AARP® | Medicare Supplement Plans insured by UnitedHealthcare Insurance Company

MyDirectives®

ADVANCE CARE PLAN
for

It is very important for you to discuss your medical treatment goals and wishes with your healthcare advocates, your family, and your medical team. Advance care plans are simply expressions of your medical treatment goals, preferences and priorities. There is no guarantee that your medical care team, including your doctors, will follow all of your wishes. It is still important to document your wishes and talk with your advocates and care team about them so they know what your preferences are in case you cannot speak for yourself.

Part 1 – Appointment of a Primary Healthcare Advocate (may also be referred to as a Healthcare Agent, Proxy or Substitute Decision-Maker) and Alternate Healthcare Advocates

I am appointing the person or persons below as my healthcare advocate(s) and, if applicable, as my alternate healthcare advocate(s), and I am granting to each of them the authority to make medical treatment decisions on my behalf and to consult with my doctors and others, when necessary. The power to make medical treatment decisions that I am granting to my healthcare advocate(s) is expressly subject to, and limited by, the choices that I have expressed below. If my medical treatment choices are not clear, then subject to any limitations I have placed on my healthcare advocate(s), I am authorizing and directing my healthcare advocate(s) to make decisions in my best interests and based on what is known of my wishes.

The person I choose as my Primary Healthcare Advocate is:

Name: _____ Relationship: _____
Primary Phone: _____ Secondary Phone: _____
Address: _____
City: _____ State: _____ ZIP code: _____

If this healthcare advocate is unable or unwilling to make medical treatment decisions for me, or if my spouse is designated as my primary healthcare advocate and our marriage is annulled, or we are divorced or legally separated, **then my next choice for a healthcare advocate is:**

First Alternate Healthcare Advocate

Name: _____ Relationship: _____
Primary Phone: _____ Secondary Phone: _____
Address: _____
City: _____ State: _____ ZIP code: _____

If this alternate healthcare advocate is unable or unwilling to make medical treatment decisions for me, or if my spouse is designated as my first alternate healthcare advocate and our marriage is annulled, or we are divorced or legally separated, **then my next choice for a healthcare advocate is:**

Second Alternate Healthcare Advocate

Name: _____ Relationship: _____
Primary Phone: _____ Secondary Phone: _____
Address: _____
City: _____ State: _____ ZIP code: _____

My Healthcare Advocate's General Authority

Subject to my medical treatment choices expressed below and applicable law that requires otherwise, I grant to my healthcare advocate(s) the power to make choices and medical treatment decisions for me.

Here are some specific instructions that expand or limit the powers I have just granted to my healthcare advocate(s): _____.

If there is time, I would like my healthcare advocate(s), or the doctors on duty if I have not chosen a healthcare advocate, to consult with the following people prior to making medical treatment decisions on my behalf:

Name: _____ Relationship: _____
Primary Phone: _____ Secondary Phone: _____
Address: _____
City: _____ State: _____ ZIP code: _____

Part 2 – Expression of Medical Treatment Wishes and Desires

If I cannot express my own medical treatment wishes, I would like the doctors treating me, as well as my healthcare advocate, to make decisions based as much as possible and appropriate on my instructions below.

My Advance Care Priorities

If I cannot express my own medical treatment wishes, then I want my medical team to know that these are the things that are most important to me:

- ☐ Being free from pain
- ☐ Being with my family
- ☐ Being able to feed, bathe, and take care of myself
- ☐ Not being a financial burden to my family
- ☐ Not being a physical burden to my family
- ☐ Being at peace spiritually
- ☐ Resolving conflicts
- ☐ Avoiding prolonged dependence on machines
- ☐ Avoiding prolonged dependence on artificial or assisted nutrition through tubes
- ☐ Dying at home
- ☐ Being able to communicate
- ☐ Having my faculties

Here are some other quality of life factors that I would like for my medical team and my healthcare advocate(s) to consider:_____.

I would like for my medical team and my healthcare advocate(s) to know about the role that religion, faith or spirituality play in my life:_____.

My Preferences in Specific Circumstances

In addition to the general advance care priorities provided above, below are my treatment preferences with respect to certain specific circumstances or situations.

If I ever suffer a sudden injury or illness, like a car accident or meningitis, in which there is some likelihood of recovery, here are my medical treatment goals, preferences and priorities:

- ☐ I want doctors to do everything possible to treat me.
- ☐ I want doctors to attempt only treatments that have a good chance of working.
- ☐ I do not want aggressive treatment. Doctors should only focus on making me comfortable.
- ☐ I want my healthcare advocate to decide how aggressively doctors should treat me.
- ☐ I have the following additional thoughts:_____.

When it comes to life-sustaining treatments, if I ever suffer a sudden injury or illness and there is some likelihood of recovery,

- ☐ I want doctors to take all measures necessary to sustain my life.
- ☐ I only want doctors to attempt life-sustaining treatments for a limited time.
- ☐ I do not want life-sustaining treatments. Doctors should only focus on making me comfortable.
- ☐ I want my healthcare advocate to make decisions on life-sustaining treatments.
- ☐ I have the following additional thoughts:_____.

Although I understand that, depending on the situation and circumstances, doctors may not be able to follow my wishes, if I ever suffer a sudden injury or illness and there is some likelihood of recovery, here are my general thoughts on cardiopulmonary resuscitation (CPR):

- ☐ I want CPR attempted <u>unless</u> my doctors say I have a terminal illness or a severe, irreversible brain injury, OR I have little chance of long-term survival if my heart or breathing stop, and an attempt to resuscitate me would cause me significant suffering, OR it simply will not work in my condition.
- ☐ I do not want CPR attempted.
- ☐ I want my healthcare advocate to decide for me.
- ☐ I have the following additional thoughts:

If my health is deteriorating because of a terminal illness such as, but not limited to, cancer, a brain injury, or Alzheimer's disease, and my chances of recovery are low, here are my medical treatment goals, preferences and priorities:

- ☐ I want doctors to do everything possible to treat me.
- ☐ I want doctors to attempt only treatments that have a good chance of working.

- ☐ I do not want aggressive treatment. Doctors should only focus on making me comfortable.
- ☐ I want my healthcare advocate to decide how aggressively doctors should treat me.
- ☐ I have the following additional thoughts:_____.

When it comes to life-sustaining treatments, if my health is deteriorating because of a terminal illness and my chances of recovery are low,

- ☐ I want doctors to take all measures necessary to sustain my life.
- ☐ I only want doctors to attempt life-sustaining treatments for a limited time.
- ☐ I do not want life-sustaining treatments. Doctors should only focus on making me comfortable.
- ☐ I want my healthcare advocate to make decisions on life-sustaining treatments.
- ☐ I have the following additional thoughts:_____.

Although I understand that, depending on the situation and circumstances, doctors may not be able to follow my wishes, if my health is deteriorating because of a terminal illness and my chances of recovery are low, here are my general thoughts on cardiopulmonary resuscitation (CPR):

- ☐ I want CPR attempted unless my doctors say I have a terminal illness or a severe, irreversible brain injury, OR I have little chance of long-term survival if my heart or breathing stop, and an attempt to resuscitate me would cause me significant suffering, OR it simply will not work in my condition.
- ☐ I do not want CPR attempted.
- ☐ I want my healthcare advocate to decide for me.
- ☐ I have the following additional thoughts:

My End-of-Life Preferences

If it were possible to choose, here is where I would like to spend my final days:

- ☐ At home.
- ☐ In the hospital.
- ☐ In a care facility.
- ☐ I'm not sure.

Here are some additional thoughts that I would like for my medical team and my healthcare advocate(s) to know about where I'd like to spend my final days if I could choose:_____.

Unless I have stated otherwise somewhere else in this advance care plan, I understand that my healthcare advocate may reconsider my treatment choices expressed above in light of my other instructions contained elsewhere in this advance care plan or new medical information.

Part 3 – Decisions on Organ Donation and Autopsy

Consent to Donate

- ☐ I consent to donate **all** organs and tissues that may help save someone else's life.
- ☐ I consent to donate all organs and tissues **except**:_____
- ☐ I want to donate my entire body to science.
- ☐ I don't want to donate my organs.
- ☐ I'd like my healthcare advocate to decide that after I die.
- ☐ I'm not sure.

Here are some additional thoughts that I would like for my medical team and my healthcare advocate to know about organ donation:_____.

Autopsy

- ☐ I want an autopsy if my doctor thinks it will help my family or others.
- ☐ I want an autopsy only if there are questions about my death.
- ☐ I don't want an autopsy.

Here are some additional thoughts that I would like for my medical team and my healthcare advocate to know about autopsy:_____.

Part 4 – My Thoughts

MyDirectives® Advance Care Plan for insured members of AARP Medicare Supplement plans insured by UnitedHealthcare offers people a list of optional questions that can be answered by typing text in a text box or by uploading a video or audio file for each question. Only those questions answered by **[First Name/Last Name]** appear here.

In case I'm being cared for by a person(s) who doesn't know me very well, I'd like my following thoughts to be known.

My Likes / Joys

Describe your favorite items, such as flowers or photographs, that you might like to have nearby, and list other things that might make you more comfortable. Please list your likes or joys here.

My Dislikes / Fears

Maybe you're afraid of the dark, being left alone, or needles. Perhaps there are certain visitors you don't want to see, or maybe you're concerned about the care of someone else or a pet. Please list your dislikes or fears here.

How to Care for Me

Do you prefer to be bathed in the morning, maintain your appearance, certain pillows or blankets, wear a bathrobe or certain slippers when possible, or to be kept warm or cool?

My Environment

What would create a healing or comforting environment for you? Would you like to have sunlight and fresh air if possible? Do you prefer a certain type of music to be played? Would you like to have certain visitors or pets around you?

My Religion

Do you identify with a particular religion or faith? Type here.

Would you like for someone from your religion or faith contacted, or do you have special religious rituals, dietary issues or other wishes you'd like your caregivers to know about?

My Unfinished Business

Sometimes people have unfinished emotional business that needs to be addressed. Are there any thoughts, comments or wishes you'd like to express to anyone?

If I were to pass away

Record any pre-arranged funeral or burial plans, or express any wishes that you'd like healthcare providers, family or friends to follow, if possible.

Laughter

Tell your caregivers what makes you laugh. There's growing evidence of the role laughter can play in healing and grieving. Just knowing what makes you laugh may be comforting to others.

Messages to people who Matter to Me

If you can't express yourself, use this space to say something to your healthcare advocate, family and friends.

Information people may need to know

List or provide information about where others can find your important documents or information that may be needed.

Part 5 – Signing the Advance Care Plan

I am emotionally and mentally competent to make this advance care plan. I understand the purpose and effect of this advance care plan, I agree with everything that is written in this document, and I have made this document knowingly, willingly and after careful deliberation.

_____ _____

Signature (or my signature signed by the person named below) Date

I cannot sign my name, so I have asked the person indicated below to sign this advance care plan for me.

_____

Signature of the person who I asked to sign this advance care plan for me.

_____

Printed name of the person who I asked to sign this advance care plan for me.

Some state laws require witness or notary signatures on advance directives. Talk to an attorney or local bar association to find out the specific requirements for your state – examples are below to assist in this process. If you are in a state that requires witnesses or notary, you will need to take additional steps.

Statement of Witnesses

I declare that the person who signed this advance care plan, or who asked another to sign this advance care plan on his/her behalf, is the individual identified in the document, and he/she did so in my presence or otherwise provided satisfactory proof to me of his/her identity. I believe him/her to be of sound mind and at least 18 years of age. I personally witnessed him/her sign this document or ask the person indicated to do so, or I received proof of his/her identity that I believe is adequate, and I believe that he/she did so voluntarily. By signing this document as a witness, I certify that I am:

- At least 18 years of age.
- Not related to the person signing this document by blood, marriage or adoption.
- Not a healthcare advocate appointed by the person signing this document.
- Not directly financially responsible for that person's healthcare.
- Not a healthcare provider directly serving the person at this time.
- Not an employee (other than a social worker or chaplain), officer, director, or partner of a healthcare provider (or any parent organization of such healthcare provider) directly serving the person at this time.
- Not aware that I am entitled to or have a claim against the person's estate.

Witness number 1:

Signature _____ Date _____

Print Name _____ Email Address _____

Address _____

Witness number 2:

Signature _____ Date _____

Print Name _____ Email Address _____

Address _____

Instructions for Notarization:

Residents of certain jurisdictions may have the advance care plan signed by a notary public registered in their jurisdiction instead of having two witnesses sign the advance care plan.

Notary Public

On _____ (date), _____ (name) acknowledged in my presence or by sufficient electronic means his/her signature on this advance care plan or acknowledged that he/she authorized the person signing this advance care plan to sign on his/her behalf. I am not named as a healthcare advocate or alternate healthcare advocate in this document.

(Notary Stamp)

_____
Signature of Notary

_____
Email Address

My commission
expires on:_____