VERMONT
Advance Directive
Planning for Important Health Care Decisions

CaringInfo
1731 King St., Suite 100, Alexandria, VA 22314

800/658-XXXX

CaringInfo, 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 CaringInfo 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. Vermont maintains an Advance Directive Registry. By filing your advance directive with the registry, your health care provider and loved ones may be able to find a copy of your directive in the event you are unable to provide one. You can read more about the registry, including instructions on how to file your advance directive, at http://healthvermont.gov/vadr/index.aspx.

6. 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 VERMONT ADVANCE DIRECTIVE

This packet contains a legal document, a **Vermont 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. You may complete and or all of the parts of this advance directive, depending on your advance-planning needs. You must complete Part 9.

Part 1. Appointment of an Agent. This part lets you name an adult, your "agent," to make decisions about your medical care—including decisions about life-sustaining procedures—if you can no longer speak for yourself. This is especially useful because it appoints someone to speak for you any time you are unable to make your own medical decisions, not only at the end of life.

Your agent's authority will become effective:

- When your physician determines that you no longer have the **capacity** to make health care decisions, such as when you are unconscious or cannot communicate, and your physician has made reasonable efforts to notify you and your agent of such determination; or
- **Immediately** upon signing the advance directive if you so specify; or
- When a **condition** you specify is met, such as diagnosis of a debilitating disease such as Alzheimer's Disease or serious mental illness; or
- When an **event** occurs that you want to mark the start of your agent's authority, such as when you move to a nursing home or other institution.

Part 2 allows you to specify who may and may not be involved in determining your health care.

Part 3 allows you to record a statement of your values and goals to help guide your health care.

Part 4 allows you to record your health care treatment wishes if you are close to death or are unconscious and unlikely to become conscious again.

Part 5 allows you to record your wishes for treatment other than at the end of life.

Part 6 allows you to record your wishes regarding organ and tissue donation.

Part 7 allows you to appoint an agent for the disposition of your remains and to record your wishes regarding the final disposition of your remains.

Part 8 allows you to record any other advance planning consideration that you do not feel is adequately covered by the other parts.

Part 9 contains the witnessing and signature provisions to make your document effective.

This 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 an advance directive tailored to your needs.
Note: This document will be legally binding only if the person completing it is an individual of sound mind who is 18 years or older.

COMPLETING YOUR VERMONT ADVANCE DIRECTIVE

How do I make my Vermont Advance Directive legal?

In Part 9, you must sign and date your document in front of two witnesses, aged 18 or older. Neither witness can be your spouse, agent, parent, brother, sister, child, grandchild, or reciprocal beneficiary.

If you are in a hospital, nursing home, or residential care facility when you complete your advance directive, you will need a third person's signature to certify that he or she has explained the advance directive to you and that you understand the impact and effect of what you are doing. This third person may be a hospital designee, a long-term care ombudsman, an attorney licensed to practice in Vermont, a clergyperson, or a probate division of the superior court designee.

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 and third person as your alternate agent(s). 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 your doctor or other health care clinician to be your agent. If you are in a residential facility, a health care facility, or a correctional facility, an owner, operator, employee and/or contractor of the facility cannot be your agent unless such person is related to you by blood, marriage, civil union, or adoption.

Part 7 allows you to appoint a person, also called an agent, to oversee the final disposition of your remains. This person may not be an unrelated funeral director, crematory operator, cemetery operator or an employee of a funeral director, crematory operator, or cemetery operator. He or she also may not be an unrelated employee or representative of an organ procurement organization.

Can I add personal instructions to my Vermont Advance Directive?

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?

You may revoke your Advance Directive by completing a new advance directive.

You may revoke or suspend all or part of your Advance Directive by doing any of the following things:

1. Signing a statement suspending or revoking the designation of your agent;
2. Personally informing your doctor and having him or her note that on your record;
3. By burning, tearing, or obliterating the Advance Directive either personally or at your direction when you are present;
4. For any provision (other than designation of your agent), when you state orally or in writing, or indicating by any other act of yours that your intent is to suspend or revoke any Part or statement contained in your Advance Directive; or
5. By executing a new Advance Directive.

What other important information should I know?

You may expressly provide in your Advance Directive that, in the event you lack capacity to make health care decisions, your agent may authorize or withhold health care over your objection. In order for this provision to be effective, the following must occur:

1. You must name an agent in your Advance Directive;
2. Your agent must accept in writing the responsibility for authorizing or withholding health care over your objection;
3. Your physician must sign this provision and affirm that you understood the benefits, risks, and alternatives of such a provision;
4. A long-term care ombudsman, an attorney licensed to practice in Vermont, a clergyperson, or a probate division of the superior court designee must sign a statement affirming that he or she has explained the provision to you and you appear to understand the provision and are free from duress or undue influence (this person must be a disinterested party and independent of the hospital if you are in the hospital when the provision is executed);
5. You must specify the treatments to which this provision applies; and
6. You must acknowledge that you are knowingly and voluntarily waiving the right to refuse or receive treatment at a time of incapacity, as determined by your physician and one other physician.

If you decide to include language regarding care given over your objection, you may wish to speak with your health care provider or an attorney with experience in drafting advance directives regarding this language. Any such language may be included in Part 8 of the Vermont Advance Directive.

Your agent does not have the authority to consent to voluntary sterilization.

ADVANCE DIRECTIVE

PRINT YOUR NAME, DATE OF BIRTH, DATE, ADDRESS, TELEPHONE NUMBER, AND EMAIL ADDRESS

My Name _____ Date of Birth _____

Date signed _____

Address _____ City _____ Zip _____

Phone _____ Email _____

PART 1 – APPOINTMENT OF AN AGENT

1. I want my agent to make decisions for me: (choose one statement below)

INITIAL ONLY ONE

_____ when I am no longer able to make health care decisions for myself, or

_____ immediately, allowing my agent to make decisions for me right now, or

_____ when the following condition or event occurs (to be determined as follows):

_____

_____

PRINT THE NAME OF YOUR AGENT

2. I appoint _____ as my health care Agent to make any and all health care decisions for me, except to the extent that I state otherwise in this Advance Directive. (You may cross out the italicized phrase if authority is unrestricted.)

PRINT ADDRESS, RELATIONSHIP, DAY TELEPHONE NUMBERS, AND EMAIL ADDRESS OF YOUR AGENT

Address _____ Relationship (optional) _____

_____

Tel. (daytime) _____ cell phone _____

(evening) _____ email _____

PRINT THE NAME OF YOUR ALTERNATE AGENT

PRINT ADDRESS, RELATIONSHIP, TELEPHONE NUMBERS, AND EMAIL ADDRESS OF YOUR ALTERNATE AGENT

3. If this health care agent is unavailable, unable or unwilling to do this for me, I appoint _____ to be my Alternate Agent.

Address _____Relationship (optional) _____

Tel. (daytime) _____cell phone _____

(evening) _____email _____

PRINT THE NAME OF YOUR SECOND ALTERNATE AGENT

PRINT ADDRESS, RELATIONSHIP, TELEPHONE NUMBERS AND EMAIL ADDRESS OF YOUR NEXT ALTERNATE AGENT

And if my Alternate Agent is unavailable, unable or unwilling to do this, I appoint _____ as my Next Alternate Agent.

Address _____ Relationship (optional) _____

Tel. (daytime) _____cell phone _____

(evening) _____ email _____

4. General guidance for my agent: When making health care decisions for me, my agent should think about what action would be consistent with past conversations we have had, my treatment preferences as expressed in this or any other document, my religious and other beliefs and values, and how I have handled medical and other important issues in the past. If what I would decide is still unclear, then my agent should make decisions for me that my agent believes are in my best interest, considering the benefits, burdens, and risks of my current circumstances and treatment options.

PRINT ADDITIONAL INSTRUCTIONS, IF ANY, FOR YOUR AGENT HERE

ATTACH ADDITIONAL PAGES IF NEEDED

5. I give the following further instructions, if any, for my agent's guidance:

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

(attach additional pages if needed)

PART 2 – OTHERS WHO MAY BE INVOLVED IN MY CARE

PRINT YOUR DOCTOR'S OR CLINICIAN'S NAME, ADDRESS AND PHONE NUMBER

1. My Doctor or other Health Care Clinician:

Name _____ Phone _____

Address _____

OR

Name _____ Phone _____

Address _____

LIST PEOPLE WHO MAY BE CONSULTED ABOUT YOUR HEALTH CARE DECISIONS

2. Other people whom my agent MAY consult about medical decisions on my behalf;

_____

_____

LIST PEOPLE WHO SHOULD NOT BE CONSULTED ABOUT YOUR HEALTH CARE DECISIONS

Those who should NOT be consulted by my agent include:

_____

LIST PEOPLE YOU WANT TO HAVE INFORMATION ABOUT YOUR CONDITION

3. My health agent or health care provider may give information about my condition to the following adults and minors:

_____

_____

LIST PEOPLE YOU DON'T WANT TO BE ABLE TO CHALLENGE YOUR AGENT OR CLINICIAN IN COURT REGARDING THE INSTRUCTIONS AND/OR APPOINTMENTS IN THIS DOCUMENT

4. The person(s) named below shall NOT be entitled to bring a court action on my behalf concerning matters covered by this advance directive, nor serve as a health care decision maker for me.

_____
_____
_____
_____
_____
_____
_____
_____

(attach additional pages if needed)

INITIAL TO INDICATE WHO YOU WANT NOMINATED AS YOUR GUARDIAN, IN THE EVENT A COURT DECIDES THAT YOU NEED ONE

LIST ALTERNATE GUARDIANS, IF ANY

LIST PEOPLE YOU DON'T WANT NOMINATED AS YOUR GUARDIAN

5. If I need a guardian in the future, I ask the court to consider appointing the following person:

_____ My health care agent

_____ The following person:

Name _____ Phone _____

Address _____

You may also list alternative preferred guardians, or persons that you would not want to have appointed as guardians.

Alternate preferred guardians:_____

Persons I would not want to be my guardian: _____

_____

PART 3 – STATEMENT OF VALUES AND GOALS

STATE IN YOUR OWN WORDS WHAT IS MOST IMORTANT TO YOU REGARDING YOUR HEALTH CARE

Use the space below to state in your own words what is most important to you.

STATE GENERAL ADVICE ABOUT HOW TO APPROACH YOUR HEALTH CARE CHOICES

General advice about how to approach health care choices depending upon your current or future state of health or the chances of success of various treatments.

STATE OTHER VALUES AND GOALS TO HELP GUIDE HEALTH CARE DECISIONS MADE ON YOUR BEHALF

Other statement of values and goals to help guide health care decisions made on your behalf.

PART 4 – END-OF-LIFE WISHES

If the time comes when I am close to death or am unconscious and unlikely to become conscious again (initial all that apply):

INITIAL ONLY ONE OF CHOICES 1-3

1. _____ I **do** want all possible treatments to extend my life.

   - or -

2. _____ I **do not** want my life extended by any of the following means:

   _____ breathing machines (ventilator or respirator)

   _____tube feeding (feeding and hydration by medical means)

   _____ antibiotics

   _____ other medications whose purpose is to extend my life

   _____ any other means

   _____ Other (specify) _____

INITIAL ALL THAT APPLY TO YOU OF CHOICES 4-7

3. _____ I want my **agent to decide** what treatments I receive, including tube feeding.

4. _____ I want care that preserves my dignity and that provides **comfort and relief** from symptoms that are bothering me.

5. _____ I want **pain medication** to be administered to me even though this may have the unintended effect of hastening my death.

6. _____ I want **hospice** care when it is appropriate in any setting.

7. _____ I would prefer to **die at home** if this is possible.

ADD OTHER WISHES AND INSTRUCTIONS, IF ANY

8. Other wishes and instructions: (state below or use additional pages):

_____

_____

_____

_____

_____

PART 5 – OTHER TREATMENT WISHES

INITIAL ALL THAT APPLY TO YOU

1. _____I wish to have a **Do Not Resuscitate (DNR) Order** written for me.

2. _____ If I am in a critical health crisis that may not be life-ending and more time is needed to determine if I can get better, I want treatment started. If, after a reasonable period of time, it becomes clear that I will not get better, I want all life extending treatment stopped. This includes the use of breathing machines or tube feeding.

3. If I am conscious but become unable to think or act for myself and will likely not improve, I do not want the following life-extending treatment:
   - _____ breathing machines (ventilators or respirators)
   - _____ feeding tubes (feeding and hydration by medical means)
   - _____ antibiotics
   - _____ other medications whose purpose is to extend life
   - _____ other treatment to extend my life
   - _____ other _____

4. _____ If the likely cost, risks and burdens of treatment are more than I wish to endure, I do not want life-extending treatment. The costs, risks and burdens that concern me the most are: _____

   _____

5. _____ If it is determined that I am pregnant at the time this Advance Directive becomes effective, I want:
   - _____ all life sustaining treatment, (or)
   - _____ only the following life sustaining treatments:
     - _____ breathing machines (ventilators or respirators)
     - _____ feeding tubes (feeding and hydration by medical means)
     - _____ antibiotics
     - _____ other medications whose purpose is to extend life
     - _____ any other treatment to extend my life
   - _____ other _____
   - _____ no life sustaining treatment.

LIST HOSPITALS OR TREATMENT FACILITIES NAME, ADDRESS AND PHONE NUMBERS

6. **Hospitalization** – If I need care in a hospital or treatment facility, the following facilities are listed in order of preference:

Hospital/Facility _____ Address _____
Tel. # _____

Hospital/Facility _____ Address _____
Tel. # _____

LIST HOSPITALS OR TREATMENT FACILITIES YOU WANT TO AVOID, AND REASON

I would like to avoid being treated in **the following facilities:**

Hospital/Facility _____

Hospital/Facility _____

LIST MEDICATIONS OR TREATMENTS YOU WOULD LIKE TO RECEIVE

7. **I prefer the following medications or treatments:** Use more space or additional sheets for this section, if needed.

_____

LIST MEDICATIONS OR TREATMENTS YOU WOULD LIKE TO AVOID AND REASONS

Avoid **use of the following medications or treatments:**

List medications/treatments:

_____

_____

INTIAL AND CIRCLE THE ONE THAT APPLIES TO YOU

8. **Consent for Student Education, Treatment Studies, or Drug Trials**

_____**I do / do not** (circle one) wish to participate in student medical education.

_____**I do / do not** (circle one) wish to participate in treatment studies or drug trials.

(or)

_____ I authorize **my agent to consent** to any of the above.

PART 6 – ORGAN AND TISSUE DONATION

I want my agent (if I have appointed one) and all who care about me to follow my wishes about organ donation if that is an option at the time of my death. (Initial below all that apply.)

INITIAL ONLY ONE

_____**I do <u>not</u> wish to be an organ donor.**

_____**I wish to donate the following organs and tissues:**

INITIAL YOUR ORGAN DONATION CHOICES

_____ any needed organs or tissues
_____major organs (heart, lungs, kidneys, etc.)
_____tissues such as skin and bones
_____eye tissue such as corneas

Agent for organ donation (optional)

YOU MAY CHOOSE SOMEONE TO MAKE ORGAN DONATION DECISIONS FOR YOU

_____ I wish my agent to make any decisions for anatomical gifts

OR

_____ I wish the following person(s) to make any decisions:

_____

_____

INITIAL HERE IF YOU WANT TO DONATE YOUR BODY TO SCIENCE

_____**I desire to donate my body to research or educational programs.**

(Note: you will have to make your own arrangements through a Medical School or other program.)

PART 7 – DISPOSITION OF MY BODY AFTER DEATH

1. **My Directions for Burial or Disposition of My Remains after Death.**

INITIAL ONLY ONE

_____I want a funeral followed by burial in a casket at the following location, if possible (please tell us where the burial plot is located and whether it has been pre-purchased): _____ (or)
_____ I want to be cremated and want my ashes buried or distributed as follows:

_____ (or)

____ I want to have arrangements made at the direction of my agent or family.

Other instructions: _____
(for example, you may include contact information for Medical School programs if you have made arrangements to donate your body for research or education.)

2. Agent for disposition of my body (select one)**:**

INITIAL ONLY ONE

_____ I want my health care agent to decide arrangements after my death.
If he or she is not available, I want my alternate agent to decide.
_____ I appoint the following person to decide about and arrange for the disposition of my body after my death:

PRINT NAME, ADDRESS, TELEPHONE NUMBERS, AND EMAIL ADDRESS OF THE PERSON YOU WANT TO DECIDE ARRANGEMENTS AFTER YOUR DEATH

Name _____ Address _____

Telephone _____ Cell phone _____ Email _____

(or)

_____ I want my family to decide.

3. If an autopsy is suggested following my death:

INITIAL ONLY ONE

_____ I support having an autopsy performed.
_____ I would like my agent or family to decide whether to have it done.

4. I have already made funeral or cremation arrangements with:

PRINT NAME, ADDRESS, AND TELEPHONE NUMBER OF THE PERSON YOU MADE FUNERAL OR CREMATION ARRANGEMENTNTS WITH

Name _____ Tel. _____

Address _____

PART 8 – OTHER INSTRUCTIONS

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

I give the following instructions:

(attach additional pages if needed)

PART 9 – SIGNATURE AND WITNESSES

PRINT YOUR NAME, DATE OF BIRTH, AND TODAY'S DATE

My Name _____DOB _____ Date _____

I declare that this document reflects my desires regarding my future health care, (organ and tissue donation and disposition of my body after death, and that I am signing this advance directive of my own free will.

SIGN AND DATE

Signed _____ Date _____

YOUR WITNESSES MUST SIGN, DATE, AND PRINT THEIR NAMES HERE

Acknowledgement of Witnesses

I affirm that the Principal appears to understand the nature of an Advance Directive and to be free from duress or undue influence.

Signed _____ Date _____

Print Name _____

Signed _____ Date _____

Print Name _____

Acknowledgement by the person who explained the Advance Directive if the principal is a current patient or resident in a hospital, or other health care facility.

IF YOU ARE IN A HOSPITAL, NURSING HOME, OR RESIDENTIAL CARE FACILITY, A THIRD PERSON MUST SIGN, DATE, AND PRINT HIS/HER NAME, ADDRESS, TITLE, AND TELEPHONE NUMBER

I affirm that:

- The maker of this Advance Directive is a current patient or resident in a hospital, nursing home or residential care facility,
- I am an ombudsman, recognized member of the clergy, an attorney licensed to practice in Vermont, or a probate division of the superior court designee or hospital designee, and
- I have explained the nature and effect of the Advance Directive to the Principal and it appears that the Principal is willingly and voluntarily executing it.

Signature_____Date _____

Name _____

Address _____

Title/position _____ Tel. _____

Courtesy of CaringInfo
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 Vermont Advance Directive 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 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 document 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. Vermont maintains an Advance Directive Registry. By filing your advance directive with the registry, your health care provider and loved ones may be able to find a copy of your directive in the event you are unable to provide one. You can read more about the registry, including instructions on how to file your advance directive, at http://healthvermont.gov/vadr/index.aspx.

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.

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

7. Remember, you can always revoke your Vermont document.

8. Be aware that your Vermont 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," "do not resuscitate orders," or "clinician orders for life-sustaining treatment" 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.

   Vermont authorizes a "Clinician Orders for Life-Sustaining Treatment" or "COLST" form that addresses these issues. We suggest you speak to your physician if you are interested in obtaining one. **CaringInfo 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 CaringInfo 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 InfoLine
$64	helps us provide webinars to hospice

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