ARKANSAS
Advance Directive
Planning for Important Health Care Decisions

Caring Connections
1731 King St,, Suite 100, Alexandria, VA 22314

800/658-XXXX

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.

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

Note: The following is not a substitute for legal advice. While Caring Connections updates the following information and form to keep them up-to-date, changes in the underlying law can affect how the form will operate in the event you lose the ability to make decisions for yourself. If you have any questions about how the form will help ensure your wishes are carried out, or if your wishes do not seem to fit with the form, you may wish to talk to your health care provider or an attorney with experience in drafting advance directives. **If you have other questions regarding these documents, we recommend contacting your state attorney general's office.**

Using these Materials

BEFORE YOU BEGIN

1. Check to be sure that you have the materials for each state in which you may receive health care.

2. These materials include:
    - 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.

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 the form and give it to the person you have appointed to make decisions on your behalf, your family, friends, health care 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 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.

Introduction to Your Arkansas Declaration and Durable Power of Attorney for Health Care

This packet contains your **Arkansas Declaration and Durable Power of Attorney for Health Care**. This legal document 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.

Page 1 of your document contains your **Declaration**, which allows you to state your wishes about medical care in the event that you either: (1) develop a terminal condition and are unable to make your own medical decisions; or (2) are in a permanently unconscious state. The declaration becomes effective when you are in either of these states, your doctor and one other doctor has determined you are in such a state, and the declaration has been communicated to your doctor. Page 1 includes a space for you to include additional directions in the event you are terminally ill or permanently unconscious.

Pages 2 and 3 of your document contain your **Arkansas Durable Power of Attorney for Health Care**, which lets you name an **Agent** to make decisions about your medical care any time you lose the ability to make medical decisions for yourself. Page 3 of your document allows you to include directions in the event you lose the ability to make medical decisions for yourself. These directions are triggered any time you lose capacity, and are not dependent on you becoming terminally ill or permanently unconscious.

Your durable power of attorney for health care also appoints your agent as your **Health Care Proxy** to make decisions about your medical care — including decisions about life sustaining treatment — if you are terminally ill and can no longer make your own decisions about health care or are permanently unconscious.

Your durable power of attorney for health care goes into effect when your doctor determines that you are no longer able to make or communicate your health care decisions.

Page 4 of your document is your signature page. Your signature must be witnessed by two people who are 18 years of age or older, or, alternatively, your signature may be notarized on page 5.

Note: This form authorizes mental health care decisions to be made by your agent/proxy, but does not go into detail regarding mental health issues. If you would like to make advance care plans involving mental illness, you should talk to your physician and an attorney about a durable power of attorney.

Following your Arkansas declaration and durable power of attorney for health care is an organ donation form.
Note: These documents will be legally binding only if the person completing them is a competent adult (at least 18 years old) or an emancipated or married minor.

Instructions for Completing Your Arkansas Declaration and Durable Power of Attorney

How do I make my Arkansas Declaration and Durable Power of Attorney for Health Care legal?

The law requires that you sign or someone signs at your direction on your behalf your Declaration and Durable Power of Attorney for Health in the presence of two witnesses, who must be 18 years of age or older, or, alternatively, your signature may be notarized.

Whom should I appoint as my Agent/Proxy?

Your agent/proxy is the person you appoint to make decisions about your medical care if you become unable to make those decisions yourself. Your agent/proxy may be a family member or a close friend whom you trust to make serious decisions. The person you name as your agent/proxy should clearly understand your wishes and be willing to accept the responsibility of making medical decisions for you. **To avoid any confusion, you should name the same person as your agent/proxy in the Directive section as you name in the Durable Power of Attorney section.**

You can appoint a second person as your alternate agent/proxy. The alternate will step in if the first person you name as an agent/proxy is unable, unwilling, or unavailable to act for you.

Can I add personal instructions to my Declaration?

One of the strongest reasons for naming an agent/proxy 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 it may help your agent/proxy carry out your wishes, but be careful that you do not unintentionally restrict your agent/proxy's power to act in your best interest. In any event, be sure to talk with your agent/proxy about your future medical care and describe what you consider to be an acceptable "quality of life."

What if I change my mind?

You may revoke the instructions in your declaration at any time and in any manner, regardless of your mental or physical condition. Your revocation becomes effective when you (or a witness to your revocation) notify your doctor or other health care provider, who must then make the revocation a part of your medical record.

You may revoke your agent/proxy's power under your durable power of attorney for health care at any time by executing a new durable power of attorney for health care or by otherwise specifying in writing that you wish to revoke it.

What other important facts should I know?

A pregnant patient's Arkansas Declaration will not be honored if it is possible that the fetus could develop to the point of live birth with continued application of life-sustaining treatment.

Instructions for Completing Your Arkansas Organ Donation Form

How do I make my Arkansas Organ Donation Form legal?

The law requires that you sign your Organ Donation Form in the presence of two witnesses. Both witnesses must be 18 years of age or older. At least one of the witnesses must be a disinterested party (i.e. not a family member nor potential recipient of your donation).

Who may receive my anatomical gift?

Under Arkansas law, you may make a gift of all or part of your body for transplantation, therapy, research, or education to any of the following entities: a tissue or eye bank or any other organ procurement organization; hospital; accredited medical school, dental school, college, or university; or any individual designated as the recipient by you.

Can others make a gift for me?

Unless you explicitly prohibit such gifts, your agent/proxy or a family member has the authority to make anatomical gifts on your behalf.

Can I refuse to make a gift?

You can refuse to make a gift in any of these other ways: (1) any writing — including your Organ Donation Form — signed by you refusing to make such donations; (2) in your will; or (3) during a terminal illness or injury, you communicate such refusal to at least two adults, at least one of whom is a disinterested witness.

How can I revoke my gift?

You can revoke or amend an anatomical gift by: (1) any writing signed by you revoking or amending such gift that is witnessed by at least two adults, at least one of whom is a disinterested witness; (2) by the destruction or cancellation of the document of gift, or the portion of the document of gift used to make the gift, with the intent to revoke the gift. If the gift was not made in a will, you may revoke or amend it by any form of communication during a terminal illness or injury addressed to at least two adults, at least one of whom is a disinterested witness.

ARKANSAS DECLARATION AND DURABLE POWER OF ATTORNEY FOR HEALTH CARE — PAGE 1 OF 5

INITIAL THE OPTION THAT REFLECTS YOUR WISHES (CHOOSE ONLY ONE OPTION)

IF YOU CHOOSE OPTION 2, PRINT THE NAME OF YOUR AGENT/PROXY—THIS SHOULD BE THE SAME AGENT/PROXY THAT YOU IDENTIFY ON P. 2

INITIAL THE OPTION(S) THAT REFLECT YOUR WISHES

ADD PERSONAL INSTRUCTIONS (IF ANY)

Declaration

If I should either (1) have an incurable or irreversible condition that will cause my death within a relatively short time, and I am no longer able to make decisions regarding my medical treatment; or (2) if I should become permanently unconscious, I direct my attending physician, pursuant to the Arkansas Rights of the Terminally Ill or Permanently Unconscious Act, to (initial only one)

_____ 1. Withhold or withdraw treatments that only prolong the process of dying and are not necessary to my comfort or to alleviate pain.

_____ 2. Follow the instructions of _____, whom I appoint as my health care agent/proxy to decide whether life-sustaining treatment should be withheld or withdrawn.

In addition, the following specific directives apply (initial the option(s) that apply):

_____ a. It is my specific directive that nutrition may be withheld after consultation with my attending physician.

_____ b. It is my specific directive that hydration may be withheld after consultation with my attending physician.

_____ c. It is my specific directive that nutrition may not be withheld.

_____ d. It is my specific directive that hydration may not be withheld.

Other directions in the event I am terminally ill and cannot make decisions, or I am permanently unconscious:

_____
_____
_____
_____
_____
_____
_____

ARKANSAS DECLARATION AND DURABLE POWER OF ATTORNEY FOR HEALTH CARE — PAGE 2 OF 5

PRINT YOUR NAME

I, _____, hereby
(your name)
appoint:

PRINT THE NAME, ADDRESS AND TELEPHONE NUMBER OF YOUR AGENT/PROXY

_____
(name, home address and telephone number of agent/proxy)

_____

as my health care agent/proxy to make any and all health care decisions for me, except to the extent that I state otherwise.

This Durable Power of Attorney for Health Care shall take effect in the event of my disability or incapacity, such that I become unable to make my own health care decisions. My health care agent/proxy and any alternate health care agent/proxy as appointed below shall have the authority to make all health care decisions regarding any care, treatment, service, or procedure to maintain, diagnose, treat, or provide for my physical or mental health or personal care.

If I should either (1) have an incurable or irreversible condition that will cause my death within a relatively short time and I am no longer able to make decisions regarding my medical treatment; or (2) if I should become permanently unconscious, my health care agent/proxy and any alternate health care agent/proxy shall also have the authority to make decisions regarding the providing, withholding, or withdrawing of life sustaining treatment as my Proxy pursuant to the Arkansas Rights of the Terminally Ill or Permanently Unconscious Act.

If the health care agent/proxy I appoint is unable, unwilling or unavailable to act as my health care agent/proxy, then I appoint:

PRINT THE NAME, ADDRESS AND TELEPHONE NUMBER OF YOUR ALTERNATE AGENT/PROXY

_____
(name, home address and telephone number of alternate agent/proxy)

_____

as my alternate health care agent/proxy to make any and all health care decisions for me, except to the extent that I state otherwise.

ARKANSAS DECLARATION AND DURABLE POWER OF ATTORNEY FOR HEALTH CARE — PAGE 3 OF 5

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

Other Directions, in the event of my disability or incapacitation, such that I become unable to make my own health care decisions:

SIGN AND DATE THE DOCUMENT AND PRINT YOUR ADDRESS

Signed this _____day of _____, _____.
(day) (month) (year)

Signature_____

Address _____

_____

WITNESSING PROCEDURE

Statement by Witnesses (must be 18 or older):
I declare that the person who signed above appeared to execute this declaration and durable power of attorney for health care willingly and free from duress. He or she signed (or asked another to sign for him or her) this document in my presence.

Witness _____
(Signature) (Date)

_____
(Print name)

YOUR WITNESSES MUST SIGN AND PRINT THEIR NAMES AND ADDRESSES

Address _____

_____

Witness _____
(Signature) (Date)

_____
(Print name)

Address _____

_____

SIGNING BEFORE A NOTARY PUBLIC IS AN OPTION IF YOU DO NOT HAVE TWO WITNESSES

Alternative No. 2: Sign before a notary public.

I sign my name to this Declaration and Power of Attorney for Health Care on

_____ at_____,_____.
(date) (city) (state)

SIGN AND PRINT YOUR NAME, THE DATE, AND LOCATION HERE

_____
(signature)

_____
(print name)

CERTIFICATE OF ACKNOWLEDGMENT OF NOTARY PUBLIC

State of Arkansas)
) ss.
County of _____)

A NOTARY PUBLIC MUST COMPLETE THIS SECTION

On this _____ day of _____, in the year _____, before me, _____, personally appeared
(name of notary public)

_____
(name of principal)

personally known to me (or proved to me on the basis of satisfactory evidence) to be the person whose name is subscribed to this instrument, and acknowledged that he or she executed it. I declare under penalty of perjury that the person whose name is ascribed to this instrument appears to be of sound mind and under no duress, fraud or undue influence.

NOTARY SEAL

_____
(signature of notary public)

Courtesy of Caring Connections
1731 King St., Suite 100, Alexandria, VA 22314
www.caringinfo.org, 800/658-8898

ORGAN DONATION (OPTIONAL)

INITIAL THE OPTION THAT REFLECTS YOUR WISHES

ADD NAME OR INSTITUTION (IF ANY)

PRINT YOUR NAME, SIGN, AND DATE THE DOCUMENT

YOUR WITNESSES MUST SIGN AND PRINT THEIR ADDRESSES

AT LEAST ONE WITNESS MUST BE A DISINTERESTED PARTY

ARKANSAS ORGAN DONATION FORM - PAGE 1 OF 1

Initial the line next to the statement below that best reflects your wishes. You do not have to initial any of the statements. If you do not initial any of the statements, your attorney for health care, proxy, or other agent, or your family, may have the authority to make a gift of all or part of your body under Arkansas law.

_____I do not want to make an organ or tissue donation and I do not want my attorney for health care, proxy, or other agent or family to do so.
_____ I have already signed a written agreement or donor card regarding organ and tissue donation with the following individual or institution:

Name of individual/institution:_____

_____ Pursuant to Arkansas law, I hereby give, effective on my death:

_____ Any needed organ or parts.
_____ The following part or organs listed below:

For (initial one):

_____ Any legally authorized purpose.
_____ Transplant or therapeutic purposes only.

Declarant name: _____

Declarant signature: _____, Date: _____

The declarant voluntarily signed or directed another person to sign this writing in my presence.

Witness _____Date_____

Address _____

_____

I am a disinterested party with regard to the declarant and his or her donation and estate. The declarant voluntarily signed or directed another person to sign this writing in my presence.

Witness _____Date_____

Address _____

_____

Courtesy of Caring Connections
1731 King St., Suite 100, Alexandria, VA 22314
www.caringinfo.org, 800/658-8898

You Have Filled Out Your Health Care Directive, Now What?

1. Your Arkansas Declaration and Durable Power of Attorney for Health Care is an important legal document. Keep the original signed document in a secure but accessible place. Do not put the original document in a safe deposit box or any other security box that would keep others from having access to it.

2. Give photocopies of the signed original to your agent/proxy and alternate agent/proxy, 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 document placed in your medical records.

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

4. You may also want to save a copy of your form in 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.

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

6. Remember, you can always revoke your Arkansas document.

7. Be aware that your Arkansas document will not be effective in the event of a medical emergency. Ambulance and hospital emergency department personnel are required to provide cardiopulmonary resuscitation (CPR) unless they are given a separate directive that states otherwise. These directives called "prehospital medical care directives" or "do not resuscitate orders" are designed for people whose poor health gives them little chance of benefiting from CPR. These directives instruct ambulance and hospital emergency 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. We suggest you speak to your physician if you are interested in obtaining this form. **Caring Connections does not distribute these forms.**

Congratulations!

You've downloaded **your free, state specific advance directive.**

You are taking important steps to make sure your wishes are known. Help us keep this free.

Your generous support of the National Hospice Foundation and Caring Info allows us to continue to provide these FREE resources, tools, and information to educate and empower individuals to access advance care planning, caregiving, hospice and grief services, and information.

I hope you will show your support for our mission and make a tax-deductible gift today.

Since 1992, the National Hospice Foundation has been dedicated to creating FREE resources for individuals and families facing a life-limiting illness, raising awareness for the need for hospice care, and providing ongoing professional education and skills development to hospice professionals across the nation.

Your gift strengthens the Foundation's ability to provide FREE caregiver and family resources.

Support your National Hospice Foundation by returning a **generous tax-deductible gift of $23, $47, $64,** or the most generous amount you can send.

You can help us provide resources like this advance directive FREE by sending in your gift to help others.

Please help to make this possible with your contribution! Cut along the dotted line and use the coupon below to return a check contribution of the most generous amount you can send. Thank you.

YES! I want to support the important work of the National Hospice Foundation.

$23	helps us provide free advance directives
$47	helps us maintain our free HelpLine
$64	helps us provide webinars to hospice professionals

Return to:
National Hospice Foundation
PO Box 824401
Philadelphia, PA 19182-4401

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OR donate online today: www.caringinfo.org/donate