF ATTORNEY FOR HEALTH CARE

(1) DESIGNATION OF AGENT: I designate the following person as my agent to make health care decisions for me:

____________________________________________________________
(name of agent)

____________________________________________________________
(address)

____________________________________________________________
(city) (state) (zip code)

____________________________________________________________
(home phone) (work phone)

If I revoke the authority of my agent or if my agent is not willing, able, or reasonably available to make health care decisions for me, I designate as my first alternate agent:

____________________________________________________________
(name of first alternate agent)

____________________________________________________________
(address)

____________________________________________________________
(city) (state) (zip code)

____________________________________________________________
(home phone) (work phone)
If I revoke the authority of my agent and first alternate agent or if neither is willing, able or reasonably available to make a health care decision for me, I designate as my second alternate:

____________________________________________________________
(name of second alternate agent)

____________________________________________________________
(address)

____________________________________________________________
(city)     (state)   (zip code)

____________________________________________________________
(home phone)    (work phone)

(2) AGENT’S AUTHORITY: If I do not have a qualifying condition my agent is authorized to make all health-care decisions for me, except decisions about life-sustaining procedures and as I state here:

and if I have a qualifying condition, my agent is authorized to make all health-care decisions for me, except as I state here:
(3) WHEN AGENT’S AUTHORITY BECOMES EFFECTIVE: My agent’s authority becomes effective when my primary physician determines that I lack the capacity to make my own health-care decisions. As to decisions concerning providing, withholding and withdrawal of life-sustaining procedures, my agent’s authority becomes effective when my primary physician determines I lack the capacity to make my own health-care decisions and my primary physician and another physician determine I am in a terminal condition or permanently unconscious.

(4) AGENT’S OBLIGATION: My agent shall make health-care decisions for me in accordance with this power of attorney for healthcare, any instructions I give in Section II of this form, and my other wishes to the extent known to my agent. To the extent my wishes are unknown, my agent shall make health-care decisions for me in accordance with what my agent determines to be in my best interest. In determining my best interest, my agent shall consider my personal values to the extent known to my agent.

(5) NOMINATION OF GUARDIAN: If a guardian of my person needs to be appointed for me by a court:

_____ I nominate the agent(s) whom I named in this form in the order designated to act as guardian.

_____ I nominate the following to be guardians in the order designated:

___________________________________________________________
___________________________________________________________

_____ I do not nominate anyone to be guardian.
(6) END-OF-LIFE DECISIONS: If I can no longer make my own decisions and I have a qualifying condition, I direct that my health care providers and others involved in my care provide, withhold or withdraw treatment in accordance with the choice I have marked below:

A. Choice To Prolong Life:

_____ I want my life to be prolonged as long as possible within the limits of generally accepted health care standards.

B. Choice NOT To Prolong Life:

_____ I do not want my life to be prolonged if I have a terminal condition (an incurable condition caused by injury, disease or illness which to a reasonable degree of medical certainty, makes death imminent and from which, despite the application of life sustaining procedures, there can be no recovery.) I make the following instructions regarding artificial nutrition and hydration if I have a terminal condition:

Artificial Nutrition  _____ I want  _____ I do not want
Artificial Hydration  _____ I want  _____ I do not want

_____ I do not want my life to be prolonged if I become permanently unconscious (a medical condition that has been diagnosed in accordance with currently accepted medical standards that has lasted at least 4 weeks and with reasonable medical certainty as total irreversible loss of consciousness and capacity for interaction with the environment. The term includes, without limitation, a persistent vegetative state or irreversible coma.)

I make the following instructions regarding artificial nutrition and hydration if I become permanently unconscious:

Artificial Nutrition  _____ I want  _____ I do not want
Artificial Hydration  _____ I want  _____ I do not want
(7) RELIEF FROM PAIN OR DISCOMFORT: Except as I state in the following space, I direct that treatment for alleviation of pain or discomfort be provided at all times, even if it hastens my death.

(8) OTHER HEALTH CARE INSTRUCTIONS OR WISHES: (add additional pages if needed)

SECTION III
DESIGNATION OF PRIMARY PHYSICIAN

(9) I designate the following physician as my primary physician:

___________________________________________________________
(name of physician)

___________________________________________________________
(address)

___________________________________________________________
(city) (state) (zip code)

___________________________________________________________
(phone)
(10) I am mentally competent and 18 years or more of age. I hereby make this anatomical gift to take effect upon my death. The marks in the appropriate lines and words filled into the blanks below indicate my desires.

I give:

_____ My body

_____ any needed organs or parts

_____ the following organ or parts:________________________________

To the following person or institutions:

_____ the physician in attendance at my death

_____ the hospital at which I die

_____ the following named physician, hospital storage bank or medical institution:________________________________________

_____ the following individual for treatment_______________________

For the following purposes:

_____ any purpose authorized by law

_____ transplantation

_____ therapy

_____ research

_____ medical education

(11) EFFECT OF A COPY: A copy of this form has the same effect as the original.
(12) SIGNATURE OF DECLARANT

____________________________________________________________________________________
(name)

____________________________________________________________________________________
(address)

____________________________________________________________________________________
(date)

____________________________________________________________________________________
(signature)

(13) STATEMENT OF WITNESSES

SIGNED AND DECLARED by the above named-declarant as and for his/her written declaration under 16 Del.C. §§2502 and 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. That the declarant is mentally competent.

B. That 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 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 direct financial responsibility for the declarant's medical care;
5. Has a controlling interest in or is an operator or employee of a health-care institution in which the declarant is a resident or patient; or
6. 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.

Signature of First Witness:

____________________________________________________________
(print name of first witness)

____________________________________________________________
(address of first witness)

____________________________________________________________
(signature of first witness)

____________________________________________________________
(date)

Signature of Second Witness

____________________________________________________________
(print name of second witness)

____________________________________________________________
(address of second witness)

____________________________________________________________
(signature of second witness)

____________________________________________________________
(date)
Appendix A

Glossary of Terms About End-of-life Decision Making

**Advance directive** - A general term that describes two kinds of legal documents, living wills and medical powers of attorney. These documents allow a person to give instructions about future medical care should he or she be unable to participate in medical decisions due to serious illness or incapacity. Each state regulates the use of advance directives differently.

**Artificial nutrition and hydration** - Artificial nutrition and hydration (or tube feeding) supplements or replaces ordinary eating and drinking by giving a chemically balanced mix of nutrients and fluids through a tube placed directly into the stomach, the upper intestine or a vein.

**Assisted Suicide** - Providing someone the means to commit suicide, such as a supply of drugs or a weapon, knowing the person will use these to end his or her life.

**Best Interest** - In the context of refusal of medical treatment or end-of-life court opinions, a standard for making health care decisions based on what others believe to be "best" for a patient by weighing the benefits and the burdens of continuing, withholding or withdrawing treatment.

**Brain Death** - The irreversible loss of all brain function. Most states legally define death to include brain death.

**Capacity** - In relation to end-of-life decision-making, a patient has medical decision making capacity if he or she has the ability to understand the medical problem and the risks and benefits of the available treatment options. The patient's ability to understand other unrelated concepts is not relevant. The term is frequently used interchangeably with competency but is not the same. Competency is a legal status imposed by the court.

**Cardiopulmonary Resuscitation** - Cardiopulmonary resuscitation (CPR) is a group of treatments used when someone's heart and/or breathing stops. CPR is used in an attempt to restart the heart and breathing. It may consist only of mouth-to-mouth breathing or it can include pressing on the chest to mimic the heart's function and cause blood to circulate. Electric shock and drugs also are used frequently to stimulate the heart.

**Do-Not-Resuscitate (DNR) order** - A DNR order is a physician's written order instructing health care providers not to attempt cardiopulmonary resuscitation (CPR) in case of cardiac or respiratory arrest. A person with a valid DNR order will not be given CPR under these circumstances. Although the DNR order is written at the request of a person or his or her family, it must be signed by a physician to be valid. A non-hospital DNR order is written for individuals who are at home and do not want to receive CPR.

**Emergency Medical Services (EMS):** A group of governmental and private agencies that provide emergency care, usually to persons outside of health care facilities; EMS personnel generally include paramedics, first responders and other ambulance crew.
**Euthanasia** - The term traditionally has been used to refer to the hastening of a suffering person's death or "mercy killing". Voluntary active euthanasia involves an intervention requested by a competent individual that is administered to that person to cause death, for example, if a physician gives a lethal injection with the patient's full informed consent. Involuntary or non-voluntary active euthanasia involves a physician engaging in an act to end a patient's life without that patient's full informed consent. See also Physician-hastened Death (sometimes referred to as Physician-assisted Suicide).

**Guardian ad litem** - Someone appointed by the court to represent the interests of a minor or incompetent person in a legal proceeding.

**Healthcare Agent** - The person named in an advance directive or as permitted under state law to make healthcare decisions on behalf of a person who is no longer able to make medical decisions.

**Hospice care** - A program model for delivering palliative care to individuals who are in the final stages of terminal illness. In addition to providing palliative care and personal support to the patient, hospice includes support for the patient's family while the patient is dying, as well as support to the family during their bereavement.

**Incapacity** - A lack of physical or mental abilities that results in a person's inability to manage his or her own personal care, property or finances; a lack of ability to understand one's actions when making a will or other legal document.

**Incompetent** - Referring to a person who is not able to manage his/her affairs due to mental deficiency (lack of I.Q., deterioration, illness or psychosis) or sometimes physical disability. Being incompetent can be the basis for appointment of a guardian or conservator.

**Intubation** - Refers to "endotracheal intubation" the insertion of a tube through the mouth or nose into the trachea (windpipe) to create and maintain an open airway to assist breathing.

**Life-Sustaining Treatment** - Treatments (medical procedures) that replace or support an essential bodily function (may also be called life support treatments). Life-sustaining treatments include cardiopulmonary resuscitation, mechanical ventilation, artificial nutrition and hydration, dialysis, and certain other treatments.

**Living Will** - A type of advance directive in which an individual documents his or her wishes about medical treatment should he or she be at the end of life and unable to communicate. It may also be called a “directive to physicians”, “health care declaration,” or “medical directive.” The purpose of a living will is to guide family members and doctors in deciding how aggressively to use medical treatments to delay death.
**Mechanical ventilation** - Mechanical ventilation is used to support or replace the function of the lungs. A machine called a ventilator (or respirator) forces air into the lungs. The ventilator is attached to a tube inserted in the nose or mouth and down into the windpipe (or trachea). Mechanical ventilation often is used to assist a person through a short-term problem or for prolonged periods in which irreversible respiratory failure exists due to injuries to the upper spinal cord or a progressive neurological disease.

**Medical power of attorney** - A document that allows an individual to appoint someone else to make decisions about his or her medical care if he or she is unable to communicate. This type of advance directive may also be called a health care proxy, durable power of attorney for health care or appointment of a health care agent. The person appointed may be called a health care agent, surrogate, attorney-in-fact or proxy.

**Palliative care** - A comprehensive approach to treating serious illness that focuses on the physical, psychological, spiritual, and existential needs of the patient. Its goal is to achieve the best quality of life available to the patient by relieving suffering, by controlling pain and symptoms, and by enabling the patient to achieve maximum functional capacity. Respect for the patient's culture, beliefs, and values are an essential component. Palliative care is sometimes called “comfort care” or “hospice type care.”

**Power of Attorney** - A legal document allowing one person to act in a legal matter on another’s behalf pursuant to financial or real estate transactions.

**Respiratory Arrest** - The cessation of breathing - an event in which an individual stops breathing. If breathing is not restored, an individual's heart eventually will stop beating, resulting in cardiac arrest.

**Surrogate Decision-Making** - Surrogate decision-making laws allow an individual or group of individuals (usually family members) to make decisions about medical treatments for a patient who has lost decision-making capacity and did not prepare an advance directive. A majority of states have passed statutes that permit surrogate decision making for patients without advance directives.

**Ventilator** - A Ventilator, also known as a respirator, is a machine that pushes air into the lungs through a tube placed in the trachea (breathing tube). Ventilators are used when a person cannot breathe on his or her own or cannot breathe effectively enough to provide adequate oxygen to the cells of the body or rid the body of carbon dioxide.

**Withholding or withdrawing treatment** - Forgoing life-sustaining measures or discontinuing them after they have been used for a certain period of time.
Appendix B

Legal & End-of-Life Care Resources Pertaining to Health Care Advance Directives

LEGAL SERVICES
The Delaware Community Legal Aide Society, Inc. provides legal assistance to individuals age 60 and older. There are no financial eligibility requirements.

Anyone over the age of 60 can get legal advice and information about most issues, including:
- Power of Attorney and Advance Directives
- Consumer problems
- Housing
- Benefits and more

- Must be 60 and older
- No financial eligibility required

Visit their website: [http://www.decommunitylegalaid.org/eld.html](http://www.decommunitylegalaid.org/eld.html)

OR

Call toll free 9-4:30 Monday thru Thursday and 9 to 12:30 on Friday: 1-800-773-0606 to be connected the appropriate office

END-OF-LIFE SERVICES
The Council for Older Adults in Delaware (COAD) can assist older individuals with maintaining a quality and independent life style through a variety of services and programs.

Older individuals in the state of Delaware can receive information on services including, but not limited to:
- Home Heath Care
- Caregiving
- Legal Assistance
- Housing
- Nursing Home
- Senior Nutrition Programs
- Adult Daycare

- Must be over 60
- There is a sliding fee scale based on income and assets. A car and one house would not be considered as an asset unless you have more than one of each.

To find out about other services and programs visit their website:
[http://www.growingolder.org/](http://www.growingolder.org/)

OR

Call toll free: 800-994-2255 or 740-363-6677