DELAWARE MENTAL HEALTH POWER OF ATTORNEY FORM

IMPORTANT INFORMATION

This power of attorney authorizes another person (your agent) to make decisions for you (the principal). Your agent will be able to make decisions and act on your behalf, whether or not you are able to act for yourself.

This power of attorney does not authorize the agent to make health care decisions for you. Such powers are governed by applicable laws for Advance Directives.

You should select someone you trust to serve as your agent. Unless you specify otherwise, generally the agent's authority will continue until you die or revoke the power of attorney or the agent resigns or is unable to act for you.

If your agent is unable or unwilling to act for you, your power of attorney will end unless you have named a successor agent. You may also name a second successor agent.

This power of attorney becomes effective immediately unless you state otherwise in the Special Instructions.

If you have questions about the power of attorney or the authority you are granting to your agent, you should seek legal advice before signing this form.

The following forms are available from the National Resource Center on Psychiatric Advance Directives.

Advance Health Care Directive

of

_____

This form was developed by the Committee on Law and the Elderly of the Delaware Bar Association and approved for use by the Office of the Attorney General of the State of Delaware.

GENERAL INSTRUCTIONS

You should read this form carefully before filling it in. You should fill it in completely. If there are health care decisions you do not want to make, you should strike the wording of that decision rather than leave it blank. You may not change the qualifications for witnesses or agents, even if you cross out the wording. You should write legibly.

After you have filled out the form completely, you should sign the form before a notary public. Although signing before a notary public is not legally required, it is advisable. It is advisable because the notary, as well as your witnesses, can testify as to your competence when you sign the directive, if your competence becomes an issue. Notaries, who are registered with the State, are often easier to locate later than witnesses.

You should retain your original Advance Health care Directive, and give copies to your doctor, agent, spouse, family members, and close friends, if you desire. You should explain to each person who receives a copy of your health care directive what choices you made on the form, and why. This will help if, while you lack competence, there arises a need to make a health care decision that is not explicitly set forth on your advance health care directive form.

This form does not contain all of the types of health care decisions you are legally entitled to make. For example, the form does not give you the opportunity to nominate a guardian, in the event you become incompetent and need one. Also, the form does not give you the opportunity to designate a primary care physician, or another person, to certify that you lack the capacity to make your own decisions on health care. Finally, the form does not include a provision that accommodates a person's religious or moral beliefs. If you would like to exercise these options, you should talk to an attorney. If anything on the form conflicts with your religious beliefs, you should contact your clergy.

PART I. INSTRUCTIONS FOR HEALTH CARE DECISIONS

If you are an adult who is mentally competent, you have the right to accept or refuse medical or surgical treatment, if such refusal is not contrary to existing public health laws. You may give advance instructions for medical or surgical treatment that you want or do not want. These instructions will become effective if you lose the capacity to accept or refuse medical or surgical treatment. You may limit your instructions to take effect only if you are in a specified medical condition. If you give an instruction that you do not want your life prolonged, that instruction will only take effect if you are in a "qualifying condition." A "qualifying condition" is either a terminal condition or permanent unconsciousness.

If you want to give instructions to accept or refuse medical or surgical treatment, you should fill in the spaces on the following page. You may cross out any wording you do not want.

A. END OF LIFE INSTRUCTIONS

1. Choice To Prolong Life

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

OR

2. Choice Not To Prolong Life

I do not want my life to be prolonged if (please check all that apply)

____ (i) I have a terminal condition (an incurable condition from which there is no reasonable medical expectation of recovery and which will cause my death, regardless of the use of life-sustaining treatment). In this case, I give the specific directions indicated:

	I want used	I do not want used
Artificial nutrition through a conduit	_____	_____
Hydration through a conduit	_____	_____
Cardiopulmonary resuscitation	_____	_____
Mechanical respiration	_____	_____
Other (explain) _____	_____	_____

_____ (ii) I become permanently unconscious (a medical condition that has existed at least four (4) weeks and has been diagnosed in accordance with currently accepted medical standards and with reasonable medical certainty as total and irreversible loss of consciousness and capacity for interaction with the environment. The term includes, without limitation, a persistent vegetative state or irreversible coma) and regarding the following, I give the specific directions indicated:

	I want used	I do not want used
Artificial nutrition through a conduit	_____	_____
Hydration through a conduit	_____	_____
Cardiopulmonary resuscitation	_____	_____
Mechanical respiration	_____	_____
Other (explain) _____	_____	_____

B. RELIEF FROM PAIN: Whether I choose A.1 or A.2, or neither, I direct that in all cases I be given all medically appropriate care necessary to make me comfortable and alleviate pain.

C. OTHER MEDICAL INSTRUCTION: If you wish to add to the instructions you have given above, you may do so here.

_____

_____

(use additional sheets if necessary)

PART II: POWER OF ATTORNEY FOR HEALTH CARE

Your agent may make any health care decision that you could have made while you had the capacity to make health care decisions. You may appoint an alternate agent to make health care decisions for you if your first agent is not willing, able and reasonably available to make decisions for you. Unless the persons you name as agent and alternate agent are related to you by blood, neither may own, operate or be employed by any residential long-term care institution where you are receiving care.

If you wish to appoint an agent to make health care decisions for you under these circumstances and conditions, you must fill out the section below. You may cross out any wording you do not want.

A. DESIGNATION OF AGENT: I designate _____ as my agent to make health care decisions for me. If he/she is not living, willing or able, or reasonably available, to make health care decisions for me, then I designate _____ _____ as my agent to make health care decisions for me.

_____
(name of individual you choose as agent)

_____
(address) (city) (state) (zip code)

_____
(home phone) (work phone)

_____
(name of individual you choose as alternate agent)

_____
(address) (city) (state) (zip code)

_____
(home phone) (work phone)

B. AGENT'S AUTHORITY: I grant to my agent full authority to make decisions for me regarding my health care; provided that, in exercising this authority, my agent shall follow my desires as stated in this document or otherwise known to my agent. Accordingly, my agent is authorized as follows:

1. To consent to, refuse, or withdraw consent to any and all types of medical care,treatment, surgical procedures, diagnostic procedures, medication, and the use of mechanical or other procedures that affect any bodily function;

2. To have access to medical records and information to the same extent that I amentitled to, including the right to disclose the contents to others;

3. To authorize my admission to or discharge from any hospital, nursing home,
residential care, assisted living or similar facility or service;

4. To contract for any health care related service or facility on my behalf, without myagent incurring personal financial liability for such contracts;

5. To hire and fire medical, social service, and other support personnel responsible formy care; and

6. To authorize, or refuse to authorize, any medication or procedure intended to relievepain, even though such use may lead to physical damage, addiction, or hasten the moment of (but not intentionally cause) my death.

C. WHEN AGENT'S AUTHORITY BECOMES EFFECTIVE: My agent's authority becomes effective when my attending physician determines I lack the capacity to make my own health care decisions.

D. AGENT'S OBLIGATION: My agent shall make health care decisions for me in accordance with this power of attorney for health care, any instructions I give in Part I of this form, and my other wishes to the extent known to my agent. To the extent my wishes are unknown, health care decisions by my agent shall conform as closely as possible to what I would have done or intended under the circumstances. If my agent is unable to determine what I would have done or intended under the circumstances, my agent will make health care decisions for me in accordance with what my agent determines to be my best interest. In determining my best interest, my agent shall consider my personal values to the extent known to my agent.

PART III. ANATOMICAL GIFT DECLARATION (Optional)

I hereby make the following anatomical gift(s) to take effect upon my death. The marks in the appropriate squares and words filled into the blanks below indicate my desires:

I give [ ] my body; [ ] any needed organs or parts; [ ] the following organs or parts

_____

to [ ] the physician in attendance at my death; [ ] the hospital in which I die;
[ ] the following named physician, hospital, storage bank or other medical institution

_____

for the following purpose(s):

[ ] any purpose authorized by law; [ ] transplantation;
[ ] therapy; [ ] research;
[ ] medical education.

EFFECT OF COPY: A copy of this form has the same effect as the original.

I understand the purpose and effect of this document.

_____ _____
(date) (sign your name)

_____
(print your name)

_____
(address)

_____

(city) (state) (zip code) **STATEMENT OF WITNESSES**

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

B. That neither of us is prohibited by §2503 of Title 16 of the Delaware Code from being a witness. 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 the 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 a direct financial responsibility for the declarant's medical care;
5. Has a controlling interest in or is an operator or an employee of a health care institution in which the declarant is a patient or resident; 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.

Witness

_____
(print name)

_____
(address)

_____
(city, state, zip code)

_____
(signature of witness) (date)

Witness

_____
(print name)

_____
(address)

_____
(city, state, zip code)

_____
(signature of witness) (date)

(Optional)

Sworn and subscribed to me this _____ day of _____.

My term expires: _____ _____
(Notary)