MARYLAND
Advance Directive
Planning for Important Healthcare Decisions

Courtesy of CaringInfo
www.caringinfo.org
800-658-8898

CaringInfo, a program of the National Hospice and Palliative Care Organization (NHPCO), is a national consumer engagement initiative to improve care and the experience of caregiving during serious illness and at the end of life. As part of that effort, CaringInfo provides detailed guidance for completing advance directive forms in all 50 states, the District of Columbia, and Puerto Rico.

This package includes:

- 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.

BEFORE YOU BEGIN

Check to be sure that you have the materials for each state in which you may receive healthcare. Because documents are state-specific, having a state-specific document for each state where you may spend significant time can be beneficial. A new advance directive is not necessary for ordinary travel into other states. The advance directives in this package will be legally binding only if the person completing them is a competent adult who is 18 years of age or older, an emancipated minor, or if under the age of 18, is married or is the parent of a child.

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, scan, or take a photo of 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.

5. You may also want to save a copy of your form in your electronic healthcare record, or an online personal health records application, program, or 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.

6. Maryland has contracted with a commercial service for the state's Advance Directive Registry. By preparing and storing your Advance Directive online or by filing your advance directive with the registry, your healthcare provider and loved ones may be able to find a copy of your advance directive in the event you are unable to provide one. You can read more about the registry, including instructions on how to file your advance directive, at https://www.mydirective.com.

INTRODUCTION TO YOUR MARYLAND ADVANCE HEALTH CARE DIRECTIVE

This packet contains a legal document, a **Maryland 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. Also included in an "**After My Death**" form, a document that allows you to record your decisions regarding organ donation and the final disposition of your remains.

Your Maryland Advance Directive has three parts. **Part 1**, **Selection of Health Care Agent**, lets you name someone (an agent) to make decisions about your health care. **Part II** includes your **Treatment Preferences**. This is your state's living will. It lets you state your wishes about health care in the event that you can no longer speak for yourself. Part II has specific choices laid out for you in the event you have a terminal condition, are in a persistent vegetative state (permanent unconsciousness), or develop an end-stage condition. Alternatively, you can provide your own instructions. In addition, the form allows you to choose whether your agent will have flexibility in implementing your decisions or carry out your instructions exactly as you set them out. **Part III** contains the signature and witnessing provisions so that your document will be effective.

Depending on your advance planning needs, you may complete Part I, Part II or both. However, **you must complete Part III.**

How do I make my Maryland Advance Health Care Directive legal?

You must sign and date your advance directive or direct an adult to do so for you if you are unable to sign it yourself in the presence of two witnesses, who must also sign and date the document.

Your agent may not be a witness. In addition, at least one of your witnesses must be someone who will not knowingly inherit anything from your estate or otherwise knowingly benefit from your death.

You must sign and date your "**After My Death**" form in the presence of two witnesses, who must also sign and date the document.

Whom should I appoint as my agent?

Your agent is the person you appoint to make decisions about your healthcare if you become unable to make those decisions yourself. Your agent may 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 healthcare decisions for you.

You cannot appoint as your agent:

- An owner, operator or employee of your treating health care facility
- The spouse, parent, child, or sibling of any of the above health care facility- affiliated individuals
- Someone that you have a protective order against
- Someone you are currently separated from or divorcing

However, you may appoint a person who would otherwise be barred from being your agent if that person is your guardian, spouse, domestic partner, adult child, parent, sibling, or other close relative or close friend who could be appointed as your surrogate in the event you do not appoint an agent.

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

Should I add personal instructions to my advance directive?

Yes! One of the most important reasons to execute an advance directive is to have your voice heard. When you name an agent and clearly communicate to them what you want and don't want, they are in the strongest position to advocate for you. Because the future is unpredictable, be careful that you do not unintentionally restrict your agent's power to act in your best interest. Be especially careful with the words "always" and "never." In any event, be sure to talk with your agent and others about your future healthcare and describe what you consider to be an acceptable "quality of life."

When does my agent's authority become effective?

Part 1, **Selection of Health Care Agent**, becomes effective either immediately, or when your doctor determines that you can no longer make or communicate your health care decisions, depending on how you fill out the form. Even when you make your agent's authority immediate, you retain the primary authority for your healthcare decisions as long as you are able to make your wishes known. **Part II, Treatment Preferences,** becomes effective when

your doctor determines that you can no longer make or communicate your health care decisions.

Agent Limitations

Your agent will be bound by the current laws of Maryland as they regard pregnancy and termination of pregnancies.

What if I change my mind?

If you decide to cancel your Maryland Advance Directive, you may do so at any time by:

- issuing a signed and dated written or electronic revocation,
- destroying or defacing your document,
- orally informing your doctor of your revocation, or
- executing another Maryland Advance Directive

You should notify your agent, physician, and anyone who has a photocopy of your advance directive that you have revoked it.

You may expressly waive your right to cancel your Maryland Advance Directive, including the appointment of an agent, during a period in which you have been certified incapable of making an informed decision.

Mental Health Issues

These forms do not *expressly* address mental illness, although you can state your wishes and grant authority to your agent regarding mental health issues. The National Resource Center on Psychiatric Advance Directives maintains a website (https://nrc-pad.org/) with links to each state's psychiatric advance directive forms. If you would like to make more detailed advance care plans regarding mental illness, you could talk to your physician and an attorney about a durable power of attorney tailored to your needs.

What other important facts should I know?

Be aware that your advance directive will not be effective in the event of a medical emergency, except to identify your agent. Ambulance and hospital emergency department personnel are required to provide cardiopulmonary resuscitation (CPR) unless you have a separate physician's order, which are typically called "prehospital medical care directives" or "do not resuscitate orders." DNR forms may be obtained from your state health department or department of aging (https://www.hhs.gov/aging/state-resources/index.html). Another form of orders regarding CPR and other treatments are state-specific POLST (portable orders for life sustaining treatment) (https://polst.org/form-patients/). Both a POLST and a DNR form MUST be signed by a healthcare provider and MUST be presented to the emergency responders when they arrive. These directives instruct ambulance and hospital emergency personnel not to attempt CPR (or to stop it if it has begun) if your heart or breathing should stop.

Maryland Advance Directive:

Planning for Future Health Care Decisions

PRINT YOUR NAME AND THE DATE

By: _____
(Print Name)

Date of Birth: _____
(Month/Day/Year)

Using this advance directive form to do health care planning is completely optional. Other forms are also valid in Maryland. No matter what form you use, talk to your family and others close to you about your wishes.

This form has two parts to state your wishes, and a third part for needed signatures. Part I of this form lets you answer this question: If you cannot (or do not want to) make your own health care decisions, who do you want to make them for you? The person you pick is called your health care agent. Make sure you talk to your health care agent (and any back-up agents) about this important role. Part II lets you write your preferences about efforts to extend your life in three situations: terminal condition, persistent vegetative state, and end-stage condition. In addition to your health care planning decisions, you can choose to become an organ donor after your death by filling out the form for that too.

You can fill out Parts I and II of this form, or only Part I, or only Part II. Use the form to reflect your wishes, then sign in front of two witnesses (Part III). If your wishes change, make a new advance directive.

Make sure you give a copy of the completed form to your health care agent, your doctor, and others who might need it. Keep a copy at home in a place where someone can get it if needed. Review what you have written periodically.

PART I: SELECTION OF HEALTH CARE AGENT

A. Selection of Primary Agent

I select the following individual as my agent to make health care decisions for me:

Name: _____

Address: _____

_____

Telephone Numbers: _____
(home and cell)

PRINT THE NAME, ADDRESS, AND TELEPHONE NUMBER(S) OF YOUR PRIMARY AGENT

B. Selection of Back-up Agents

(Optional; form valid if left blank)

1. If my primary agent cannot be contacted in time or for any reason is unavailable or unable or unwilling to act as my agent, then I select the following person to act in this capacity:

Name: _____ Address:

_____

Telephone Numbers: _____
(home and cell)

PRINT THE NAME, ADDRESS, AND TELEPHONE NUMBER(S) OF YOUR FIRST BACK-UP AGENT

2. If my primary agent and my first back-up agent cannot be contacted in time or for any reason are unavailable or unable or unwilling to act as my agent, then I select the following person to act in this capacity:

Name: _____ Address:

_____

Telephone Numbers: _____
(home and cell)

PRINT THE NAME, ADDRESS, AND TELEPHONE NUMBER(S) OF YOUR SECOND BACK-UP AGENT

C. Powers and Rights of Health Care Agent

I want my agent to have full power to make health care decisions for me, including the power to:

1. Consent or not consent to medical procedures and treatments which my doctors offer, including things that are intended to keep me alive, like ventilators and feeding tubes;

2. Decide who my doctor and other health care providers should be; and

3. Decide where I should be treated, including whether I should be in a hospital, nursing home, other medical care facility, or hospice program.

I also want my agent to:

1. Ride with me in an ambulance if ever I need to be rushed to the hospital; and

2. Be able to visit me if I am in a hospital or any other health care facility.

This advance directive does not make my agent responsible for any of the costs of my care.

This power is subject to the following conditions or limitations:

(Optional; form valid if left blank)

PRINT INSTRUCTIONS HERE ONLY IF YOU WANT TO LIMIT YOUR AGENT'S POWERS

D. How My Agent Is To Decide Specific Issues

I trust my agent's judgment. My agent should look first to see if there is anything in Part II of this advance directive, if I have filled out Part II, that helps decide the issue. Then, my agent should think about the conversations we have had, my religious or other beliefs and values, my personality, and how I handled medical and other important issues in the past. If what I would decide is still unclear, then my agent is to make decisions for me that my agent believes are in my best interest. In doing so, my agent should consider the benefits, burdens, and risks of the choices presented by my doctors.

E. People My Agent Should Consult

(Optional; form valid if left blank)

In making important decisions on my behalf, I encourage my agent to consult with the following people. By filling this in, I do not intend to limit the number of people with whom my agent might want to consult or my agent's power to make these decisions.

Name(s) Telephone Number(s):

PRINT THE NAMES

AND TELEPHONE NUMBERS OF ANYONE YOU WANT YOUR AGENT TO CONSULT WITH IN MAKING DECISIONS FOR YOU

PRINT ANY INSTRUCTIONS IN THE EVENT YOU ARE PREGNANT

WHEN A DECISION MUST BE MADE

F. In Case of Pregnancy

(Optional, for women of child-bearing years only; form valid if left blank)

If I am pregnant, my agent shall follow these specific instructions:

_____

_____

_____

_____

_____

_____

_____

_____

G. Access to My Health Information - Federal Privacy Law (HIPAA) Authorization

1. If, prior to the time the person selected as my agent has power to act under this document, my doctor wants to discuss with that person my capacity to make my own health care decisions, I authorize my doctor to disclose protected health information which relates to that issue.

2. Once my agent has full power to act under this document, my agent may request, receive, and review any information, oral or written, regarding my physical or mental health, including, but not limited to, medical and hospital records and other protected health information, and consent to disclosure of this information.

3. For all purposes related to this document, my agent is my personal representative under the Health Insurance Portability and Accountability Act (HIPAA). My agent may sign, as my personal representative, any release forms or other HIPAA-related materials.

H. Effectiveness of This Part

(Read both of these statements carefully. Then, initial one only.)

My agent's power is in effect:

_____ 1. Immediately after I sign this document, subject to my right to make any decision about my health care if I want and am able to.

INITIAL ONLY ONE

((or))

_____ 2. Whenever I am not able to make informed decisions about my health care, either because the doctor in charge of my care (attending physician) decides that I have lost this ability temporarily, or my attending physician and a consulting doctor agree that I have lost this ability permanently.

I. Waiver of Right to Revoke Appointment of Agent

INITIAL ONLY IF YOU WISH TO WAIVE YOUR RIGHT TO REVOKE THE APPOINTMENT OF YOUR AGENT IN

THE EVENT YOU BECOME INCAPABLE OF MAKING AN INFORMED DECISION.

(Read this section carefully. Then, initial only if you wish to waive your right to revoke the appointment of your agent upon certification of incapacity.)

_____I wish to waive my ability to revoke the appointment of my agent during a period in which the doctor in charge of my care (attending physician) and a second physician certify in writing that I am incapable of making an informed decision. In the case that I am unconscious or unable to communicate by any means, the certification of a second physician is not required.

If the only thing you want to do is select a health care agent, skip Part II. Go to Part III to sign and have the advance directive witnessed. If you also want to write your treatment preferences, use Part II. Also consider becoming an organ donor, using the separate "After my Death" form for that.

PART II: TREATMENT PREFERENCES ("LIVING WILL")

A. Statement of Goals and Values

(Optional; form valid if left blank)

I want to say something about my goals and values, and especially what's most important to me during the last part of my life:

USE THIS SPACE TO DISCUSS YOUR ADVANCE PLANNING GOALS AND VALUES ATTACH ADDITIONAL PAGES IF NEEDED

_____

_____

_____

_____

(attach additional pages if needed)

B. Preference in Case of Terminal Condition

(If you want to state your preference, initial one only. If you do not want to state a preference here, cross through the whole section.)

INITIAL YOUR PREFERENCE IN THE EVENT YOU ARE IN A TERMINAL CONDITION

INITIAL ONLY ONE PREFERENCE

_____ 1. Keep me comfortable and allow natural death to occur. I do not want any medical interventions used to try to extend my life. I do not want to receive nutrition and fluids by tube or other medical means.

((or))

_____ 2. Keep me comfortable and allow natural death to occur. I do not want medical interventions used to try to extend my life. If I am unable to take enough nourishment by mouth, however, I want to receive nutrition and fluids by tube or other medical means.

((or))

_____ 3. Try to extend my life for as long as possible, using all available interventions that in reasonable medical judgment would prevent or delay my death. If I am unable to take enough nourishment by mouth, I want to receive nutrition and fluids by tube or other medical means.

C. Preference in Case of Persistent Vegetative State

(If you want to state your preference, initial one only. If you do not want to state a preference here, cross through the whole section.)

If my doctors certify that I am in a persistent vegetative state, that is, if I am not conscious and am not aware of myself or my environment or able to interact with others, and there is no reasonable expectation that I will ever regain consciousness:

INITIAL YOUR PREFERENCE IN THE EVENT YOU ARE IN A PERSISTENT VEGETATIVE STATE

INITIAL ONLY ONE PREFERENCE

_____ 1. Keep me comfortable and allow natural death to occur. I do not want any medical interventions used to try to extend my life. I do not want to receive nutrition and fluids by tube or other medical means.

((or))

_____ 2. Keep me comfortable and allow natural death to occur. I do not want medical interventions used to try to extend my life. If I am unable to take enough nourishment by mouth, however, I want to receive nutrition and fluids by tube or other medical means.

((or))

_____ 3. Try to extend my life for as long as possible, using all available interventions that in reasonable medical judgment would prevent or delay my death. If I am unable to take enough nourishment by mouth, I want to receive nutrition and fluids by tube or other medical means.

D. Preference in Case of End-Stage Condition

(If you want to state your preference, initial one only. If you do not want to state a preference here, cross through the whole section.)

If my doctors certify that I am in an end-stage condition, that is, an incurable condition that will continue in its course until death and that has already resulted in loss of capacity and complete physical dependency:

INITIAL YOUR PREFERENCE IN THE EVENT YOU DEVELOP AN END-STAGE CONDITION

INITIAL ONLY ONE PREFERENCE

_____1. Keep me comfortable and allow natural death to occur. I do not want any medical interventions used to try to extend my life. I do not want to receive nutrition and fluids by tube or other medical means.

((or))

_____2. Keep me comfortable and allow natural death to occur. I do not want medical interventions used to try to extend my life. If I am unable to take enough nourishment by mouth, however, I want to receive nutrition and fluids by tube or other medical means.

((or))

_____ 3. Try to extend my life for as long as possible, using all available interventions that in reasonable medical judgment would prevent or delay my death. If I am unable to take enough nourishment by mouth, I want to receive nutrition and fluids by tube or other medical means.

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

E. Additional Instructions:

(You may add additional instructions, if any, here. This section may be useful to you if you have crossed through the sections above, or if your concerns are not otherwise addressed by this form.)

F. Pain Relief

No matter what my condition, give me the medicine or other treatment I need to relieve pain.

G. In Case of Pregnancy

(Optional, for women of child-bearing years only; form valid if left blank)

ADD INSTRUCTIONS HERE IF YOU WANT DIFFERENT TREATMENT IN THE EVENT YOU ARE PREGNANT

If I am pregnant, my decision concerning life-sustaining procedures shall be modified as follows:

_____

_____

_____

_____

_____

_____

H. Effect of Stated Preferences

INITIAL ONLY ONE, DEPENDING ON HOW STRICTLY YOU WANT YOUR TREATMENT PREFERENCES FOLLOWED

(Read both of these statements carefully. Then, initial one only.)

_____1. I realize I cannot foresee everything that might happen after I can no longer decide for myself. My stated preferences are meant to guide whoever is making decisions on my behalf and my health care providers, but I authorize them to be flexible in applying these statements if they feel that doing so would be in my best interest.

((or))

_____ 2. I realize I cannot foresee everything that might happen after I can no longer decide for myself. Still, I want whoever is making decisions on my behalf and my health care providers to follow my stated preferences exactly as written, even if they think that some alternative is better.

I. Waiver of Right to Revoke Treatment Preferences ("Living Will")

(Read this section carefully. Then, initial only if you wish to waive your right to revoke your stated treatment preferences upon certification of incapacity.)

INITIAL ONLY IF YOU WISH TO

WAIVE YOUR RIGHT TO REVOKE YOUR STATED TREATMENT PREFERENCES IN THE EVENT YOU BECOME INCAPABLE OF MAKING AN INFORMED DECISION.

_____I wish to waive my ability to revoke my stated treatment preferences ("Living Will") during a period in which the doctor in charge of my care (attending physician) and a second physician certify in writing that I am incapable of making an informed decision. In the case that I am unconscious or unable to communicate by any means, the certification of a second physician is not required.

PART III: SIGNATURE AND WITNESSES

By signing below as the Declarant, I indicate that I am emotionally and mentally competent to make this advance directive and that I understand its purpose and effect. I also understand that this document replaces any similar advance directive I may have completed before this date.

SIGN AND DATE YOUR DOCUMENT

_____

(Signature of Declarant) (Date)

The declarant signed or acknowledged signing this document in my presence and, based upon personal observation, appears to be emotionally and mentally competent to make this advance directive.

YOUR WITNESSES MUST SIGN AND DATE AND LIST THEIR TELEPHONE NUMBERS HERE

_____

(Signature of Witness) (Date)

Telephone Number(s): _____

_____

(Signature of Witness) (Date)

Telephone Number(s): _____

ONE WITNESS MUST NOT KNOWINGLY INHERIT ANYTHING FROM YOU OR OTHERWISE KNOWLINGLY BENEFIT FROM YOUR DEATH

(Note: Anyone selected as a health care agent in Part I may not be a witness. Also, at least one of the witnesses must be someone who will not knowingly inherit anything from the declarant or otherwise knowingly gain a financial benefit from the declarant's death. Maryland law does not require this document to be notarized.)

AFTER MY DEATH

(This form is optional. Fill out only what reflects your wishes.)

By: _____
(Print Name)

Date of Birth: _____
(Month/Day/Year)

PART I: ORGAN DONATION

(Initial the ones that you want.)

Upon my death I wish to donate:

INITIAL ONLY ONE

_____Any needed organs, tissues, or eyes.
_____ Only the following organs, tissues, or eyes:

_____

_____

I authorize the use of my organs, tissues, or eyes for the purpose of:

INITIAL ALL THAT APPLY

_____Research and education
_____Transplantation and therapy

I understand that no vital organ, tissue, or eye may be removed for transplantation until after I have been pronounced dead under legal standards. This document is not intended to change anything about my health care while I am still alive. After death, I authorize any appropriate support measures to maintain the viability for transplantation of my organs, tissues, and eyes until organ, tissue, and eye recovery has been completed. I understand that my estate will not be charged for any costs related to this donation.

PART II: DONATION OF BODY

INITIAL HERE IF YOU WANT YOUR BODY DONATED FOR MEDICAL STUDY

_____ After any organ donation indicated in Part I, I wish my body to be donated for use in a medical study program.

PART III: DISPOSITION OF BODY AND FUNERAL ARRANGEMENTS

I want the following person to make decisions about the disposition of my body and my funeral arrangements:

(Either initial the first or fill in the second.)

INITIAL ONLY ONE

_____ The health care agent who I named in my advance directive.

((or))

_____ This person:

PRINT NAME, ADDRESS, AND TELEPHONE NUMBER OF THE PERSON YOU WANT TO MAKE DECISIONS REGARDING DISPOSITION OF YOUR BODY

Name: _____

Address: _____

_____

_____

Telephone Numbers: _____
(home and cell)

If I have written my wishes below, they should be followed. If not, the person I have named should decide based on conversations we have had, my religious or other beliefs and values, my personality, and how I reacted to other peoples' funeral arrangements. My wishes about the disposition of my body and my funeral arrangements are:

PRINT ADDITIONAL INSTRUCTIONS HERE, IF ANY

_____

_____

_____

_____

PART IV: SIGNATURE AND WITNESSES

By signing below, I indicate that I am emotionally and mentally competent to make this donation and that I understand the purpose and effect of this document.

SIGN AND DATE YOUR DOCUMENT HERE

_____

(Signature of Donor) (Date)

The Donor signed or acknowledged signing this donation document in my presence and, based upon personal observation, appears to be emotionally and mentally competent to make this donation.

HERE YOUR WITNESSES SIGN AND DATE AND PRINT THEIR TELEPHONE NUMBERS HERE

_____

(Signature of Witness) (Date)

Telephone Number(s) _____

_____

(Signature of Witness) (Date)

Telephone Number(s) _____

Courtesy of CaringInfo

www.caringinfo.org