MARYLAND
Advance Directive
Planning for Important Healthcare Decisions

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

800/658-8898

Caring Info, 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 healthcare 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 Info 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 healthcare.

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 store a copy of your Advance Directive in MyDirectives, a secure, web-based system that allows you to document and store your Advance Directive in a secure database. You may share your Advance Directive electronically with your health care agent, family members, and providers. You can find out more about this resource at http://www.mydirectives.com.

INTRODUCTION TO YOUR MARYLAND ADVANCE DIRECTIVE

This packet contains two legal documents, the Maryland Advance 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, and the Maryland "After My Death," form, a document that allows you to record your decisions regarding organ donation and the final disposition of your remains.

The Maryland Advance Directive is divided into three parts. You may fill out Part I, Part II, or both, depending on your advance planning needs. You must complete Part III.

Part 1, **Selection of Health Care Agent**, lets you name someone (an agent) to make decisions about your health care. This part 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.

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 II becomes effective when your doctor determines that you can no longer make or communicate your health care decisions.

Part III contains the signature and witnessing provisions so that your document will be effective.

Following the Maryland Advance Directive is a form, called "After My Death," which allows you to record your organ donation and final remains disposition preferences.You may share your Advance Directive electronically with your health care agent, family members, and providers by using the free, secure, web-based system at http://www.mydirectives.com/

The Maryland Advance Directive form does not expressly address mental illness. If you would like to make advance care plans regarding mental illness, you should talk to your physician and an attorney about a directive tailored to your needs. The Maryland Department of Mental Health and Hygiene provides an advance directive focused on mental-health issues on its webpage at: http://bha.dhmh.maryland.gov/Documents/Advance%20Directive%20for%20Mental%20Health%20Treatment%202016%20(2).docx.

Note: This document will be legally binding only if the person completing it is either: (1) 18 years of age or older, or (2) if under the age of 18, is married or is the parent of a child.

INSTRUCTIONS COMPLETING YOUR MARYLAND ADVANCE DIRECTIVE

How do I make my Maryland Advance Directive legal?

You must sign and date your advance directive 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.

Whom should I appoint as my agent?

Your agent is the person you appoint to make decisions about your health 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 should clearly understand your wishes and be willing to accept the responsibility of making health care decisions for you.

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

Should I add personal instructions to my Appointment of Health Care Agent?

One of the strongest reasons for naming an agent is to have someone who can respond flexibly as your health care situation changes and deal with situations that you did not foresee. If you add instructions to this document it may help your agent carry out your wishes, but be careful that you do not unintentionally restrict your agent's power to act in your best interest. In any event, be sure to talk with your agent about your future medical care and describe what you consider to be an acceptable "quality of life."

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.

How do I make my "After My Death" form legal?

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

PRINT YOUR NAME AND THE DATE

MARYLAND ADVANCE DIRECTIVE

Maryland Advance Directive:

Planning for Future Health Care Decisions

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:

INITIAL ONLY ONE

_____ 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.

((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.)

MARYLAND "AFTER MY DEATH" FORM – PAGE 1 OF 3

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:

INITIAL ALL THAT APPLY

_____ For transplantation
_____ For therapy
_____ For research
_____ For medical education
_____ For any purpose authorized by law

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 Caring Info
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 Maryland Advance Directive and "After my Death" form 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 healthcare. 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(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 medical records management 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 Maryland documents.

7. Be aware that your Maryland documents 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 "emergency medical services/do not resuscitate orders" or "EMS/DNR 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 these orders. We suggest you speak to your physician if you are interested in obtaining one. **Caring Info does not distribute these forms.** To get information about a physician's order form that allows emergency medical personnel to provide comfort care instead of aggressive interventions, call the Maryland Institute for Emergency Medical Services Systems at (410) 706-4367. You can also download the Maryland EMS/DNR Order at: http://www.miemss.org

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

AD_2018

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