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VERMONT ADVANCE CARE PLANNING: FACILITATOR TRAINING

SESSION 2

MARCH 10, 2026

Learning Goals & Objectives



Appreciate legal elements for valid advance directive documents



Differentiate between and understand when to use different advance directive documents



Develop proficiency and avoid common errors when supporting individuals to accurately complete advance directive forms

Overview of Basics & Legal References

Only adults with capacity can complete an Advance Directive

Core Elements of a Valid Document

- Date, name, signature, 2 or more witnesses, explainer (where applicable; see 18 V.S.A. § 9703)
- No notary requirement and cannot use a notary in lieu of 2 witnesses

Sticky Wickets

- No agent to name – no problem, complete the other sections of the document
- Multiple/Co-Agents – see 18 V.S.A. § 9707(e)
- HIPAA – see 18 V.S.A. § 9702 (11) and 18 V.S.A. § 9711(e)
- Reciprocity and honoring other state forms - 18 V.S.A. § 9716
- Living in two states – use the form for the state that is your primary residence

Witnesses – Who Can & Who Can't

Attorneys



The appointed health care agent(s)



Immediate family members (spouse, parents, siblings, children, grandchildren)



Extended family members



Health care providers



Friends & neighbors



Signing, Witnessing and Explaining (18 V.S.A. § 9703)

Signature of Principal

- Another individual can sign for the principal if principal is physically unable

Witnesses

- TWO witnesses at least 18 years of age
 - Affirm principal appeared to understand the nature of the document and was free from duress or undue influence (voluntary)
 - Remote Witnessing permitted as of April 1, 2024

Explainer: To explain the nature and effect of the advance directive

- Hospital
 - Ombudsman, Recognized member of the clergy, attorney licensed in VT, Probate Court Designee, Mental Health Patient Representative, Hospital Explainer
- Nursing Home or Residential Care Facility
 - Same as hospital, **PLUS Clinician** (not employed by nursing home or residential care facility at time of explanation) or **Trained Volunteer** at the Nursing Home or Res. Care Facility

NAME Principal Name DOB 10/10/1950 DATE 01/01/25

PART FIVE: SIGNED DECLARATION OF WISHES

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

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

SIGNED.....Principal Signature..... DATE 01/01/2025

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)*

FIRST WITNESS (PRINT NAME) First Witness Name, relationship to principal

SIGNATURE Remote Witness (802-999-9999 or email) DATE 01/01/2025

SECOND WITNESS (PRINT NAME) Second Witness Name, relationship to principal

SIGNATURE Remote Witness (802-888-8888 or email) DATE 01/01/2025

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.*

Remote Witnessing

- Made permanent in 2024.
- Witnesses can be via phone or video call.
- Witnesses must be known to the principal and provide contact information (phone # or email).
- Witnesses do not need to “sign” on the same day but must be added after the principal has signed.
- Nature of the relationship to the principal

Digital Signature

Vermont's law relies on individuals using compliant software to execute their digital signatures. The following software can be used for digital signatures on advance directives:

DocuSign Digital Signature

Principal or facilitator will need a DocuSign Account. Witnesses do not.

VEN can create these for you (fee associated – \$55.00/hr)

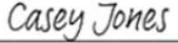


Adobe Acrobat Sign Digital Signature

Only the Adobe Acrobat Sign Digital Signature option meets the requirements – **you must be using the paid version of Adobe Acrobat** to get the correct Digital Signature option. Adobe Acrobat Standard, Pro, and Creative Cloud Accounts all come with digital signature capabilities.

Below is an example of a normal e-signature field on the left, and a digital signature on the right

Signature Approvals

Client	GlobalCorp
 <small>Hogarth Mandalick (May 8, 2017)</small>	 <small>Digitally signed by Casey Jones Date: 2017.05.08 00:55:53 -07'00'</small>
Signature Hogarth Mandalick	Signature Casey Jones
Name Visionary	Name Railroad Man
Title May 8, 2017	Title May 8, 2017
Date	Date

NOT VALID: No time stamp or watermark

VALID: includes date, time, and Adobe Watermark

Honoring Advance Directives

Obligations to Check for an AD (18 V.S.A. § 9707 & 9709)

- A health care provider, health care facility, and residential care facility shall not provide health care to a patient without capacity, except on an emergency basis, without first **attempting to determine whether the patient has an advance directive in effect.**
- Develop protocols to ensure that the provider or facility **checks the registry at the time any individual without capacity is admitted or provided services** to determine whether the individual has an advance directive

Follow the Agent or the Instructions in the AD? YES

- **§ 9707** – follow the **instructions of the agent** or the instructions contained in the advance directive **unless....**
 - Instructions are clearly inconsistent with the AD or the law
- **§ 9711** - **agent shall make health care decisions based on what the principal would have wanted.** The agent shall consider:
 - (A) the **principal's specific instructions contained in an advance directive** to the extent those directions are applicable;
 - (B) the principal's wishes expressed to the agent, guardian, or health care provider, since or prior to the execution of an advance directive, if any, to the extent those expressions are applicable; or
 - (C) the agent's knowledge of the principal's values or religious or moral beliefs.

Checklist for Basic Requirements

Registration recommended but not required for document to be valid.

Check List for Valid **VERMONT** Advance Directives

I. Vermont Documents – Required Elements

A. Advance Directive/Appointment of a Health Care Agent Forms

1. Is the **document dated**?
 - a. Yes – valid
 - b. No – NOT valid/incomplete

2. Does the document contain the **name and date of birth of the individual**?
 - a. Yes - valid
 - b. No – NOT valid/incomplete

3. Did the individual sign their document?
 - a. Yes – valid
 - b. No – NOT valid/incomplete

4. Are there 2 witness signatures (still valid if there is **only one signature in the witness section AND there is also a signature in the Explainer Section**).
 - a. 2 witness signatures – VALID
 - b. No witness or only 1 witness signature – NOT VALID/incomplete

5. Did the named agent/co-agent/alternate agent sign as a **witness**?
 - a. Yes – **NOT VALID** (named decision-maker CANNOT be a witness)
 - b. No – Valid

6. Do all pages appear to be present?
 - a. If yes – document complete
 - b. If no – document incomplete, check with sender for missing pages.

What can be included in an Advance Directive?



Healthcare Agent



Values and Priorities



Hopes and Concerns



Care and Treatment Preferences



Organ Donation Decisions



Funeral & Disposition Choices

Benefits of an HCA

Vermont does not have a comprehensive surrogacy statute, so there is no default decision-maker without an advance directive (no legal hierarchy).

Reduces questions/disagreements about who is authorized to make decisions.

Ensures the right people have access to information.

Allows health care team to share information.

Ensures there is an advocate who can work to make sure the care delivered is what is what is desired.

HCA Obligations & Authority

18 V.S.A. § 9711



-
- Be available when needed
 - Utilize **substituted judgment** when making decisions (if possible)
 - Best interest if they don't know what person would say
 - **Cannot** base decisions on their own wishes, values or beliefs
 - Agents have all the same rights and authority to make any health decisions that the person could make if they had capacity.
 - Includes forgoing life-sustaining treatment
 - **Agents do not need additional HIPAA releases** to receive information about the patient's healthcare that is relevant to decision-making.
 - They do not have blanket access to all health information when they have not been activated, and do not have access to information that is unrelated to the decisions at hand.

Common Questions

Is there anyone who can't serve as a health care agent?

Does my agent need to be a family member?

Can my agent decide who visits me in the hospital or residential care?

Others? Type them in the chat!

A hand holding a blue pen is shown writing on a document. The document has a grid pattern. The background is a blurred image of a hand writing on a document. A green horizontal bar is at the bottom of the image.

Choosing the Right Form

Making Recommendations

Previous Documents

- Is the first time completing a document?
- If it's an update, what has changed?
- What form was used previously – what did the person like or dislike about the form?

Health Care Agent

- Is there a person that the individual trusts? More than one person?
 - If there will be no agents, focus on preferences and experiences

Life Changes

- What is the motivation for completing an advance directive?
 - What are they hoping to accomplish by doing this?
- Is there new diagnosis or change to health circumstance?
 - Would you be surprised if you lost the ability to make decisions for yourself in the next year?
- Have there been changes to their social or family environment?

Preferences & Past Experiences

- Are they ready to discuss serious illness and/or end-of-life?
- Would addendums or a narrative letter be appropriate?



Appointment of a Health Care Agent

Vermont Advance Directive for Health Care Decisions

YOUR NAME DATE OF BIRTH DATE
ADDRESS
CITY STATE ZIP

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.

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

AGENT NAME EMAIL
ADDRESS
HOME PHONE WORK PHONE CELL PHONE

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

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

ALTERNATE AGENT NAME EMAIL
ADDRESS
HOME PHONE WORK PHONE CELL PHONE

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

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

NAME PHONE
ADDRESS
NAME PHONE
ADDRESS

Those who should **NOT** be consulted include:

Form: Appointment of a Healthcare Agent AD

What's included?

- Appointment of a Healthcare Agent
- General Statement of Goals/Values (optional)
 - Guidance for a catastrophic event

Who should use this form?

- Entry Level Advance Care Planning
- Beginning the process
- Not ready to discuss EOL treatments or serious illness



Appointment of a Health Care Agent

Vermont Advance Directive for Health Care Decisions

YOUR NAME DATE OF BIRTH DATE

ADDRESS

CITY STATE ZIP

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.

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

AGENT NAME EMAIL

ADDRESS

HOME PHONE WORK PHONE CELL PHONE

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

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

ALTERNATE AGENT NAME EMAIL

ADDRESS

HOME PHONE WORK PHONE CELL PHONE

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

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

NAME PHONE

ADDRESS

NAME PHONE

ADDRESS

Those who should **NOT** be consulted include:

Healthcare Agent & Alternate

NAME DOB DATE

General Comments About My Health Care Goals:

SIGNED DECLARATION OF WISHES

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

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

SIGNED DATE

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)

FIRST WITNESS (PRINT NAME)

SIGNATURE DATE

SECOND WITNESS (PRINT NAME)

SIGNATURE DATE

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.*

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.*

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

NAME

TITLE/POSITION PHONE

ADDRESS

SIGNATURE DATE

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

Vermont Advance Directive Registry DATE REGISTERED:

Health care agent Alternate health care agent

Doctor/Provider(s):

Hospital(s):

Family Member(s):

General Statements

Signing and Witnessing

Explainer Signature



Vermont Advance Directive for Health Care

YOUR NAME DATE OF BIRTH DATE
ADDRESS
CITY STATE ZIP

PART ONE: YOUR HEALTH CARE AGENT

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.

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

AGENT NAME EMAIL
ADDRESS
HOME PHONE WORK PHONE CELL PHONE

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

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

ALTERNATE AGENT NAME EMAIL
ADDRESS
HOME PHONE WORK PHONE CELL PHONE

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

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

NAME PHONE
ADDRESS
NAME PHONE
ADDRESS

Those who should **NOT** be consulted include:

(PART ONE CONTINUED NEXT PAGE)

12/18

Form: Short Form AD

What's Included?

- Appointment of a Healthcare Agent
- ADDS: Details about general priorities and values
- ADDS: EOL treatment preferences, limitations of treatment at EOL
- ADDS: Funeral/Disposition Instructions
- ADDS: Organ Donation Decisions

Who should use this form?

- People who have had values-based conversations about their healthcare
- People who have specific preferences about treatment that they want to document
- People who have had some lived experience with healthcare systems or end-of-life

Short Form: Part 1



Vermont Advance Directive for Health Care

YOUR NAME DATE OF BIRTH DATE
ADDRESS
CITY STATE ZIP

PART ONE: YOUR HEALTH CARE AGENT

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.

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

AGENT NAME EMAIL
ADDRESS
HOME PHONE WORK PHONE CELL PHONE

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

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

ALTERNATE AGENT NAME EMAIL
ADDRESS
HOME PHONE WORK PHONE CELL PHONE

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

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

NAME PHONE
ADDRESS
NAME PHONE
ADDRESS

Those who should **NOT** be consulted include:

(PART ONE CONTINUED NEXT PAGE)

9/24

ADVANCE DIRECTIVE, PAGE 2

NAME DOB DATE

I want my Advance Directive to start:

- When I cannot make my own decisions
 Now
 When this happens:

Principal
Information

Designation of
Agent(s)

PCP
Information

Continuation
of Part 1 on
Page 2

Short Form: Part 2

PART TWO: HEALTH CARE GOALS AND SPIRITUAL WISHES

My overall health care goals include:

- I want to have my life sustained as long as possible by any medical means.
- I want treatment to sustain my life only if I will:
- be able to communicate with friends and family.
 - be able to care for myself.
 - live without incapacitating pain.
 - be conscious and aware of my surroundings.
- I only want treatment directed toward my comfort.

Additional Goals, Wishes, or Beliefs I wish to express include:

People to notify if I have a life-threatening illness:

If I am dying it is important for me to be (check choice):

- At home
- In the hospital
- Other:
- No preference

My Spiritual Care Wishes include:

My Religion/Faith:

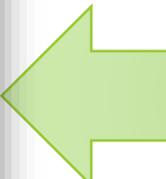
PLACE OF WORSHIP PHONE

ADDRESS

The following items or music or readings would be a comfort to me:



**Overall
Healthcare
Preferences**



**Spiritual Care /
Emotional Care**

Short Form: Part 3

*This part of the AD form does **not** take the place of a DNR/COLST.*

NAME DOB DATE

PART THREE: LIMITATIONS OF TREATMENT

You can decide what kind of treatment you want or don't want if you become **seriously ill or are dying**. Regardless of the treatment limitations expressed, you have the right to have your pain and symptoms (nausea, fatigue, shortness of breath) managed. Unless treatment limitations are stated, the medical team is required and expected to do everything possible to save your life.

1. If my heart stops (choose one):

- I DO want CPR done to try to restart my heart. I DON'T want CPR done to try to restart my heart.

CPR means cardio (heart)-pulmonary (lung) resuscitation, including chest compressions, intubation, mechanical ventilation, defibrillation and transfer to hospital.

2. If I am unable to breathe on my own (choose one):

- I DO want a breathing machine without any time limit. I want to have a breathing machine for a short time to see if I will survive or get better. I DO NOT want a breathing machine for ANY length of time. *(Does not apply if you have checked 'DO CPR' in question 1.)*

"Breathing machine" refers to a device that mechanically moves air into and out of your lungs such as a ventilator. A breathing machine is part of a CPR attempt in nearly all cases.

3. If I am unable to swallow enough food or water to stay alive (choose one):

- I DO want a feeding tube without any time limits I want to have a feeding tube for a short time to see if I will survive or get better. I DO NOT want a feeding tube for any length of time.

NOTE: If you are being treated in another state your agent may not automatically have the authority to withhold or withdraw a feeding tube. If you wish to have your agent decide about feeding tubes please check the box below.

- I authorize my agent to make decisions about feeding tubes.

4. If I am terminally ill or so ill that I am unlikely to get better (choose one):

- I DO want antibiotics or other medication to fight infection. I DON'T want antibiotics or other medication to fight infection.

If you have stated you DO NOT want CPR, a breathing machine, a feeding tube, or antibiotics under any circumstances, please discuss this with your doctor who can complete a DNR/COLST form to ensure you don't receive treatments you don't want, particularly in an emergency situation. A DNR/COLST order will be honored outside of the hospital setting.

Additional Limitations of Treatment I wish to include:

- I have attached the following addendum(s) to my advance directive:

← **CPR**

← **Breathing Machine**

← **Feeding Tube**

← **Antibiotics**

← **Additional Limitations of Treatment**

← **Addendum List**

Short Form: Part 4

ADVANCE DIRECTIVE, PAGE 4

NAME DOB DATE

PART FOUR: ORGAN/TISSUE DONATION & BURIAL/DISPOSITION OF REMAINS

My wishes for organ & tissue donation (check your choices):

- I consent to donate the following organs & tissues:
 - Any needed organs
 - Any needed tissue (skin, bone, cornea)
 - I do not wish to donate the following organs and tissues:
 - I do not want to donate any organs or tissues
 - I want my health care agent to decide
- I wish to donate my body to research or educational program(s). (Note: you will have to make your own arrangements with a medical school or other program in advance.)

My Directions for Burial/Disposition of My Remains after I Die (check & complete):

- I have a Pre-Need Contract for Funeral Arrangements:
NAME PHONE
ADDRESS
- I want the following individuals to decide about my burial or disposition of my remains (check your choices):
 - Agent
 - Alternate Agent
 - Family:NAME PHONE
ADDRESS
- Other:
NAME PHONE
ADDRESS

Specific Wishes (check your choices):

- I want a Wake/Viewing
- I prefer a Burial — If possible at the following location: (cemetery, address, phone number)
- I prefer Cremation — With my ashes kept or scattered as follows:
- I want a Funeral Ceremony with a burial or cremation to follow
- I prefer only a Graveside Ceremony
- I prefer only a Memorial Ceremony with burial or cremation preceding
- Other Details: (such as music, readings, Officiant)

← Organ
Donation

← Burial/
Disposition of
Remains

← Funeral/Disposition
Specific Wishes

Short Form: Part 5

ADVANCE DIRECTIVE, PAGE 5

NAME DOB DATE

PART FIVE: SIGNED DECLARATION OF WISHES

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

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

SIGNED..... DATE

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)*

FIRST WITNESS
(PRINT NAME)

SIGNATURE DATE

SECOND WITNESS
(PRINT NAME)

SIGNATURE DATE

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.*

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.*

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

NAME

TITLE/POSITION PHONE

ADDRESS

SIGNATURE DATE

← **Principal Signature**

← **Witness Signatures**
Must have 2 adult witnesses

← **Explainer Signature**
Counts as 1 Witness.
Only required if principal is in a hospital or LTC setting.

Advance Directive

MY NAME DATE OF BIRTH DATE SIGNED

ADDRESS

CITY STATE ZIP

PHONE EMAIL

PART 1: MY HEALTH CARE AGENT

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

** Normally these statements are separate choices, but it is conceivable that they could be concurrent.*

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.)

Address: _____

Relationship (optional): _____

Tel. (daytime): _____ (evening): _____

cellphone: _____ email: _____

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): _____ (evening): _____

cellphone: _____ email: _____

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): _____ (evening): _____

cellphone: _____ email: _____

4. I want to appoint two or more people to be co-agents and have listed them on page two of this Part.

Form: Long Form AD

What's Included?

- Appointment of a Healthcare Agent
- Statement of Goals & Values, Preferences
- Funeral/Disposition Instructions
- Organ Donation
- ADDS: Co-Agent appointment and Instructions
- ADDS: More details about EOL treatments and serious illness situations
- ADDS: Psychiatric treatment considerations
- ADDS: Ulysses Clause (Waiver of the Right to Request/Refuse Treatment)

Who should use this form?

- People who need more space to describe goals, preferences and specific treatment situations
- People with special circumstances (psychiatric conditions, dementia, etc)

Name: _____ Date of Birth _____ Date: _____

Advance Directive for Health Care

A Vermont Advance Directive Form in Plain Language

My Name: _____

My Date of Birth: _____

My Address: _____

My Phone Number: _____

This is a legal form. You have the right to make your own health care decisions. This form tells your friends, family, and health care providers what matters to you if you cannot speak for yourself.

You can fill out just Part 1, just Part 2, or both. You don't have to answer every question. If you skip something, draw a line through it.

You must sign in Part 3.

All pages need to include:

- Your name
- Your date of birth
- The date you are completing this form

After your advance directive is signed and witnessed, make copies for:

- Yourself
- Your health care agent
- Your health care providers/hospital
- Other people that you want to know your values (friends, family, etc.)
- The Vermont Advance Directive Registry (Registration is recommended. The form to register is attached at the end of this document)

Coming Soon! Plain Language Form

What's Included

- Appointment of a Healthcare Agent
- Healthcare Values and Goals
- Funeral & Burial Instructions
- Organ Donation
- ADDS: Quality of life descriptions and priorities
- ADDS: Plain language instructions and glossary
- ADDS: Values focused questions
- ADDS: Differentiates EOL priorities from other situations
- **OMITS: Menu of Specific Treatments**

Who should use this form?

- Anyone ready to do more than appoint a healthcare agent
- People who may not have someone to appoint as an agent
- Alternative to the Short Form AD

Summary of Form Elements

Appointment of a Health Care Agent

- Included in all advance directives

Goals, Values, and Serious Illness or EOL Treatment Preferences

- Short Form, Plain Language Form, Long Form

Organ & Body Donation Choices

- Short Form, Plain Language Form, Long Form

Funeral & Disposition Arrangements

- Short Form, Plain Language Form, Long Form

Signing and Witnessing

- Included in all advance directives



Adding Addendums

- Advance directives are not limited to the available forms
 - Many addendum documents can be added to customize individual documents to the needs of each person.
 - Types of addendums can include:
 - Letters to healthcare agents/care teams
 - Disease-specific addendums (e.g. Dementia Directives, Do-not-spoon feed requests)
 - Statements of religious/spiritual values
- To add an addendum, reference the document being added in the text of the advance directive in the care and treatment goals/preferences section
 - “See attached addendum “Titled” for additional instructions.”
 - Include name, date of birth and date of the advance directive on the addendum.

Updating Advance Directives



Changes to priorities and preferences are to be expected as we age



New information (diagnoses, disease progression) or healthcare experiences (hospitalization, death of close friends or family) are very likely to alter an individual's perspective on future treatment or quality of life.

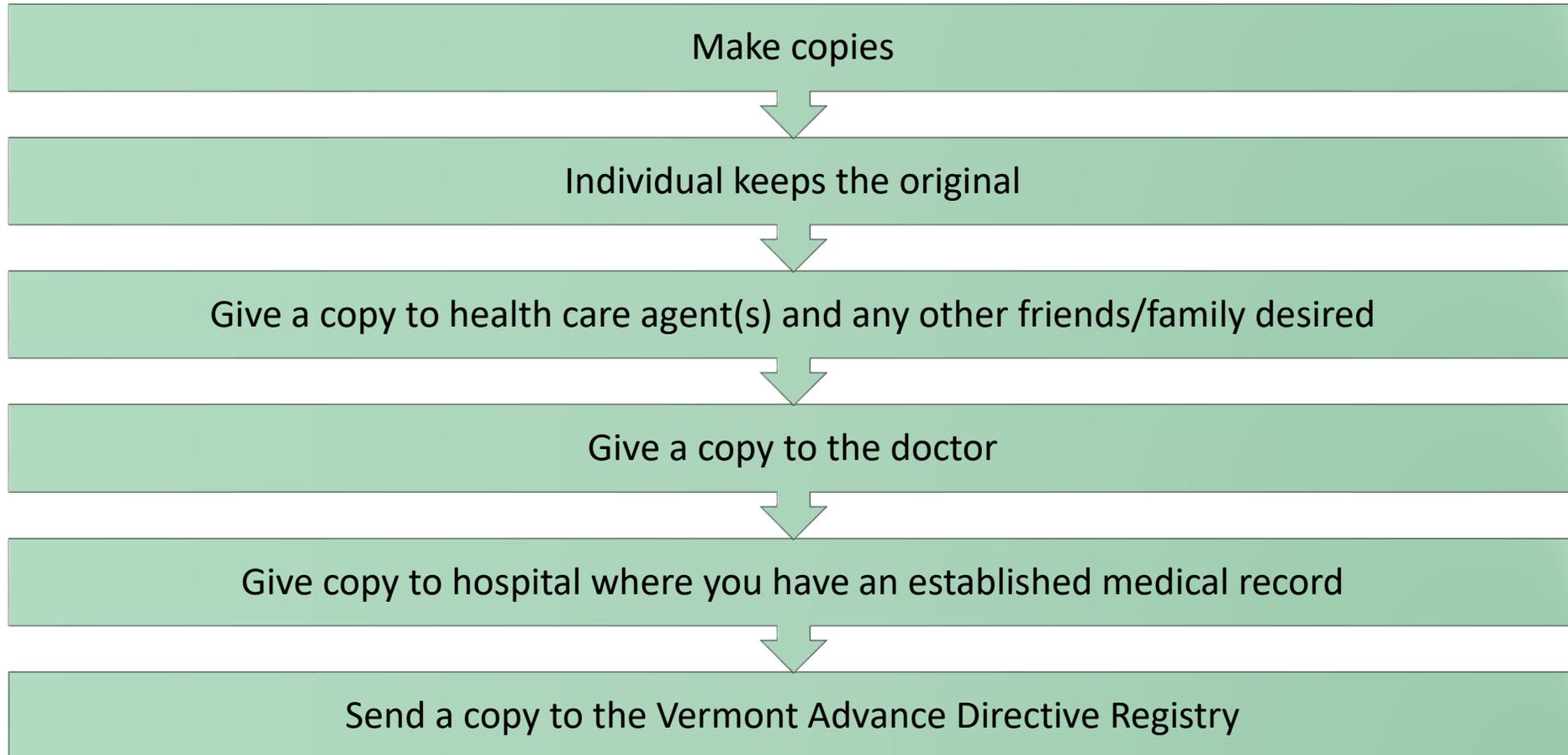


Regular review and updates are necessary to make advance directives effective.



When changes need to be made, complete a new advance directive with updated signing and witnessing.

After a Document is Completed





After this session:

- Start your own advance directive
 - Already have your document completed? Get out your copy and review it – it might be time to make updates!
- Consider why you chose the form you chose – what stage are you at in your ACP journey?
- On March 31st, a dedicated session will walk you through the process of uploading your own advance directive to the VT Advance Directive Registry.
 - Plan to discuss your directive with your health care agent, attorney and/or health care provider.