NORTH CAROLINA
Advance Directive
Planning for Important Healthcare Decisions

Caring Connections, 1700 Diagonal Road, Suite 625, Alexandria, VA 22314
www.caringinfo.org, 800/658-8898

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.

The goal of Caring Connections is for consumers to hear a unified message promoting awareness and action for improved end-of-life care. Through these efforts, NHPCO seeks to support those working across the country to improve end-of-life care and conditions for all Americans.

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 always up to date.

CARING CONNECTIONS

HelpLine

You can call our toll-free HelpLine, 800/658-8898, if you have any difficulty understanding your state-specific advance directive, or if you are dealing with a difficult end-of-life situation and need immediate information. We can help provide resources and information on questions like these:

- How do I communicate my end-of-life wishes to my family?
- What type of end-of-life care is available to me?
- What questions should I ask my mother's doctors about her end-of-life care?

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 to join the effort to improve community, state and national end-of-life care.

HOW TO USE THESE MATERIALS

1. Check to be sure that you have the materials for your state. You should complete a form for the state in which you expect to 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.

3. Read the instructions in their entirety. They give you specific information about the requirements in your state.

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

5. When you begin to complete the form, refer to the gray instruction bars - they indicate where you need to mark, insert your personal instructions, or sign the form.

6. Talk with your family, friends, and physicians about your decision to complete an advance directive. Be sure the person you appoint to make decision on your behalf understands your wishes.

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, you may call our toll free number 800/ 658-8898 and a staff member will be glad to assist you.

For more information contact:

The National Hospice and Palliative Care Organization
1700 Diagonal Road, Suite 625
Alexandria, VA 22314

Call our HelpLine: 800/658-8898
Visit our Web site: www.caringinfo.org

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INTRODUCTION TO YOUR NORTH CAROLINA ADVANCE DIRECTIVE

This packet contains two legal documents that protect 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. The **North Carolina Health Care Power of Attorney** lets you name someone to make decisions about your medical care—including decisions about life support—if you can no longer speak for yourself. The Health Care Power of Attorney is especially useful because it appoints someone to speak for you any time you are unable to make your own medical or mental health treatment decisions, not only at the end of life. It becomes effective when a physician you designate or your attending physician determines in writing that you are unable to make or communicate decisions about your medical care. For mental health decisions, the determination may be made by a psychologist you designate or an eligible psychologist.

2. The **North Carolina Declaration of a Desire for a Natural Death** is your state's living will. It lets you state your wishes about medical care in the event that you become terminally and incurably ill or enter a persistent vegetative state and can no longer make your own medical decisions. The Declaration becomes effective if your death would occur without the use of life-sustaining medical care. (One other doctor must agree with your attending physician's opinion of your medical condition.)

Caring Connections recommends that you complete both of these documents 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 (at least 18 years old).

COMPLETING YOUR NORTH CAROLINA HEALTH CARE POWER OF ATTORNEY

Whom should I appoint as my agent?

Your agent is the person you appoint to make decisions about your medical care 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 must be at least 18 years of age and should clearly understand your wishes and be willing to accept the responsibility of making medical decisions for you. (An agent may also be called an "attorney-in-fact" or "proxy.")

You can appoint a second and third person as your alternate agent(s). The alternate will step in if the first person you name as agent is unable, unwilling or unavailable to act for you. Any person who is providing your health care for compensation cannot serve as your agent or alternate agent.

How do I make my North Carolina Health Care Power of Attorney legal?

In order to make your Health Care Power of Attorney legally binding, you must:

1. Sign your document in the presence of two witnesses, who must also sign the document to show that they believe you to be of sound mind and that they do not fall into any of the categories of people who cannot be witnesses. These witnesses cannot be:

- related to you or your spouse within the third degree,
- entitled to any portion of your estate,
- a person who has a claim against any portion of your estate,
- your doctor or mental health treatment provider or an employee of your doctor or mental health treatment provider,
- an employee of a health care facility in which you are a patient, or
- an employee of a nursing home or any group-care home in which you are a resident

2. Have your signature and the signatures of your witnesses acknowledged by a notary public.

Should I add personal instructions to my North Carolina Health Care Power of Attorney?

On page 2 of the Health Care Power of Attorney you may name the physician(s) who will determine when you lack the ability to make health care decisions. You may also name the physician or psychologist who will determine when you lack the ability to make mental health treatment decisions.

If you do not designate a physician or a psychologist or if the physician(s) or psychologist you designate is unavailable, unable or unwilling to make the determination, your attending physician will make the determination. If you do not wish to designate a physician because of religious or moral beliefs, you may designate a competent adult of your choice to determine when you lack the ability to make health care decisions. The person you designate must not be your agent or involved in providing your health care for compensation. The person's determination that you lack competence to make medical decisions must be certified in writing and acknowledged before a notary public.

COMPLETING YOUR NORTH CAROLINA HEALTH CARE POWER OF ATTORNEY (CONTINUED)

Caring Connections advises you not to add further instructions under section 4 of this document. One of the strongest reasons for naming an agent is to have someone who can respond flexibly as your medical situation changes and deal with situations that you did not foresee. If you add instructions to this document, you might unintentionally restrict your agent's power to act in your best interest.

Instead, we urge you to talk with your 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 medical treatments or conditions, you should use your North Carolina Declaration (the living will).

What if I change my mind?

You may revoke your Health Care Power of Attorney at any time while you are still able to make and communicate health care decisions by:

- signing and dating a written revocation,
- executing a new Health Care Power of Attorney, or
- any other action, such as destroying the document, that indicates your intent to revoke your agent's power.

Your revocation becomes effective once you notify your agent(s) and your doctor or psychologist. Your Health Care Power of Attorney is automatically revoked if you appoint your spouse as your agent and your marriage ends (unless you have appointed an alternate agent).

COMPLETING YOUR NORTH CAROLINA DECLARATION OF A DESIRE FOR A NATURAL DEATH

How do I make my Declaration legal?

In order to make your Declaration legally binding, you must:

1. Sign your Declaration in the presence of two witnesses, who must also sign the document to show that you signed the Declaration in their presence and are of sound mind and that they do not fall into any of the categories of people who cannot be your witness. These witnesses **cannot**:

- be related within the third degree to you or your spouse,
- be entitled to any portion of your estate upon your death,
- have any claim against you,
- be your doctor or an employee of your doctor,
- be an employee of a health care facility in which you are a patient, or an employee of a nursing home or any group-care home in which you are a resident, or
- have a claim against your estate.

2. Have your signature and the signatures of your witnesses acknowledged before a notary public or Clerk (or Assistant Clerk) of the Superior Court.

Can I add personal instructions to my Declaration?

Yes. You can add personal instructions in the part of the document called "Other directions." For example, you may want to refuse specific treatments by a statement such as, "I especially do not want cardiopulmonary resuscitation, a respirator, or antibiotics." You may also want to emphasize pain control by adding instructions such as, "I want to receive as much pain medication as necessary to ensure my comfort, even if it may hasten my death."

If you do not want to receive artificial nutrition and hydration you should initial the appropriate instructions on page 1 of your document.

If you have appointed an agent and you want to add personal instructions to your Declaration, it is a good idea to write a statement such as "Any questions about how to interpret or when to apply my Declaration are to be decided by my agent."

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."

What if I change my mind?

You may revoke your Declaration at any time and in any manner, regardless of your mental or physical condition. Your revocation becomes effective once you, or somebody acting on your behalf, notify your doctor.

AFTER YOU HAVE COMPLETED YOUR DOCUMENTS

1. Your North Carolina Health Care Power of Attorney and North Carolina Declaration are important legal documents. Keep the original signed documents in a secure but accessible place. Do not put the original documents in a safe deposit box or any other security box that would keep others from having access to them.

2. Give photocopies of the signed originals to your agent and alternate agent, 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 documents placed in your medical records.

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

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

5. Remember, you can always revoke one or both of your North Carolina documents.

6. Be aware that your North Carolina 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. 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 or consult the Caring Connections booklet "Cardiopulmonary Resuscitation, Do-Not-Resuscitate Orders and End-Of-Life Decisions."

INSTRUCTIONS

(Notice: This document gives the person you designate as your health care agent broad powers to make health care decisions, including mental health treatment decisions for you. Except to the extent that you express specific limitations or restrictions on the authority of your health care agent, this power includes the power to consent to your doctor not giving treatment or stopping treatment necessary to keep you alive, admit you to a facility, and administer certain treatments and medications. This power exists only as to those health care decisions for which you are unable to give informed consent.

This form does not impose a duty on your health care agent to exercise granted powers, but when a power is exercised, your health care agent will have to use due care to act in your best interests and in accordance with this document. For mental health treatment decisions, your health care agent will act according to how the health agent believes you would act if you were making the decision. Because the powers granted by this document are broad and sweeping, you should discuss your wishes concerning life-sustaining procedures, mental health treatment, and other health care decisions with your health care agent.

Use of this form in the creation of a health care power of attorney is lawful and is authorized pursuant to North Carolina law. However, use of this form is an optional and nonexclusive method for creating a health care power of attorney and North Carolina law does not bar the use of any other or different form of power of attorney for health care that meets the statutory requirements.)

1. Designation of health care agent.

PRINT YOUR NAME

I, _____, being of sound mind,
(name)

PRINT THE NAME, ADDRESS AND TELEPHONE NUMBERS OF YOUR AGENT

hereby appoint _____
(name of health care agent)

_ _
(home address)

_ _
(home telephone number) (work telephone number)

as my health care attorney-in-fact (herein referred to as my "health care agent") to act for me and in my name (in any way I could act in person) to make health care decisions for me as authorized in this document.

ALTERNATE AGENTS (OPTIONAL)

PRINT THE NAME, ADDRESS AND TELEPHONE NUMBERS OF YOUR ALTERNATE AGENTS

If the person named as my health care agent is not reasonably available or is unable or unwilling to act as my agent, then I appoint the following persons (each to act alone and successively, in the order named), to serve in that capacity: *(Optional)*

A . ____

(name of first alternate health care agent)

____

(home address)

____

(home telephone number) *(work telephone number)*

B. ____

(name of second alternate health care agent)

____

(home address)

____

(home telephone number) *(work telephone number)*

Each successor health care agent designated shall be vested with the same power and duties as if originally named as my health care agent.

NAME THE PHYSICIAN (S) WHO WILL DETERMINE WHEN YOU CAN NO LONGER MAKE MEDICAL DECISIONS (OPTIONAL)

2. Effectiveness of appointment.
Absent revocation, the authority granted in this document shall become effective when and if the physician or physicians designated below determine that I lack sufficient understanding or capacity to make or communicate decisions relating to my health care and will continue in effect during my incapacity, until my death. This determination shall be made by the following physician or physicians:

NAME THE PHYSICIAN(S) OR ELIGIBLE PSYCHOLOGIST(S) WHO WILL DETERMINE WHEN YOU CAN NO LONGER MAKE MENTAL HEALTH TREATMENT DECISIONS

For decisions related to mental health treatment, this determination shall be made by the following physician or eligible psychologist:

3. General statement of authority granted.
Except as indicated in section 4 below, I hereby grant to my health care agent named above full power and authority to make health care decisions, including mental health treatments decisions, on my behalf, including, but not limited to, the following:

A. To request, review, and receive any information, verbal or written, regarding my physical or mental health, including, but not limited to, medical and hospital records, and to consent to the disclosure of this information,

B. To employ or discharge my health care providers,

C. To consent to and authorize my admission to and discharge from a hospital, nursing or convalescent home, or other institution,

D. To consent and to authorize my admission to and retention in a facility for the care or treatment of mental illness.

E. To consent to and authorize the administration of medications for mental health treatment and electro-convulsive treatment (ECT) commonly referred to as "shock treatment."

F. To give consent for, to withdraw consent for, or to withhold consent for, X-ray, anesthesia, medication, surgery, and all other diagnostic and treatment procedures ordered by or under the authorization of a licensed physician, dentist, or podiatrist. This authorization specifically includes the power to consent to measures for relief of pain.

G. To authorize the withholding or withdrawal of life-sustaining procedures when and if my physician determines that I am terminally ill, permanently in a coma, suffer severe dementia, or am in a persistent vegetative state. Life-sustaining procedures are those forms of medical care that only serve to artificially prolong the dying process and may include mechanical ventilation, dialysis, antibiotics, artificial nutrition and hydration, and other forms of medical treatment which sustain, restore or supplant vital bodily functions. Life-sustaining procedures do not include care necessary to provide comfort or alleviate pain.

I DESIRE THAT MY LIFE NOT BE PROLONGED BY LIFE-SUSTAINING PROCEDURES IF I AM TERMINALLY ILL, PERMANENTLY IN A COMA, SUFFER SEVERE DEMENTIA, OR AM IN A PERSISTENT VEGETATIVE STATE.

H. To exercise any right I may have to make a disposition of any part or all of my body for medical purposes, to donate my organs, to authorize an autopsy, and to direct the disposition of my remains.

I. To take any lawful actions that may be necessary to carry out these decisions, including the granting of releases of liability to medical providers.

LIST LIMITATIONS ON YOUR AGENT'S POWER (IF ANY)

4. Special provisions and limitations.
A. In exercising the authority to make health care decisions on my behalf, the authority of my health care agent is subject to the following special provisions and limitations:

B. In exercising the authority to make mental health decisions on my behalf, the authority of my health care agent is subject to the following special provisions and limitations.

C. Notice: This health care power of attorney may incorporate or be combined with an advance instruction for mental health treatment, executed in accordance with Part 2 of Article 3 of Chapter 122C of the General Statutes, which you may use to state your instructions regarding mental health treatment in the event that you lack sufficient understanding or capacity to make or communicate mental health treatment decisions. Because your health care agent's decisions must be consistent with any statements you have expressed in an advance instruction, you should indicate here whether you have executed an advance instruction for mental health treatment.

5. Guardianship provision.
If it becomes necessary for a court to appoint a guardian of my person, I nominate my health care agent acting under this document to be the guardian of my person, to serve without bond or security. The guardian shall act consistently with G.S. 35A-1201 (a) (5).

6. Reliance of third parties on health care agent.
A. No person who relies in good faith upon the authority of or any representations by my health care agent shall be liable to me, my estate, my heirs, successors, assigns, or personal representatives, for actions or omissions by my health care agent.

B. The powers conferred on my health care agent by this document may be exercised by my health care agent alone, and my health care agent's signature or act under the authority granted in this document may be accepted by persons as fully authorized by me and with the same force and effect as if I were personally present, competent, and acting on my own behalf. All acts performed in good faith by my health care agent pursuant to this power of attorney are done with my consent and shall have the same validity and effect as if I were present and exercised the powers myself, and shall inure to the benefit of and bind me, my estate, my heirs, successors, assigns, and personal representatives. The authority of my health care agent pursuant to this power of attorney shall be superior to and binding upon my family, relatives, friends, and others.

7. Miscellaneous provisions.
A. I revoke any prior health care power of attorney.

B. My health care agent shall be entitled to sign, execute, deliver, and acknowledge any contract or other document that may be necessary, desirable, convenient, or proper in order to exercise and carry out any of the powers described in this document and to incur reasonable costs on my behalf incident to the exercise of these powers; provided, however, that except as shall be necessary in order to exercise the powers described in this document relating to my health care, my health care agent shall not have any authority over my property or financial affairs.

C. My health care agent and my health care agent's estate, heirs, successors, and assigns are hereby released and forever discharged by me, my estate, my heirs, successors, and assigns and personal representatives from all liability and from all claims or demands of all kinds arising out of the acts or omissions of my health care agent pursuant to this document, except for willful misconduct or gross negligence.

D. No act or omission of my health care agent, or of any other person, institution, or facility acting in good faith in reliance on the authority of my health care agent pursuant to this health care power of attorney shall be considered suicide, nor the cause of my death for any civil or criminal purposes, nor shall it be considered unprofessional conduct or as lack of professional competence. Any person, institution, or facility against whom criminal or civil liability is asserted because of conduct authorized by this health care power of attorney may interpose this document as a defense.

SIGN AND DATE YOUR DOCUMENT

8. Signature of principal.
By signing here, I indicate that I am mentally alert and competent, fully informed as to the contents of this document, and understand the full import of this grant of powers to my health care agent.

_____ _____
signature of principal date

WITNESSING PROCEDURE

9. Signatures of Witnesses.
I hereby state that the Principal, _____, being of sound mind, signed the foregoing health care power of attorney in my presence, and that I am not related to the principal by blood or marriage, and I would not be entitled to any portion of the estate of the principal under any existing will or codicil of the principal or as an heir under the Intestate Succession Act, if the principal died on this date without a will. I also state that I am not the principal's attending physician, nor an employee of the principal's attending physician, nor an employee of the health facility in which the principal is a patient, nor an employee of a nursing home or any group-care home where the principal resides. I further state that I do not have any claim against the principal.

WITNESSES SIGN AND DATE YOUR DOCUMENT BELOW

Witness: _____ Date: _____

Witness: _____ Date: _____

A NOTARY PUBLIC MUST COMPLETE THIS SECTION OF YOUR DOCUMENT

STATE OF NORTH CAROLINA
COUNTY OF _____

CERTIFICATE

I, _____,

a Notary Public for _____ County, North Carolina,

hereby certify that _____ appeared before me and swore to me and to the witnesses in my presence that this instrument is a health care power of attorney, and that he/she willingly and voluntarily made and executed it as his/her free act and deed for the purposes expressed in it.

I further certify that _____

and _____, witnesses,

appeared before me and swore that they witnessed _____

_____ sign the attached health care power of attorney, believing him/her to be of sound mind; and also swore that at the time they witnessed the signing (i) they were not related within the third degree to him/her or his/her spouse, and (ii) they did not know nor have a reasonable expectation that they would be entitled to any portion of his/her estate upon his/her death under any will or codicil thereto then existing or under the Intestate Succession Act as it provided at that time, and (iii) they were not a physician attending him/her, nor an employee of an attending physician, nor an employee of a health facility in which he/she was a patient, nor an employee of a nursing home or any group-care home in which he/she resided, and (iv) they did not have a claim against him/her. I further certify that I am satisfied as to the genuineness and due execution of the instrument.

This the _____ day of _____,20_____.

Notary Public _____

My Commission Expires: _____

Courtesy of Caring Connections
1700 Diagonal Road, Suite 625, Alexandria, VA 22314
www.caringinfo.org, 800/658-8898

INSTRUCTIONS

PRINT YOUR NAME

INITIAL THE INSTRUCTIONS THAT REFLECT YOUR WISHES

ADD PERSONAL INSTRUCTIONS (IF ANY)

NORTH CAROLINA DECLARATION OF A DESIRE FOR A NATURAL DEATH – PAGE 1 OF 3

I, _____,
(name)

being of sound mind, desire that, as specified below, my life not be prolonged by extraordinary means or by artificial nutrition or hydration if my condition is determined to be terminal and incurable or if I am diagnosed as being in a persistent vegetative state. I am aware and understand that this writing authorizes a physician to withhold or discontinue extraordinary means or artificial nutrition or hydration, in accordance with my specifications set forth below:
(Initial any of the following, as desired):

_____ If my condition is determined to be terminal and incurable, I authorize the authorize the following:

____ My physician may withhold or discontinue extraordinary means only.

____ In addition to withholding or discontinuing extraordinary means if such means are necessary, my physician may withhold or discontinue either artificial nutrition or hydration, or both.

_____ If my physician determines that I am in a persistent vegetative state, I authorize the following:

____ My physician may withhold or discontinue extraordinary means only.

____ In addition to withholding or discontinuing extraordinary means if such means are necessary, my physician may withhold or discontinue either artificial nutrition or hydration, or both.

Other directions:

SIGN AND DATE THE DOCUMENT

This the _____ day of _____, _____.
(day) (month) (year)

Signature _____

WITNESSING PROCEDURE

I hereby state that the declarant, _____, being of sound mind signed the above declaration in my presence and that I am not related to the declarant by blood or marriage and that I do not know or have a reasonable expectation that I would be entitled to any portion of the estate of the declarant under any existing will or codicil of the declarant or as an heir under the Intestate Succession Act if the declarant died on this date without a will. I also state that I am not the declarant's attending physician or an employee of the declarant's attending physician, or an employee of a health facility in which the declarant is a patient or an employee of a nursing home or any group-care home where the declarant resides. I further state that I do not now have any claim against the declarant.

WITNESSES SIGN HERE

Witness _____

Witness _____

A NOTARY PUBLIC, CLERK OR ASSISTANT CLERK OF SUPERIOR COURT MUST COMPLETE THIS SECTION

CERTIFICATE

I, _____, Clerk (Assistant Clerk) of Superior Court or Notary Public (circle one as appropriate) for

_____ County hereby certify that

_____, the declarant, appeared before me and swore to me and to the witnesses in my presence that this instrument is his Declaration of a Desire for a Natural Death, and that he had willingly and voluntarily made and executed it as his free act and deed for the purposes expressed in it.

I further certify that _____and

_____, witnesses, appeared before me

and swore that they witnessed _____, declarant, sign the attached declaration, believing him to be of sound mind; and also swore that at the time they witnessed the declaration (i) they were not related within the third degree to the declarant or to the declarant's spouse, and (ii) they did not know or have a reasonable expectation that they would be entitled to any portion of the estate of the declarant upon the declarant's death under any will of the declarant or codicil thereto then existing or under the Intestate Succession Act as it provided at that time, and (iii) they were not a physician attending the declarant or an employee of an attending physician or an employee of a health facility in which the declarant was a patient or an employee of a nursing home or any group-care home in which the declarant resided, and (iv) they did not have a claim against the declarant. I further certify that I am satisfied as to the genuineness and due execution of the declaration.

This the _____ day of_____.

Clerk (Assistant Clerk) of Superior Court or Notary Public (circle one as appropriate) for the County of _____

Courtesy of Caring Connections
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