Uteuzi wa Wakala wa Huduma ya Utunzaji

Mwelekezo wa mapema kuhusu matibabu wa Vermont

Appointment of a Health Care Agent

Vermont Advance Directive for Health Care Decisions

SWAHILI

JINA LAKO YOUR NAME | **TAREHE YA KUZALIWA** DATE OF BIRTH | **TAREHE** DATE

ANWANI ADDRESS

JIJI CITY | **JIMBO** STATE | **POSTA** ZIP

Wakala wako **wa huduma ya utunzaji** anaweza kufanya maamuzi ya utunzaji wa afya kwa niaba yako ikiwa huwezi au hutaki kufanya maamuzi wewe mwenyewe. Unapaswa kumchagua mtu unayemwamini, anayeelewa matakwa yako na anayekubali kutenda kama wakala wako. Daktari wako **HAWEZI** kuwa wakala wako isipokuwa kama ni jamaa. Wakala wako **HAWEZI** kuwa mmiliki, mwendesha shughuli, mfanyakazi au mkandarasi wa kituo cha huduma ya utunzaji, kituo cha huduma za afya au kituo cha kurekebisha tabia unapoishi wakati wa kukamilisha mwelekezo wako wa mapema kuhusu matibabu.

Your health care agent can make health care decisions for you when you are unable or unwilling to make decisions for yourself. You should pick someone that you trust, who understands your wishes and agrees to act as your agent. Your health care provider may **NOT** be your agent unless they are a relative. Your agent may **NOT** be the owner, operator, employee or contractor of a residential care facility, health care facility or correctional facility where you reside at the time your advance directive is completed.

Ninamteua mtu huyu awe **WAKALA** wangu wa huduma ya afya:

I appoint this person to be my health care **AGENT:**

JINA LA WAKALA AGENT NAME | **BARUA PEPE** EMAIL

ANWANI ADDRESS

SIMU YA NYUMBANI HOME PHONE | **SIMU YA KAZINI** WORK PHONE | **SIMU YA MKONONI** CELL PHONE

(Ukiwateua **WAKALA WASHIRIKA**, waandike kwenye karatasi tofauti)

(If you appoint **CO-AGENTS**, list them on a separate sheet of paper)

Ikiwa wakala huyu **hapatikani**, hataki au hawezi kutenda kama wakala wangu, ninamteua mtu huyu awe **WAKALA wangu MWINGINE:**

If this agent is unavailable, unwilling or unable to act as my agent, I appoint this person as my **ALTERNATE AGENT:**

WAKALA MWINGINE ALTERNATE AGENT NAME | **BARUA PEPE** EMAIL

ANWANI ADDRESS

SIMU YA NYUMBANI HOME PHONE | **SIMU YA KAZINI** WORK PHONE | **SIMU YA MKONONI** CELL PHONE

Watu wengine wanaoweza kutoa maoni kuhusu maamuzi ya matibabu kwa niaba yangu ni pamoja na:

Others who may be consulted about medical decisions on my behalf include:

Mtoa huduma wa msingi (Daktari, Msaidizi wa Daktari au Muuguzi):

Primary care provider (Physician, PA or Nurse Practitioner):

JINA NAME | **SIMU** PHONE

ANWANI ADDRESS

JINA NAME | **SIMU** PHONE

ANWANI ADDRESS

Watu WASIOPASWA kutoa maoni ni pamoja na:

Those who should NOT be consulted include:

JINA NAME | **TEREHE YA KUZALIWA** DOB | **TAREHE** DATE

Maoni ya jumla Kuhusu Malengo yangu ya Huduma ya Utunzaji:

General Comments About My Health Care Goals:

AZIMIO LA MATAKWA LILITIWA SAINI / SIGNED DECLARATION OF WISHES

Lazima utie saini mbele ya mashahidi WAWILI ambao ni watu wazima. Watu wafuatao **hawawezi** kutia saini kama mashahidi: wakala (mawakala), mwenzi wa ndoa, wazazi, ndugu, watoto au wajukuu wako.

You must sign this in the presence of TWO adult witnesses. The following people may **not** sign as witnesses: your agent(s), spouse, parents, siblings, children or grandchildren.

Ninatangaza kwamba hati hii inaonyesha matakwa yangu ya huduma za afya na kwamba ninatia saini kwenye Mwelekezo huu wa Mapema kuhusu matibabu kwa hiari.

I declare that this document reflects my health care wishes and that I am signing this Advance Directive of my own free will.

IMETIWA SAINI SIGNED ..... **TAREHE** DATE

Ninathibitisha kwamba aliyetia saini alionekana kuwa anaelewa maana ya mwelekezo huu wa mapema kuhusu matibabu na hakushurutishwa au kushawishiwa wakati wa kutia saini. (Tafadhali tia saini na uchapishe)

I affirm that the signer appeared to understand the nature of this advance directive and to be free from duress or undue influence at the time this was signed. (Please sign and print)

SHAHIDI WA 1 (JINA LILILOCHAPISHWA)
WITNESS 1 (PRINT NAME)

SAINI SIGNATURE ..... **TAREHE** DATE

SHAHIDI WA 2 (JINA LILILOCHAPISHWA)
WITNESS 2 (PRINT NAME)

SAINI SIGNATURE ..... **TAREHE** DATE

Ikiwa mtu anayetia saini kwenye hati hii analazwa au kwa sasa yeye ni mgonjwa **hospitalini**, lazima mojawapo wa watu wafuatao atie saini na athibitishe kwamba amemwelezea mgonjwa maana na athari za mwelekezo wa mapema kuhusu matibabu na alionekana kwamba anaelewa na hakuwa ameshurutishwa au kushawishiwa wakati wa kutia saini: *mfafanuzi wa hospitali aliyeteuliwa, mchunguzi maalum, mwakilishi wa mgonjwa wa afya ya akili, kasisi anayetambuliwa, wakili wa Vermont, au Mteule wa Mahakama ya Uthibitisho.*

If the person signing this document is being admitted to or is a current patient in a **hospital**, one of the following must sign and affirm that they have explained the nature and effect of the advance directive and the patient appeared to understand and be free from duress or undue influence at the time of signing: *designated hospital explainer, ombudsman, mental health patient representative, recognized member of the clergy, Vermont attorney, or Probate Court designee.*

Ikiwa mtu anayetia saini kwenye hati hii analazwa au kwa sasa yuko katika **kituo cha utunzaji wa wazee au makazi ya utunzaji**, lazima mojawapo wa watu wafuatao atie saini na athibitishe kwamba amemwelezea mgonjwa maana na athari za mwelekezo wa mapema kuhusu matibabu na alionekana kwamba anaelewa na hakuwa ameshurutishwa au kushawishiwa wakati wa kutia saini: *mchunguzi maalum, kasisi anayetambuliwa, wakili wa Vermont, Mteule wa Mahakama ya Uthibitisho, mfafanuzi wa hospitali aliyeteuliwa, mwakilishi wa mgonjwa wa afya ya akili, daktari ambaye hajaajiriwa na kituo hicho, au mfanyakazi wa kujitolea aliyefunzwa ipasavyo wa kituo cha utunzaji wa wazee/makazi ya utunzaji.*

If the person signing this document is being admitted to or is a resident in a **nursing home or residential care facility**, one of the following must sign and affirm that they have explained the nature and effect of the advance directive and the resident appeared to understand and be free from duress or undue influence at the time of signing: *an ombudsman, recognized member of the clergy, Vermont attorney, Probate Court designee, designated hospital explainer, mental health patient representative, clinician not employed by the facility, or appropriately trained nursing home/residential care facility volunteer.*

Mfafanuzi kama ilivyoelezwa hapa juu pia anaweza kutenda kama mojawapo wa mashahidi wawili wanaohitajika.

The explainer as outlined above may also serve as one of the two required witnesses.

JINA NAME

CHEO/KAZI TITLE/POSITION | **SIMU** PHONE

ANWANI ADDRESS

SAINI SIGNATURE ..... **TAREHE** DATE

Watu wafuatao wana nakala ya Mwelekezo wa Mapema kuhusu matibabu (tafadhali tia alama):

The following have a copy of my Advance Directive (please check):

- ☐ **Usajili wa Mwelekezo wa Mapema kuhusu matibabu wa Vermont** Vermont Advance Directive Registry — **TAREHE ILIYOANDIKISHWA:** DATE REGISTERED:
- ☐ **Wakala wa huduma ya utunzaji** Health care agent
- ☐ **Wakala mwingine wa huduma ya utunzaji** Alternate health care agent
- ☐ **Daktari/Mtoa(Watoa) huduma:** Doctor/Provider(s):
- ☐ **Hospitali:** Hospital(s):
- ☐ **Mwanafamilia(Wanafamilia):** Family Member(s):

FOMU WAZI
CLEAR FORM

VERMONT
DEPARTMENT OF HEALTH

Registry Use Only
Received: _____
Confirmed: _____

Usajili wa Mwelekezo wa Mapema kuhusu matibabu wa Vermont
Fomu ya Makubaliano ya Usajili na Idhini ya Kubadilisha
(Hati za A na B kulingana na Sheria ya Mwelekezo wa Mapema kuhusu matibabu wa Vermont)

Vermont Advance Directive Registry
Registration Agreement & Authorization to Change Form (Documents A & B per the Vermont Advance Directive Rule)

Maelekezo / Directions

1. Soma Sera ya Usajili kwenye ukurasa wa 3 na ujaze sehemu muhimu hapa chini. Tafadhali andika au uchapishe kwa wazi.
   Read the Registration Policy on page 3 and complete the relevant sections below. Please type or print clearly.
   a. **Wasajili wa mara ya kwanza:** Jaza Taarifa ya Msajili Inayohitajika na Hati ya A.
      First-time Registrants: Complete the Required Registrant Information & Document A.
   b. **Kusasisha Mwelekezo wa Mapema kuhusu matibabu ulio kwenye faili:** Jaza Taarifa ya Msajili Inayohitajika na Hati ya B.
      Updating an Advance Directive already on file: Complete the Required Registrant Information & Document B.
2. Ambatisha nakala ya mwelekezo wa mapema kuhusu matibabu iliyotiwa saini na kushuhudiwa.
   Attach a signed and witnessed copy of your advance directive.
3. Usajili **lazima** ujumuishe Makubaliano wa Usajili uliokamilishwa na uliotiwa saini au Idhini ya Kubadilisha fomu na nakala ya mwelekezo wa mapema kuhusu matibabu iliyotiwa saini na kushuhudiwa.
   Registrations **must** include a completed and signed Registration Agreement or Authorization to Change form and a copy of the signed and witnessed advance directive document.
4. Baada ya fomu kukamilishwa na kutiwa saini, tuma fomu kwenye barua pepe, barua ya posta **au** faksi:
   Once forms are completed and signed, send forms by email, mail **or** fax:

Tuma barua pepe kwenye: VADRSubmissions@uslwr.com
E-mail to:

Au utume barua ya posta kwa: Vermont Advance Directive Registry (VADR)
Or Mail to: PO Box 2789
Westfield, NJ 07091-2789

Au Faksi kwa: 908- 654-1919
Or Fax to:

Kwa taarifa ya ziada tembelea: http://healthvermont.gov/vadr/ au piga simu 1-888-548-9455
For additional information visit: http://healthvermont.gov/vadr/ or call 1-888-548-9455

Taarifa za Msajili Zinazohitajika / Required Registrant Information

Jina: La kwanza _____ La kati _____ La mwisho _____ Kiambishi tamati _____
Name: First Middle Last Suffix

Tarehe ya Kuzaliwa: __ __ / __ __ / __ __ __ __
Date of Birth:

Anwani ya Msingi ya Kutumia Barua:
Primary Mailing Address: _____

Mji/Jiji: _____ **Jimbo:** _____ **Msimbo wa posta:** _____
Town/City: State: Zip code:

Nambari ya simu: Ya msingi: (__ __ __) __ __ __-__ __ __ __ Nyingine: (__ __ __) __ __ __-__ __ __ __
Phone Number: Primary Other:

Je, ungependa tuwasiliane na wewe kupitia barua pepe? ☐ **Hapana** ☐ **Ndiyo**
Would you like to be contacted by e-mail? No Yes

Anwani ya Barua Pepe:
Email Address: _____

Anwani ya Pili ya Kutumia Barua (ikiwa inahusika):
Secondary Mailing Address (if applicable): _____

Mji/Jiji: _____ **Jimbo:** _____ **Msimbo wa posta:** _____
Town/City: State: Zip code:

Wawasiliani wa Dharura / Emergency Contacts

Wa msingi: Jina:
Primary: Name: _____

Uhusiano na Msajili: _____ Nambari ya simu: (__ __ __) __ __ __-__ __ __ __
Relationship to Registrant: Phone Number:

Wa pili: Jina:
Secondary: Name: _____

Uhusiano na Msajili: _____ Nambari ya simu: (__ __ __) __ __ __-__ __ __ __
Relationship to Registrant: Phone Number:

VERMONT
DEPARTMENT OF HEALTH

Registry Use Only
Received: _____
Confirmed: _____

NOTISI: Mawasilisho yote kwa Usajili yanapaswa kujumuisha nakala iliyosainiwa na iliyoshuhudiwa ya Mwelekezo wa Mapema kuhusu matibabu wa Msajili. Hii inahusu mawasilisho yote ya kwanza na masasisho ya hati zilizopo.
NOTICE: All submissions to the Registry must include a signed and witnessed copy of the registrant's Advance Directive. This applies to both first-time submissions and updates to existing documents.

Hati ya A: Makubaliano ya Usajili
Document A: Registration Agreement

Jaza sehemu hii **tu** ikiwa hii ni mara yako ya kwanza ya kusajili mwelekezo wako wa mapema kuhusu matibabu.
Complete this section **only** if this is your first time registering your advance directive.

Mimi, _____ **(jina lililochapishwa)** ninaomba kwamba mwelekezo wangu wa mapema kuhusu matibabu usajiliwe katika Usajili wa Mwelekezo wa Mapema kuhusu matibabu wa Vermont, na ninakubali ufikiwe kama inavyoruhusiwa na sheria ya Vermont. Kwa kutia saini hapa chini, ninakubali na kuthibitisha kwamba: taarifa iliyotolewa ni sahihi; Nimesoma, nimeelewa, na ninakubaliana na masharti ya Sera ya Kujiandikisha kwenye Usajili; Nitalinda nambari yangu ya kitambulisho cha usajili na programu ya ununuzi ili isifikiwe na watu ambao hawajaidhinishwa; na nitajulisha Usajili haraka kwa maandishi kuhusu mabadiliko ya taarifa yangu ya usajili au mwelekezo wa mapema kuhusu matibabu. Nimekubali kwa hiari bila kulazimishwa, kushurutishwa, au kushawishiwa na mtu mwingine yeyote. Ninaelewa kwamba mtu yeyote anayeweza kufikia programu yangu ya ununuzi anaweza kuitumia kupata hati zangu na taarifa za kibinafsi. Idhini hii inatumika hadi nitakapoibatilisha.

I, _____ **(print name)** request that my advance directive be registered in the Vermont Advance Directive Registry, and authorize its access as allowed by Vermont law. By signing below, I acknowledge and affirm that: the information provided is accurate; I have read, understand, and agree to the terms of the Registry Registration Policy; I will safeguard my registrant identification number and wallet card from unauthorized access; and I will immediately notify the Registry in writing of changes to my registration information or advance directive. I execute this agreement voluntarily and without coercion, duress, or undue influence by any party. I understand that anyone who has access to my wallet card can use it to gain access to my documents and personal information. This authorization remains in effect until I revoke it.

Saini ya Msajili: _____ **Tarehe:** _____
Signature of Registrant: **Date:**

Hati ya B: Idhini ya Kubadilisha
Document B: Authorization to Change

Jaza **tu** ikiwa umejisajili kwa sasa na unasasisha mwelekezo wa mapema kuhusu matibabu ambao upo kwenye faili na Usajili.
Complete **only** if you are currently registered and making updates to an advance directive already on file with the registry.

Tia alama kwenye kisanduku kilicho hapa chini kinachohusu uwasilishaji wako.
Check the box below that applies to your submission.

☐ **Rekebisha:** Tia alama kwenye kisanduku ili urekebishe mwelekezo wako wa mapema kuhusu matibabu uliopo. Historia ya hati ya awali itahifadhiwa kwenye faili yako.
Amend: Check this box to amend your existing advance directive. Prior document history will be retained in your file.

☐ **Badilisha:** Tia alama kwenye kisanduku hiki ili ubadilishe mwelekezo wako wa mapema kuhusu matibabu uliopo. Historia ya hati ya awali haitahifadhiwa kwenye faili yako.
Replace: Check this box to replace your existing advance directive. Prior document history will not be retained in your file.

☐ **Simamisha:** Tia alama kwenye kisanduku hiki ili ughairi sehemu yote au sehemu fulani ya mwelekezo wako wa mapema kuhusu matibabu kwa muda maalum uliobainishwa.
Suspend: Check this box to temporarily inactivate all or part of your advance directive for a defined period of time.

Tarehe ya Kuanza: _____ **Tarehe ya Kumaliza:** _____
Begin Date: End Date:

☐ **Batilisha:** Tia alama kwenye kisanduku hiki ili ufute mwelekezo wako wa mapema kuhusu matibabu kutoka kwenye Usajili. (Hii ni kuondoa kabisa kutoka kwenye Usajili)
Revoke: Check this box to delete your advance directive from the registry. (This is a permanent removal from the Registry)

Mimi, _____ **(jina lililochapishwa)** ninathibitisha kwamba fomu hii inawakilisha kwa usahihi mabadiliko ambayo nimefanya, na mabadiliko haya ni sahihi. Isitoshe, ninaidhinisha kwamba mabadiliko hayo yaonekane kwenye Usajili wa Mwelekezo wa Mapema kuhusu matibabu.

I, _____ **(print name)** certify that this form accurately represents the changes I have made, and these changes are accurate. Additionally, I authorize the changes to be reflected in the Advance Directive Registry.

Saini ya Msajili: _____ **Tarehe:** _____
Signature of Registrant: Date:

VERMONT
DEPARTMENT OF HEALTH

Sera ya Usajili / Registration Policy

Mwelekezo wa Mapema kuhusu matibabu ni hati ya kisheria inayowasilisha matakwa ya mtu kuhusu matibabu yake na maamuzi yake kuhusu mwisho wa maisha endapo asijiweze au ikiwa hawezi kufanya maamuzi hayo. Usajili wa Mwelekezo wa Mapema kuhusu matibabu wa Vermont ni hifadhidata inayowaruhusu watu wahifadhi nakala yao ya mwelekezo wa mapema kuhusu matibabu kwenye hifadhidata salama. Hifadhidata hiyo inaweza kupatikana inapohitajika na wahudumu wa afya walioidhishwa, vituo vya huduma za afya, makazi ya huduma ya utunzaji, wakurugenzi wa mazishi, na waendeshaji wa tanuu ya kuchomea maiti. Kwa taarifa ya ziada tembelea: http://healthvermont.gov/vadr/.

An advance directive is a legal document that conveys a person's wishes regarding their health care treatment and end of life choices should they become incapacitated or otherwise unable to make those decisions. The Vermont Advance Directive Registry is a database that allows people to electronically store a copy of their advance directive document in a secure database. That database may be accessed when needed by authorized health care providers, health care facilities, residential care facilities, funeral directors, and crematory operators. For more information, visit: http://healthvermont.gov/vadr/.

1. Ili uandikishe mwelekezo wa mapema kuhusu matibabu, lazima msajili ajaze na atume fomu ya Makubaliano ya Usajili pamoja na nakala ya hati ya mwelekezo wa mapema kuhusu matibabu kwa:

   To register an advance directive, the registrant must complete and send the Registration Agreement form along with a copy of the advance directive document to:

   The Vermont Advance Directive Registry
   PO Box 2789
   Westfield, New Jersey 07091-2789

2. Baada ya kupokea makubaliano ya Usajili na viambatisho, Usajili utachanganua mwelekezo wa mapema kuhusu matibabu na kuuhifadhi kwenye hifadhidata pamoja na taarifa ya kumtambua msajili kutoka kwenye Makubaliano ya Usajili. Usajili utatumia msajili barua ya uthibitisho pamoja na nambari ya usajili, maelekezo ya kutumia nambari ya usajili kwa ajili ya kufikia hati kwenye tovuti ya Usajili, programu ya ununuzi, na vibandiko vya kubandika kwenye leseni ya dereva au kadi ya bima. Usajili hautumiki mpaka barua ya uthibitisho upokelewe na msajili amekamilisha nyenzo za usajili.

   Upon receipt of the Registration Agreement and attachments, the Registry will scan the advance directive and store it in the database along with registrant identifying information from the Registration Agreement. The Registry will send a confirmation letter to the registrant along with a registration number, instructions for using the registration number to access documents at the Registry website, a wallet card, and stickers to affix to a driver's license or insurance card. The registration is not effective until receipt of the confirmation letter and registration materials is made by registrant.

3. Wasajili wanapaswa kushiriki nambari ya usajili kutoka kwenye programu ya ununuzi na mtu yeyote anayepaswa kufikia mielekezo ya mapema kuhusu matibabu: kwa mfano, wakala wa msajili, wanafamilia, au daktari. Mtu yeyote anaweza kufikia mwelekezo ya mapema kuhusu matibabu wa mtu mwingine kwa kutumia nambari ya usajili. Isitoshe, ikiwa nambari ya usajili haipatikani kwa urahisi, mhudumu wa afya aliyeidhinishwa anaweza kutafuta mwelekezo maalum wa mapema kuhusu matibabu kwenye Usajili kwa kutumia taarifa za kibinafsi za kumtambua msajili.

   Registrants should share the registration number from the wallet card with anyone that should have access to their advance directives: for example, the registrant's agent, family members, or physician. Anyone may access a person's advance directive using the registration number. Additionally, when the registration number is not readily available, an authorized health care provider can search the Registry for a specific person's advance directive using a registrant's personal identifying information.

4. Msajili ana jukumu la kuhakikisha kwamba:

   The registrant is responsible for ensuring that:

   a. Mwelekezo wa mapema kuhusu matibabu umetekelezwa vizuri kwa mujibu wa sheria za jimbo ya Vermont.

      The advance directive is properly executed in accordance with the laws of the state of Vermont.

   b. Nakala ya mwelekezo wa mapema kuhusu matibabu iliyotumwa kwa Usajili, ikiwa ni nakala ya awali, ni sahihi na inaweza kusomwa.

      The copy of the advance directive sent to the Registry, if a photocopy of the original, is correct and readable.

   c. Taarifa iliyo katika Makubaliano ya Usajili na hati za mwelekezo wa mapema kuhusu matibabu ni sahihi na imesasishwa.

      The information in both the Registration Agreement and advance directive documents is accurate and up to date.

   d. Usajili unajulishwa haraka iwezekanavyo kuhusu mabadiliko yoyote kwenye mwelekezo wa mapema kuhusu matibabu au taarifa ya usajili kwa kukamilisha na kuwasilisha Idhini ya Kubadilisha fomu na mabadiliko yaliyoongezwa, au ikiwezekana, na nakala iliyosasishwa ya mwelekezo wa mapema kuhusu matibabu kwa Usajili.

      The Registry is notified as soon as possible of any changes to the advance directive or registration information by completing and submitting an Authorization to Change form with the changes appended, or preferably, with an updated copy of the advance directive to the Registry.

5. Usajili wa awali pamoja na mabadiliko yafuatayo na masasisho ya taarifa ya usajili au hati za mwelekezo wa mapema kuhusu matibabu hazilipishwi.

   Initial registration as well as subsequent changes and updates to the registration information or the advance directive documents are free of charge.

6. Makubaliano ya Usajili yataendelea kutumika mpaka Usajili upokee taarifa za kuaminika kwamba msajili amekufa, au msajili anaomba kwa maandishi kwamba Makubaliano ya Usajili yaishe. Makubaliano yanapoisha, Usajili utaondoa mwelekezo wa msajili wa mapema kuhusu matibabu kutoka kwenye hifadhidata ya Usajili, na watoa huduma hawatapata tena faili.

   The Registration Agreement shall remain in effect until the Registry receives reliable information that the registrant is deceased, or the registrant requests in writing that the Registration Agreement be terminated. When the Agreement is terminated, the Registry will remove registrant's advance directive from the Registry database, and the file will no longer be accessible to providers.

7. Msajili tu ndiye anayeweza kubadilisha masharti ya Makubaliano ya Usajili.

   Only the Registry can change the terms of the Registration Agreement.