~ Massachusetts ~

Health Care Proxy
Christian Version

NOTICE TO PERSON MAKING THIS DOCUMENT

You have the right to make decisions about your health care. No health care may be given to you over your objection, and necessary health care may not be stopped or withheld if you object.

Because your health care providers in some cases may not have had the opportunity to establish a long–term relationship with you, they are often unfamiliar with your beliefs and values and the details of your family relationships. This poses a problem if you become physically or mentally unable to make decisions about your health care.

In order to avoid this problem, you may sign this legal document to specify the person whom you wish to make health care decisions for you if you are unable to participate in medical treatment decisions and make those decisions personally. That person is known as your health care agent. You should take some time to discuss your thoughts and beliefs about medical treatment with the person or persons whom you have specified. You may state in this document any types of health care that you do or do not desire, and you may limit the authority of your health care agent. If your health care agent is unaware of your desires with respect to a particular health care decision, he or she is required to determine what would be in your best interests in making the decision.

This is an important legal document. It gives your health care agent broad powers to make health care decisions for you. It revokes any prior health care proxies that you may have made. If you wish to change your Health Care Proxy, you may revoke this document at any time by destroying it, by directing another person to destroy it in your presence, by signing a written and dated statement, or by stating that it is revoked in the presence of two witnesses. If you revoke, you should notify your health care agent(s), your health care provider(s), and any other person(s) to whom you have given a copy. If your health care agent is your spouse and your marriage is annulled or you are divorced after signing this document, the document is invalid.

Do not sign this document unless you clearly understand it. It is suggested that you keep the original of this document with your personal papers where it can be easily accessed by your health care agent, close family, or friends, if needed.

STATE OF MASSACHUSETTS
HEALTH CARE PROXY

Written in accordance to Massachusetts General Laws §§ 201D:1-201D:17

DESIGNATION OF HEALTH CARE AGENT

I, _____, residing at
Print your full legal name

_____, _____, _____, _____, appoint as
Street City State Zip Code

my Health Care Agent _____, (____) _____
Name of person you choose as agent Phone

of _____, _____, _____, _____.
Street City State Zip Code

Optional: If my agent is unwilling or unable to serve then I appoint as my Alternate Health Care Agent

_____, (____) _____
Name of person you choose as alternate agent Phone

of _____, _____, _____, _____.
Street City State Zip Code

STATEMENT OF DESIRES, SPECIAL PROVISIONS, OR LIMITATIONS

My agent shall have the authority to make all health care decisions for me, subject to any limitations I state below, if I am unable to make decisions myself. My agent's authority becomes effective if my attending physician determines in writing that I lack the capacity to make or to communicate health care decisions as I would if I had the capacity to make them, except the following list of specific desires, provisions, or limitations I wish to place on my agent's authority:

1. I request that the attached Addendum (pages 5-11) be included as a valid part of this Health Care Proxy.
2. I request, but not as a requirement, that my agent consult my clergy regarding health care decisions.
3. _____

_____

_____

_____

_____

[Attach additional pages, if needed]

The principal and the witnesses must sign the document at the same time.

SIGNATURE OF PRINCIPAL

(Person creating this Health Care Proxy)

I direct my agent to make decisions on the basis of my agent's assessment of my personal wishes. If my personal wishes are unknown, my agent is to make decisions on the basis of my agent's assessment of my best interests. Photocopies of this Health Care Proxy shall have the same force and effect as the original.

Signature: _____

Date: _____

Complete the following only if the principal is physically unable to sign.

I have signed the principal's name above at his or her direction in the presence of the principal and two witnesses.

Signature: _____ Print name: _____

_____, _____, _____, _____
Street City State Zip Code

STATEMENT OF WITNESSES

We the undersigned, each witnessed the signing of this Health Care Proxy by the principal or at the direction of the principal and state that the principal appears to be at least 18 years of age, of sound mind, and under no constraint or undue influence. Neither of us is named as the health care agent or alternate in this document.

In our presence this _____ day of _____, _____.
Date Month Year

Witness #1

Signature: _____

Print name: _____

Address: _____

_____

Witness #2

Signature: _____

Print name: _____

Address: _____

_____

HEALTH CARE AGENT STATEMENT
(Optional)

We have read this document carefully and accept the appointment.

Health Care Agent:

Signature: _____

Print name: _____

Date: _____

Alternate Health Care Agent:

Signature: _____

Print name: _____

Date: _____

ADDENDUM TO THE STATE OF MASSACHUSETTS HEALTH CARE PROXY

GENERAL STATEMENT OF AUTHORITY GRANTED

As the principal of this document, I desire to have my health care decisions made in accordance with this Addendum to the Health Care Proxy – Christian Version. The purposes of this Addendum are to provide a witness to my Christian belief that life is a gift from God, and to provide direction for my agent to make decisions that are consistent with my Christian faith.

Unless I have specified otherwise in this document, if I ever have incapacity I instruct my health care provider to obtain the health care decision of my agent, if I need treatment, for all of my health care and treatment. I have discussed my desires thoroughly with my agent and believe that he or she understands any philosophy regarding the health care decisions I would make if I were able. I desire that my wishes be carried out through the authority given to my agent under this document.

If I am unable, due to my incapacity, to participate in making a health care decision, my agent is instructed to make the health care decision for me, but my agent should try to discuss with me any specific proposed health care if I am able to communicate in any manner, including by blinking my eyes. If this communication cannot be made, my agent shall base his or her decision on any health care choices that I have expressed prior to the time of the decision. If I have not expressed a health care choice about the health care in question and communication cannot be made, my agent shall base his or her decision on what he or she believes to be in my best interest.

MY HEALTH CARE STATEMENT OF BELIEFS

My philosophy regarding the health care decisions I would make, if I were able to participate in medical treatment decisions, is based on my belief that life is a gift from God and in the inherent value of human life. It is my desire that all reasonable efforts be made to sustain my life and health.

I believe that death is the normal end of earthly life and that God takes life by his decision. Therefore, I reject any attempt to end my life when God would sustain it, regardless of any diminished state of quality to my life, even if I have a disability. Similarly, I reject any attempt to lengthen my life when it is clear God intends to take it.

I believe life begins at conception. Therefore, if I have been diagnosed as pregnant and my physician knows of this diagnosis, I request that every effort be made to save the life of my unborn child in full recognition that two lives are at stake, both equal in value and worthy of protection.

HEALTH CARE DIRECTIVES

1. I direct my agent to consent to the following health care:
   a. Health care that is intended to relieve pain or to make me comfortable.
   b. Health care to cure or improve any physical or mental condition which can be cured or improved. This includes health care that is intended to be used temporarily or because it is potentially effective.

2. My agent has no authority to consent to any act or omission intended to cause or hasten my death.

3. I instruct my agent to ensure that my attending physician and other health care providers provide my health care based on my health care philosophy and my health care directives as set forth in this document.

4. Should it become clear that God wishes to take my life, namely that I am diagnosed to have a terminal illness or injury where death is imminent, I direct that life–sustaining procedures be withheld or withdrawn, and that I be permitted to die in God's time. I do *not* give consent for the withholding or withdrawal of nutrition or hydration, even if I am diagnosed to have a terminal illness or injury, if doing so would cause my death by starvation or dehydration rather than from the terminal condition or injury.

5. If God allows the quality of my life to be diminished but gives me strength to continue living for an indeterminate amount of time, I request that reasonable care be administered to me to sustain my life and ease discomfort as much as possible.

EXCEPTIONS TO HEALTH CARE DIRECTIVES

1. My agent may refuse consent to health care that would not be effective in terms of my survival.

2. If I have an incurable terminal illness or injury where I am in the final stages of dying, and it is medically certain that my death will occur within hours or a few days, my agent may consent to the withholding or withdrawal of any health care that is not intended to relieve pain or make me comfortable.

3. If I have an incurable terminal illness or injury, and it is medically certain that my death will occur within six (6) months, my health care agent may consent to the withholding or withdrawal of life–sustaining health care. However, I still desire health care for easily treatable acute and chronic conditions, and health care that is intended to relieve pain or make me comfortable.

4. If I have a total, chronic, and irreversible loss of consciousness, this condition must be diagnosed with medical certainty by two physicians, one of whom is my attending physician and the other is an expert in diagnosing my condition. Upon such diagnosis, my agent may consent to the withholding or withdrawal of certain life–sustaining health care, remaining faithful to the directives found in the rest of this document. I still desire health care for easily treatable acute and chronic conditions and health care that is intended to relieve pain or make me comfortable.

NUTRITION AND HYDRATION

Food and fluids

1. I believe that nutrition and hydration are basic human needs which should be provided to me even though providing them may require medical expertise and technology.

2. If I check "Yes" to the "Withhold or withdraw a feeding tube" option in the next section, then a feeding tube may only be withheld or withdrawn from me if:
   a. I have an incurable terminal illness or injury where I am in the final stage of dying, and it is medically certain that my death will occur within hours or a few days, and
   b. The withholding or withdrawal of the feeding tube would not result in my death from malnutrition or dehydration, or complications of malnutrition or dehydration, rather than from my underlying terminal illness or injury.

PROVISION OF FEEDING TUBE

If I have checked "Yes" to the following, my agent may have a feeding tube withheld or withdrawn from me, unless my physician has advised that, in his or her professional judgment, this will cause me pain or will reduce my comfort. If I have checked "No" to the following, my agent may not have a feeding tube withheld or withdrawn from me.

My agent may not have orally ingested nutrition or hydration withheld or withdrawn from me unless provision of the nutrition or hydration is medically contraindicated.

Withhold or withdraw a feeding tube **Yes ❑** **No ❑**

If I have not checked either "Yes" or "No" immediately above, my agent may not have a feeding tube withheld or withdrawn from me.

PREGNANT WOMEN

If I am pregnant, the following applies:

1. My agent is authorized to make health care decisions on behalf of my unborn child as an individual patient.

2. Health care necessary to sustain the life or health of my unborn child should be provided unless it is medically certain that my unborn child would not survive even if the health care were provided.

3. It is my desire that all reasonable efforts be made to sustain both my life and health and the life and health of my unborn child.

4. Even if I have an incurable illness or injury, or I am legally determined to be brain dead, it is my desire to receive all health care, to remain on any necessary life support systems, and to receive nutrition and hydration until my unborn child can sustain life apart from my body, unless it is medically certain that my unborn child would not survive even if I receive such health care.

5. No one is authorized to consent to an abortion for me unless it is directly and medically necessary to prevent my death.

HEALTH CARE DECISIONS FOR PREGNANT WOMEN

If I have checked "Yes" to the following, my agent may make health care decisions for me if he/she knows I am pregnant. If I have checked "No" to the following, my agent may not make health care decisions for me if he/she knows I am pregnant.

Health care decision if I am pregnant **Yes ❑** **No ❑**

If I have not checked either "Yes" or "No" immediately above, my agent may not make health care decisions for me if he or she knows I am pregnant.

In no event is my agent authorized to make medical treatment decisions to withhold or withdraw treatment for me if I am pregnant that would result in my death.

LIMITATIONS ON MENTAL HEALTH TREATMENT

My agent may not admit or commit me on an inpatient basis to an institution for mental diseases, a state treatment facility, or a treatment facility. My agent may not consent to experimental mental health research or psycho surgery, electroconvulsive treatment, or drastic mental health treatment procedures for me.

INSPECTION AND DISCLOSURE OF INFORMATION RELATING TO MY PHYSICAL OR MENTAL HEALTH

Subject to any limitations in this document, my agent has the authority to do all of the following:

1. Request, review, and receive any information, verbal or written, regarding my physical or mental health, including medical and hospital records.

2. Execute on my behalf any documents that may be required in order to obtain this information.

3. Consent to the disclosure of this information.

ADMISSION TO NURSING HOMES

My agent may admit me to a nursing home for short–term stays for recuperative care or respite care.

If I have checked "Yes" to the following, my agent may admit me for a purpose other than recuperative care or respite care, but if I have checked "No" to the following, my agent may not so admit me:

A nursing home **Yes** ❑ **No** ❑

If I have not checked either "Yes" or "No" immediately above, my agent may only admit me for short–term stays for recuperative care or respite care.

HIPAA RELEASE STATEMENT

I intend for my health care agent to be treated as I would with respect to my rights regarding the use and disclosure of my individual protected health information or other medical records. I grant to my agent the right to receive, disclose, or release, without restriction, all of my protected health information. This release statement applies to any information that is governed by the Health Insurance Portability and Accountability Act (HIPAA) of 1996.

The principal and the witnesses must sign the document at the same time.

SIGNATURE OF PRINCIPAL

(Person creating this Health Care Proxy)

I HAVE READ THIS ADDENDUM TO THE MASSACHUSETTS HEALTH CARE PROXY – CHRISTIAN VERSION. I UNDERSTAND THAT IT ALLOWS ANOTHER PERSON TO MAKE LIFE AND DEATH DECISIONS FOR ME IF I AM INCAPABLE OF MAKING SUCH DECISIONS. I ALSO UNDERSTAND THAT I CAN REVOKE THIS HEALTH CARE PROXY AND ADDENDUM AT ANY TIME BY NOTIFYING MY AGENT, MY PHYSICIAN, OR THE FACILITY IN WHICH I AM A PATIENT OR RESIDENT.

I sign my name to this Addendum to the Massachusetts Health Care Proxy – Christian Version on the _____ day of

_____, _____ at _____, _____
Month Year City State

Signature: _____ Print name: _____

(The signing of this document by the principal revokes all previous Health Care Proxy documents.)

Complete the following only if the principal is physically unable to sign.

I have signed the principal's name above at his or her direction in the presence of the principal and two witnesses.

Signature: _____ Print name: _____

STATEMENT OF WITNESSES

I declare under penalty of perjury that the principal has identified himself or herself to me, that the principal signed or acknowledged this health care proxy in my presence, that I believe the principal to be of sound mind, that the principal has affirmed that the principal is aware of the nature of the document and is signing it voluntarily and free from duress, that the principal requested that I serve as witness to the principal's execution of this document, that I am not the person appointed as agent by this document, and that I am not a provider of health or residential care, an employee of a provider of health or residential care, the operator of a community care facility, or an employee of an operator of a health care facility.

I declare that I am not related to the principal by blood, marriage, or adoption and that to the best of my knowledge I am not entitled to any part of the estate of the principal on the death of the principal under a will or by operation of law.

Witness #1

Signature: _____

Print name: _____

Address: _____

_____

Witness #2

Signature: _____

Print name: _____

Address: _____

_____

STATEMENT OF AGENT

I understand that _____ has designated me to be his or her agent if he or she
Name of principal
is ever found to have incapacity and unable to participate in making health care decisions himself or herself. This designation shall not become effective unless the principal is unable to participate in medical treatment decisions.

_____ has discussed his or her desires regarding health care decisions with me.
Name of principal

Agent's signature: _____ Phone: (_____) _____

Address: _____

STATEMENT OF ALTERNATE AGENT

The State of Massachusetts does not require you to choose an alternate agent, but we recommend that you do. The alternate agent will assume the role of agent in the event your primary agent is unable or unwilling to carry out the duties as described. By signing this document, the alternate agent is acknowledging the medical directives that are stated in this document and accepting the responsibilities of agent in the case where the primary agent is unable or unwilling to serve as agent.

Alternate agent's signature: _____ Phone: (_____) _____

Address: _____

CLERGY
(Optional)

The principal has requested that the agent consult me, as the principal's clergy, regarding any health care decisions. I understand that this request has been made and am willing to work with the agent to help meet the directives as described in this Health Care Proxy document and attached Addendum.

Clergy's signature: _____

Church name: _____ Phone: (_____) _____

Church address: _____

I have given copies of this Health Care Proxy – Christian Version to:

_____

_____

_____

_____

_____

_____