

Georgia Advance Directive for Health Care

In order to have a legal document that expresses your wishes for the health care you want to receive at the end of your life, you should complete a Georgia Advance Directive for Health Care. In completing the Georgia Advance Directive for Health Care, you will do two things:

- legally appoint someone as your Health Care Agent to make health care decisions for you when you cannot or do not want to speak for yourself, and
- formally state your preferences for the medical treatments you do or do not want to receive.

Things You Should Know

- You do not need to hire a lawyer to complete a Georgia Advance Directive for Health Care. The document includes instructions on how to complete the form. However, you are encouraged to consult your lawyer, doctor, or other professionals to help you make informed decisions.
- As a competent adult, you have the right to refuse any unwanted treatments or procedures for any reason, even treatments that could keep you alive (unless you are pregnant with a viable fetus).
- The Georgia Advance Directive for Health Care covers only health care decisions. *It has no effect over financial affairs that are unrelated to your health care.*
- You or your Health Care Agent are responsible for notifying your doctor and other health care providers that you have a Georgia Advance Directive for Health Care.
- If you choose not to complete a Georgia Advance Directive for Health Care, there may be restrictions on the health care decisions that relatives or friends can make for you.
- If a doctor or other health care provider has direct knowledge of your preferences as documented in your Georgia Advance Directive for Health Care or expressed by your Health Care Agent, he is required to abide by your preferences as long as your preferences are legal. If the doctor or health care provider is unwilling to honor your preferences, he must assist in transferring your care to another provider.
- Georgia law protects a doctor or health care provider who, in good faith, follows your preferences as documented in the Georgia Advance Directive for Health Care or directed by your Health Care Agent.
- It is against Georgia law for any person willfully to hide, cancel or alter another person's health care directive, its amendments or cancellation.
- Another person can complete a Georgia Advance Directive for Health Care for you but only with your expressed consent and in your presence. Once you have been determined to be incapable of making your own decisions, you cannot complete a Georgia Advance Directive for Health Care, nor can someone else complete one for you.
- A hospital, nursing facility, home health company, or hospice program cannot refuse to admit you because you do not have a Georgia Advance Directive for Health Care.
- Completing a Georgia Advance Directive for Health Care will have no effect on your ability to buy, pay

premiums on, or collect on any type of insurance, including health, life, and disability insurance. You cannot be required to have a Georgia Advance Directive for Health Care in order to obtain health insurance.

- The laws on honoring health care directives differ from state to state. Because the Georgia Advance Directive for Health Care you complete in Georgia expresses your preferences about medical care, it will influence that care no matter where you are treated. However, there is a possibility that this Georgia Advance Directive for Health Care may not be honored in another state. If you spend a great deal of time in another state, you may want to complete a document that meets all the requirements of that state.
- If you have an emergency and your Georgia Advance Directive for Health Care is not readily available, life sustaining treatments may be started. Treatment can be stopped if it is discovered that it is not what you want.
- The Georgia Advance Directive for Health Care is not connected to any government health care program, such as Medicare or Medicaid. Any competent adult may complete a Georgia Advance Directive for Health Care regardless of how they pay for their health care.
- The Georgia Advance Directive for Health Care allows you to appoint a Health Care Agent – this is a person who will have the legal power to make decisions regarding your health care – but ONLY when you are *incapable* of making those decisions yourself or choose not to make your own decisions. You may be *incapable* of making your own decisions because you are unconscious, mentally ill, in a coma, in the advanced stages of Alzheimer's Disease or are otherwise unable to make your own decisions. *You do not have to be terminally ill or near death for your Health Care Agent to be able to make decisions for you, but you must be incapable*

of making your own decisions or choose not to make your own decisions.

- Georgia law protects your Health Care Agent as long as he or she acts in “good faith” and in accordance with your instructions.
- Your Health Care Agent cannot be held responsible for the cost of your medical care. However, if you have named your spouse as your Health Care Agent, your spouse may be responsible for the cost of your medical care because he or she is your spouse.
- A change in your marital status may revoke the appointment of your Health Care Agent.
- The Georgia Advance Directive for Health Care also will give you the option to nominate someone to serve as your *guardian*. A court may appoint a guardian if it determines that you are not able to make significant responsible decisions for yourself. You may nominate the same person you designated as your Health Care Agent to serve as your guardian. However, if you chose to nominate someone else to be your guardian, you should be aware that the person named as your Health Care Agent would have priority over your guardian in making your health care decisions, unless a court determines otherwise.
- The person you name as your Health Care Agent will have broad powers to make health care decisions for you, including the power to require, consent to, or withdraw any type of personal care or medical treatment for any physical or mental condition.
- Your Health Care Agent can agree to admit or discharge you from any hospital, nursing home, or other institution.
- Georgia law does not allow your Health Care Agent to put you in a mental hospital against your will or to make decisions about sterilization or psychosurgery.

- The law does not require the person you name as your Health Care Agent to act for you. You must ask that person if he or she is willing to accept this responsibility.
- Your Health Care Agent must use due care to act for your benefit and in accordance with your Georgia Advance Directive for Health Care.
- A court can take away the powers of your Health Care Agent if it finds that your Agent is not acting according to your preferences or that your Agent is not competent to make decisions.
- You may appoint a Health Care Agent as well as one or more back-up Agents, in case your primary Agent is not available when decisions need to be made.
- You can choose anyone who is over 18 years of age or older to be your Health Care Agent. The only restriction is that you cannot appoint your doctor or any other person who directly provides health care to you.
- Unless you expressly limit the duration of or revoke your Georgia Advance Directive for Health Care, or a court acting in your behalf terminates it, your Health Care Agent may exercise the powers you have given him or her throughout your lifetime, even after you become disabled, incapacitated, or incompetent.
- If you change your mind, your Georgia Advance Directive for Health Care can be easily amended or canceled.

Note: This information is a general summary of the rights of competent adults in Georgia. It does not contain all the technical details of the law. Also, it does not deal with decisions for minors or for those who are now mentally incapable, nor does it apply to treatment outside of Georgia. It is not the intent of this document to provide specific legal or medical advice. Individuals are encouraged to consult professionals such as physicians, clergy and lawyers to help them make informed decisions.

Georgia Advance Directive for Health Care

Name: _____

Address: _____

Social Security Number: _____

Date of Birth: _____

Copies of this document have been given to:

1: _____

(Provide complete name, address and phone number)

2: _____

(Provide complete name, address and phone number)

3: _____

(Provide complete name, address and phone number)

4: _____

(Provide complete name, address and phone number)

5: _____

(Provide complete name, address and phone number)

This advance directive for health care has four parts:

Part I: Health Care Agent.

This part allows you to choose someone to make health care decisions for you when you cannot (or do not want to) make health care decisions for yourself. The person you choose is called a Health Care Agent. You may also have your Health Care Agent make decisions for you after your death with respect to an autopsy, organ donation, body donation, and final disposition of your body. You should talk to your Health Care Agent about this important role.

Part II: Treatment Preferences.

This part allows you to state your treatment preferences if you have a terminal condition or if you are in a state of permanent unconsciousness. PART TWO will become effective only if you are unable to communicate your treatment preferences. Reasonable and appropriate efforts will be made to communicate with you about your treatment preferences before PART TWO becomes effective. You should talk to your family and others close to you about your treatment preferences.

Part Three: Guardianship.

This part allows you to nominate a person to be your guardian should one ever be needed.

Part Four: Effectiveness and Signatures.

This part requires your signature and the signatures of two witnesses. You must complete PART FOUR if you have filled out any other part of this form.

You may fill out any or all of the first three parts listed above. You must fill out PART FOUR of this form in order for this form to be effective.

You should give a copy of this completed form to people who might need it, such as your Health Care Agent, your family, and your physician. Keep a copy of this completed form at home in a place where it can easily be found if it is needed. Review this completed form periodically to make sure it still reflects your preferences. If your preferences change, complete a new Georgia Advance Directive for Health Care.

Using this form of advance directive for health care is completely optional. Other forms of advance directives for health care may be used in Georgia.

You may revoke this completed form at any time. This completed form will replace any advance directive for health care, durable power of attorney for health care, health care proxy, or living will that you have completed before completing this form.

Part One: Health Care Agent

PART ONE will be effective even if PART TWO is not completed. A physician or health care provider who is directly involved in your health care may not serve as your Health Care Agent. If you are married, a future divorce or annulment of your marriage will revoke the selection of your current spouse as your Health Care Agent. If you are not married, a future marriage will revoke the selection of your Health Care Agent unless the person you selected as your Health Care Agent is your new spouse.

1. Health Care Agent

I select the following person as my Health Care Agent to make health care decisions for me:

Name: _____

Address: _____

Telephone Numbers: _____
(Home, Work, and Mobile)

2. Back-Up Health Care Agent

This section is optional. PART ONE will be effective even if this section is left blank.

If my Health Care Agent cannot be contacted in a reasonable time period and cannot be located with reasonable efforts or for any reason my Health Care Agent is unavailable or unable or unwilling to act as my Health Care Agent, then I select the following, each to act successively in the order named, as my back-up Health Care Agent(s):

Back-up Health Care Agent #1:

Name: _____

Address: _____

Telephone Numbers: _____
(Home, Work, and Mobile)

Back-up Health Care Agent #2:

Name: _____

Address: _____

Telephone Numbers: _____
(Home, Work, and Mobile)

3. General Powers of Health Care Agent

My Health Care Agent will make health care decisions for me when I am unable to communicate my health care decisions or I choose to have my Health Care Agent communicate my health care decisions.

My Health Care Agent will have the same authority to make any health care decision that I could make. My Health Care Agent's authority includes, for example, the power to:

- Admit me to or discharge me from any hospital, skilled nursing facility, hospice, or other health care facility or service;
- Request, consent to, withhold, or withdraw any type of health care; and
- Contract for any health care facility or service for me, and to obligate me to pay for these services (and my Health Care Agent will not be financially liable for any services or care contracted for me or on my behalf).

My Health Care Agent will be my personal representative for all purposes of federal or state law related to privacy of medical records (including the Health Insurance Portability and Accountability Act of 1996) and will have the same access to my medical records that I have and can disclose the contents of my medical records to others for my ongoing health care.

My Health Care Agent may accompany me in an ambulance or air ambulance if in the opinion of the ambulance personnel protocol permits a passenger. My Health Care Agent may visit or consult with me in person while I am in a hospital, skilled nursing facility, hospice, or other health care facility or service if its protocol permits visitation.

My Health Care Agent may present a copy of this advance directive for health care in lieu of the original and the copy will have the same meaning and effect as the original.

I understand that under Georgia law:

- My Health Care Agent may refuse to act as my health care agent;
- A court can take away the powers of my Health Care Agent if it finds that my Health Care Agent is not acting properly; and
- My Health Care Agent does not have the power to make health care decisions for me regarding psychosurgery, sterilization, or treatment or involuntary hospitalization for mental or emotional illness, mental retardation, or addictive disease.

4. Guidance for Health Care Agent

When making health care decisions for me, my Health Care Agent should think about what action would be consistent with past conversations we have had, my treatment preferences as expressed in PART TWO (if I have filled out PART TWO), 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 Health Care Agent should make decisions for me that my Health Care Agent believes are in my best interest, considering the benefits, burdens, and risks of my current circumstances and treatment options.

5. Powers of Health Care Agent After Death

A. AUTOPSY

My Health Care Agent will have the power to authorize an autopsy of my body unless I have limited my Health Care Agent's power by initialing below.

_____ My Health Care Agent will not have the power to authorize an autopsy of my body
(Initials) (unless an autopsy is required by law).

B. Organ Donation and Donation of Body

My Health Care Agent will have the power to make a disposition of any part or all of my body for medical purposes pursuant to the Georgia Anatomical Gift Act, unless I have limited my Health Care Agent's power by initialing below.

Initial each statement that you want to apply.

_____ My Health Care Agent will not have the power to make a disposition of my body for use in a
(Initials) medical study program.

_____ My Health Care Agent will not have the power to donate any of my organs.
(Initials)

C. Final Disposition of Body

My Health Care Agent will have the power to make decisions about the final disposition of my body unless I have initialed below.

_____ I want the following person to make decisions about the final disposition of my body:
(Initials)

Name: _____

Address: _____

Telephone Numbers: _____
(Home, Work, and Mobile)

I wish for my body to be:

_____ Buried OR _____ Cremated
(Initials) (Initials)

Part Two: Treatment Preferences

PART TWO will be effective only if you are unable to communicate your treatment preferences after reasonable and appropriate efforts have been made to communicate with you about your treatment preferences. PART TWO will be effective even if PART ONE is not completed. If you have not selected a Health Care Agent in PART ONE, or if your health care agent is not available, then PART TWO will provide your physician and other health care providers with your treatment preferences. If you have selected a Health Care Agent in PART ONE, then your Health Care Agent will have the authority to make all health care decisions for you regarding matters covered by PART TWO. Your Health Care Agent will be guided by your treatment preferences and other factors described in Section (4) of PART ONE.

6. Conditions

PART TWO will be effective if I am in any of the following conditions:

Initial each condition in which you want PART TWO to be effective.

_____ A terminal condition, which means I have an incurable or irreversible condition that will result
(Initials) in my death in a relatively short period of time.

_____ A state of permanent unconsciousness, which means I am in an incurable or irreversible
(Initials) condition in which I am not aware of myself or my environment and I show no behavioral response to my environment.

My condition will be determined in writing after personal examination by my attending physician and a second physician in accordance with currently accepted medical standards.

7. Treatment Preferences

State your treatment preference by initialing (A), (B), or (C). If you choose (C), state your additional treatment preferences by initialing one or more of the statements following (C). You may provide additional instructions about your treatment preferences in the next section. You will be provided with comfort care, including pain relief, but you may also want to state your specific preferences regarding pain relief in the next section.

If I am in any condition that I initialed in Section (6) above and I can no longer communicate my treatment preferences after reasonable and appropriate efforts have been made to communicate with me about my treatment preferences, then:

A. _____
(Initials) Try to extend my life for as long as possible, using all medications, machines, or other medical procedures that in reasonable medical judgment could keep me alive. If I am unable to take nutrition or fluids by mouth, then I want to receive nutrition or fluids by tube or other medical means.

Or

B. _____
(Initials) Allow my natural death to occur. I do not want any medications, machines, or other medical procedures that in reasonable medical judgment could keep me alive but cannot cure me. I do not want to receive nutrition or fluids by tube or other medical means except as needed to provide pain medication.

Or

C. _____
(Initials) I do not want any medications, machines, or other medical procedures that in reasonable medical judgment could keep me alive but cannot cure me, except as follows:

Initial each statement that you want to apply to option C.

_____ If I am unable to take nutrition by mouth, I want to receive nutrition by tube or other medical means.
(Initials)

_____ If I am unable to take fluids by mouth, I want to receive fluids by tube or other medical means.
(Initials)

_____ If I need assistance to breathe, I want to have a ventilator used.
(Initials)

_____ If my heart or pulse has stopped, I want to have cardiopulmonary resuscitation (CPR) used.
(Initials)

8. Additional Statements

This section is optional. PART TWO will be effective even if this section is left blank. This section allows you to state additional treatment preferences, to provide additional guidance to your Health Care Agent (if you have selected a Health Care Agent in PART ONE), or to provide information about your personal and religious values about your medical treatment. For example, you may want to state your treatment preferences regarding medications to fight infection, surgery, amputation, blood transfusion, or kidney dialysis. Understanding that you cannot foresee everything that could happen to you after you can no longer communicate your treatment preferences, you may want to provide guidance to your Health Care Agent (if you have selected a Health Care Agent in PART ONE) about following your treatment preferences. You may want to state your specific preferences regarding pain relief.

9. In Case of Pregnancy

PART TWO *will be effective even if this section is left blank.*

I understand that under Georgia law, PART TWO generally will have no force and effect if I am pregnant unless the fetus is not viable and I indicate by initialing below that I want PART TWO to be carried out.

_____ I want PART TWO to be carried out if my fetus is not viable.
(Initials)

Part Three: Guardianship

10. Guardianship

PART THREE is optional. This advance directive for health care will be effective even if PART THREE is left blank. If you wish to nominate a person to be your guardian in the event a court decides that a guardian should be appointed, complete PART THREE. A court will appoint a guardian for you if the court finds that you are not able to make significant responsible decisions for yourself regarding your personal support, safety, or welfare. A court will appoint the person nominated by you if the court finds that the appointment will serve your best interest and welfare. If you have selected a Health Care Agent in PART ONE, you may (but are not required to) nominate the same person to be your guardian. If your Health Care Agent and guardian are not the same person, your Health Care Agent will have priority over your guardian in making your health care decisions, unless a court determines otherwise.

State your preference by initialing (A) or (B). Choose (A) only if you have also completed PART ONE.

A. _____ I nominate the person serving as my Health Care Agent under PART ONE to serve as my guardian.
(Initials)

OR

B. _____ I nominate the following person to serve as my guardian:
(Initials)

Name: _____

Address: _____

Telephone Numbers: _____
(Home, Work, and Mobile)

Part Four: Effectiveness and Signatures

This advance directive for health care will become effective only if I am unable or choose not to make or communicate my own health care decisions.

This form revokes any advance directive for health care, durable power of attorney for health care, health care proxy, or living will that I have completed before this date.

Unless I have initialed below and have provided alternative future dates or events, this advance directive for health care will become effective at the time I sign it and will remain effective until my death (and after my death to the extent authorized in Section (5) of PART ONE).

_____ This advance directive for health care will become effective on or upon _____
(Initials) and will terminate on or upon _____.

You must sign and date or acknowledge signing and dating this form in the presence of two witnesses. Both witnesses must be of sound mind and must be at least 18 years of age, but the witnesses do not have to be together or present with you when you sign this form.

A witness:

- *Cannot be a person who was selected to be your Health Care Agent or back-up Health Care Agent in PART ONE;*
- *Cannot be a person who will knowingly inherit anything from you or otherwise knowingly gain a financial benefit from your death; or*
- *Cannot be a person who is directly involved in your health care.*

Only one of the witnesses may be an employee, agent, or medical staff member of the hospital, skilled nursing facility, hospice, or other health care facility in which you are receiving health care (but this witness cannot be directly involved in your health care).

By signing below, I state that I am emotionally and mentally capable of making this advance directive for health care and that I understand its purpose and effect.

(Signature of Declarant) (Date)

The declarant signed this form in my presence or acknowledged signing this form to me. Based upon my personal observation, the declarant appeared to be emotionally and mentally capable of making this advance directive for health care and signed this form willingly and voluntarily.

(Signature of First Witness) (Date)

Print Name: _____

Address: _____

(Signature of Second Witness) (Date)

Print Name: _____

Address: _____

This form does not need to be notarized.

Acceptance by Health Care Agent (Optional)

Your Health Care Agent and back-up Agents are not required by law to act for you nor is it mandatory that they sign this document. However, their signatures provide assurances that they are willing to serve in this capacity.

I accept this appointment to serve as the Health Care Agent for _____.

I understand I must act in accordance with the preferences of the person I represent, as expressed in this Georgia Advance Directive for Health Care or otherwise made known to me. I understand that this document allows me to decide about _____'s medical care only while he/she cannot do so or chooses not to do so. I understand that the person who appointed me may revoke this appointment at any time.

I certify that the signature of my agent and back-up agent(s) is correct:

(Signature of Health Care Agent) *(Date)* *(Signature of Principal)*

(Signature Back-up #1) *(Date)* *(Signature of Principal)*

(Signature Back-up #2) *(Date)* *(Signature of Principal)*

Review (Optional)

It is important that you occasionally review your Georgia Advance Directive for Health Care to make sure this document continues to reflect your treatment preferences. Indicate each time you review the document below.

If you do not review your Georgia Advance Directive for Health Care it will continue to remain in effect as completed, unless you cancel it.

I have reviewed this Georgia Advance Directive for Health Care and confirm by my signature that this document continues to convey my preferences as of the date specified.

Signature: _____ Date: _____

Signature: _____ Date: _____

Signature: _____ Date: _____

Signature: _____ Date: _____

Signature: _____ Date: _____

What To Do Now

Here are some suggestions to help ensure that your wishes for your final health care are followed:

- Make sure the person you have named as your Health Care Agent and your back-up Agent know what you want. If you have not shared your wishes with these individuals, talk to them the first chance you get.
- Keep your signed original Individual Worksheet and Georgia Advance Directive for Health Care some place where they can be found easily. Do not put them in a safe deposit box which requires a key or combination to open. Tell your Health Care Agent and other loved ones where to find your original documents.
- Give copies of your Individual Worksheet and Georgia Advance Directive for Health Care to your Agent, back-up Agents, and anyone else you think should know what you want (family members, lawyer, spiritual advisor, etc.). Keep a list of the people you give them to in case you change your mind.
- Tell your doctor you have completed a Georgia Advance Directive for Health Care and discuss your decisions with him or her. If you would like, have your doctor put a copy of your Georgia Advance Directive for Health Care in your medical record.
- Use one of the Wallet Cards included in this booklet to indicate that you have completed a Georgia Advance Directive for Health Care and where it can be found. Carry it with you.
- If you are being admitted to a hospital or nursing home, take a copy of your Georgia Advance Directive for Health Care with you. Ask that it be placed in your medical record.
- Plan to review and update your Individual Worksheet and Georgia Advance Directive for Health Care occasionally. As the circumstances of your life change (growing older, being diagnosed with an illness, etc.), your views may change. Marriage, the birth of a child or the death of a loved one may also influence how you feel. Your loved ones will want to know that your Georgia Advance Directive for Health Care is a true expression of your wishes and may have questions about a document that is several years old. Initial and date the forms each time you review them so your loved ones will know you have not changed your mind.
- If you do change your mind, you can cancel your Georgia Advance Directive for Health Care at any time. Be sure to notify everyone who has copies that you are writing a new advance directive, thereby canceling the document they have.
- If you are terminally ill and wish to die at home, you should talk to your doctor, other caregivers, and family members about situations when you might or might not want an ambulance called. If an ambulance is called, the emergency team must give you life-prolonging care until you can get to a hospital and be evaluated by a doctor, unless you have a Do Not Resuscitate/ Allow Natural Death order that is clearly visible in your home or you are wearing an orange arm band or necklace indicating that you have a Do Not Resuscitate/ Allow Natural Death order.

- If you become terminally ill, you can call a hospice in your area and ask for information about the care they can give to you and your family. Many of these programs will work directly with your doctor to arrange for you to have hospice services in addition to your medical care.
- If you are traveling outside of Georgia, it is a good idea to take a copy of your Georgia Advance Directive for Health Care with you. Most states will honor an out-of-state document, but some require that it conform to their own laws. If you are going to receive medical care out of state, ask the medical facility where you will be treated to give you information about their laws and requirements.