Appendix 6: Health Care Directives for Priests

DIOCESE OF BISMARCK DURABLE POWER OF ATTORNEY PLANNING DOCUMENT

DURABLE POWER OF ATTORNEY

Date and Location of ORIGINAL COPY of your DURABLE POWER OF ATIORNEY:

_____

Is an ORIGINAL filed with the Diocese of Bismarck?

_____

Name, Address and Phone Number of your Durable Power of Attorney:

_____

_____

Relationship of your Durable Power of Attorney: _____

A Guide to Health Care Directives

A Resource from the North Dakota Catholic Conference

Health Care Directives give instructions for future health care decisions. To assist people who wish to have a health care directive, the North Dakota Catholic Conference has prepared a Catholic Health Care Directive that meets the state's legal requirements, expresses Church teaching, and reflects the recommendations of church, health care, and community leaders. This Guide answers some basic questions about the law, Church teaching, and completing a health care directive.

What do all these terms mean?

A **"living will"** usually means a document in which a person states *only* his or her health care wishes. A **"durable power of attorney for health care"** usually means a document in which a person appoints someone to make health care decisions on his or her behalf. **"Advance directive"** usually means a living will, a durable power of attorney for health care, or a combination of the two. **"Health care directive"** is what North Dakota state law calls any advance directive. A **"health care agent"** is what state law calls the person appointed through a health care directive to make health care decisions for another.

Why would I want a health care directive?

A health care directive can help make sure that your health care wishes are followed when you cannot speak for yourself. In addition, a health care directive can help your family and friends during what may be a difficult time.

What happens if I don't have a health care directive?

In North Dakota, if you have not appointed a health care agent and you are unable to make or communicate health care decisions; state law determines who makes health care decisions for you. The law authorizes persons in the following categories, *in the order listed,* to make decisions: your health care agent unless a court specifically authorizes a guardian to make decisions for you, your court-appointed guardian or custodian, your spouse, any of your children, your parents, your adult brothers and sisters, your grandparents, your adult grandchildren, and an adult friend or close relative. No one in a lower category may make the decision if someone in a higher category has refused to consent.

When making a health care decision, the authorized person must determine whether you would consent to the care if you were able to do so. If the person is unable to make this determination, he or she may only consent to the proposed health care if it jg in your best interests.

Do I need to use a special form?

No. North Dakota law has an *optional* health care directive form, but many other forms exist that meet the state's legal requirements. In fact, you do not have to use a preprinted form.

Any written statement that meets these requirements is valid in N01th Dakota:

- States the name of the person to whom it applies;
- Includes a health care directive, the appointment of an agent, or both;
- Is signed and dated by the person to whom it applies or by another person authorized to sign on behalf of the person to whom it applies;
- Is executed by a person with the capacity to understand, make, and communicate decisions; and
- Contains verification of the required signature, either by a notary public or by qualified witnesses.

If you are Catholic, the North Dakota Catholic Conference suggests that you use the *Catholic Health Care Directive* form. If the form is not included with this document, you can get one by calling the conference at l-888-419-1237 or by downloading it at *ndcatholic.org.*

Do I need an attorney? What will this cost?

No. It is not necessary to have an attorney provide or fill out the form. However, you should contact an attorney if you have legal questions regarding advance care planning. Health care directive forms are available at no cost from a number of sources, including the North Dakota Catholic Conference.

Should I appoint a health care agent or just write down my wishes?

The North Dakota Catholic Conference recommends that your health care directive include the appointment of a health care agent.

Written instructions alone are only as good as your ability to accurately predict every possible future medical condition and every future medical treatment option. This is an almost impossible task. In addition, without a health care agent, the person interpreting those instructions might be someone who does not truly know what you wanted.

By appointing a health care agent, you can make sure that someone who cares about you will apply your wishes and personal beliefs to the health care choices at hand -just as you would do. Even if you appoint a health care agent, you can still give written health care instructions to direct, guide, and even limit the actions of your agent.

Why does the hospital always ask if I have a living will? Do I have to have one?

Federal law requires health care providers to ask you if have an advance directive. By habit, they often use the term "living will." You are not required to have any advance directive and you do not have to use the form they provide.

Who can be my health care agent?

In North Dakota, your agent must be 18 years of age or older and must accept the appointment in writing. Talk beforehand to the person you wish to appoint. Find out if the person is willing to accept the responsibility. Tell the person about your wishes and preferences for care. Be sure the person is willing and able to follow your wishes.

I already have an advance directive. Do I need a new one? What if I want a new one?

Valid advance directives completed under the old law (before August 1, 2005) will still be honored. Validly executing a new health care directive automatically revokes any older advance directive. Inform everyone who might have a copy of that old document that it is no longer valid and that you have a new health care directive.

On health care directive forms, who is the "principal," "declarant," and "agent?"

You, the person executing a health care directive, are the "principal." When verifying your identity before a witness or notary public, you are also the "declarant." The person you appoint as your health care agent is the "agent."

Will an advance directive that I completed in another state be accepted in North Dakota?

Yes, so long as it complies with the laws of that state and is not contrary to certain North Dakota laws, such as the law against assisted suicide.

Will a health care directive that I completed in North Dakota be accepted in another state?

Most states have reciprocity statutes that give recognition to advance directives completed in other states. Even if a health care directive completed in North Dakota does not meet some of the technical requirements of another state's law, the directive should still be followed since it expresses the your wishes.

What should I do with my health care directive?

Provide a copy of your health care directive to your doctor and any other health care providers such as your hospital, nursing facility, hospice, or home health agency. In addition, you may want to give copies of your health care directive to other persons, such as close family members, your priest, and your attorney, if you have one.

DIOCESE OF BISMARCK

HEALTH CARE DIRECTIVE PLANNING DOCUMENT

HEALTH CARE DIRECTIVE:

Date and Location of ORIGINAL COPY of your HEALTHCARE DIRECTIVE:

_____

Is an ORIGINAL filed with the Diocese of Bismarck?

_____

Name, Address and Phone Number of your Health Care Power of Attorney:

_____

_____

Relationship of your Healthcare Power of Attorney: _____

A Catholic Health Care Directive

My Health Care Agent

I, _____, trust and appoint_____ as my health care agent. As my health care agent, this person can make health care decisions for me if I am unable to make and communicate health care decisions for myself.

If my health care agent is not reasonably available, I trust and appoint_____ as my health care agent instead.

Health Care Agent Information

Name: _____
Address:_____
Phones:_____
_____
Relationship:_____

Alternate Health Care Agent Information

Name:_____
Address:
Phones:_____
_____
Relationship:_____

My Wishes

This is what I want my health care agent – or if I have no health care agent, whoever will make decisions regarding my care - to do if I am unable to make and communicate health care decisions for myself. Most of what I state here is general in nature since I cannot anticipate all the possible circumstances of a future illness. If I have not given specific instructions, then my agent must decide consistent with my wishes and beliefs.

As a Catholic, I believe that God created me for eternal life in union with Him. I understand that my life is a precious gift from God and that this truth should inform all decisions with regards to my health care. I have a duty to preserve my life and to use it for God's glory. Suicide, euthanasia, and acts that intentionally and directly would cause my death by deed or omission, are never morally acceptable. However, I also know that death, being conquered by Christ, need not be resisted by any and every means and that I may refuse any medical treatment that is excessively burdensome or would only prolong my imminent death. Those caring for me should avoid doing anything that is contrary to the moral teaching of the Catholic Church.

- Medical treatments may be foregone or withdrawn if they do not offer a reasonable hope of benefit to me or are excessively burdensome.
- There should be a presumption in favor of providing me with nutrition and hydration, including medically assisted nutrition and hydration, if they are of benefit to me.
- In accord with the teachings of my Church, I have no moral objection to the use of medication or procedures necessary for my comfort even if they may indirectly and unintentionally shmien my life.
- If my death is imminent, I direct that there be forgone or withdrawn treatment that will only maintain a precarious and burdensome prolongation of my life, unless those responsible for my cal'e judge at that time that there are special and significant reasons why I should continue to receive such treatment.
- If Ifall terminally ill, I ask that I be told of this so that I might prepare myself for death, and I ask that efforts be made that I be attended by a Catholic priest and receive the Sacraments of Reconciliation, Anointing, and Eucharist as viaticum.

Believing none of the following directives conflicts with the teachings of my Catholic faith or the directives listed above, I add the fo1lowing directives: *(You do not need to complete this section. If you do, you can use an extra sheet, if needed.)*

Making an Anatomical Gift (Optional)

So long as it is consistent with Catholic moral teaching, I would like to be an organ and tissue donor at the time of my death. I wish to donate the following (initial one statement):

[ ] Any needed organs and tissue.
[ ] Only the following organs and tissue:

This is a two page document. This health care directive form was prepared to reflect the requirements in North Dakota law as of August 1, 2007. It may not meet the legal requirements of another jurisdiction.

Your Signature (The person making this health care directive) ***[This section must be completed.]***

I sign this Health Care Directive on_____(date) at_____(city), _____ (state).

_____ *(you sign here)*

If you have attached additional pages to this form, date and sign each of them at the same time you date and sign this form.

*To be valid , this health care directive must be **notarized** or **witnessed** when you sign. **If witnessed:** At least one witness must not be a health care or long.ierm care provider providing you with direct care or an employee of that provider.*

None of the following may be a notary or witness:
1.A person you designate as your agent or alternate agent;
2. *Your spouse;*
3.A person related to you by blood, marriage, or adoption;
4. A person entitled to inherit any part of your estate upon your death; or
5. *A person who has,. at the time of executing this document, any claim against your estate.*

Acceptance of Appointment by Health Care Agent

I accept this appointment and agree to serve as a health care agent. I understand I have a duty to act in good faith, consistent with the desires expressed in this document, and that this document gives me authority to make health care decisions for the principal only when he or she is unable to make and communicate his or her own decisions. I understand that the principal may revoke this appointment at any time, in any manner. If I choose to withdraw during the time the principal is competent, I must notify the principal of my decision. If I choose to withdraw when the principal is not competent, l must notify the principal's physician.

_____

(Signature of agent) (date)

_____

(Signature of alternate agent) (date)

Option 1: To be Completed by a Notary Public

In my presence on_____(date), _____(name of declarant) acknowledged the declarant's signature on this document or acknowledged that the declarant directed the person signing this document to sign on the declarant's behalf.

_____ My commission expires_____, 20___.

(Signature of Notary Public)

Option 2: To be Completed by Two Witnesses

Witness One:

(1) In my presence on_____(date), _____(name of declarant) acknowledged the declarant's signature on this document or acknowledged that the declarant directed the person signing this document to sign on the declarant's behalf.
(2) I am at least eighteen years of age.
(3) If I am a health care provider or an employee of a health care provider giving direct care to the declarant, I must initial this box [ ].
I certify that the information in (1) through (3) is true and correct.

_____ _____

(Signature of Witness One) (Address)

Witness Two:

(1) In my presence on_____ (date), _____ (name of declarant) acknowledged the declarant's signature on this document or acknowledged that the declarant directed the person signing this document to sign on the declarant's behalf.
(2) I am at least eighteen years of age.
(3) If I am a health care provider or an employee of a health care provider giving direct care to the declarant, I must initial this box: [ ].
I certify that the information in (1) through (3) is true and correct

_____ _____

(Signature of Witness Two) (Address)

For more information, contact the North Dakota Catholic Conference, 103 South Third, Suite 10, Bismarck, ND 58501: 701-223-2519, 1-886419-1237; web: ndcatholic.org; e-mail: ndcatholic@btinet.net