

# **CONNECTICUT Advance Directive Planning for Important Health Care Decisions**

## ***Caring Info***

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

[www.caringinfo.org](http://www.caringinfo.org)

*800/658-8898*

Caring Info, a program of the National Hospice and Palliative Care Organization (NHPCO), is a national consumer engagement initiative to improve care at the end of life.

## **It's About How You LIVE**

*It's About How You LIVE* is a national community engagement campaign encouraging individuals to make informed decisions about end-of-life care and services. The campaign encourages people to:

- L**earn about options for end-of-life services and care
- I**mplement plans to ensure wishes are honored
- V**oice decisions to family, friends and health care providers
- E**ngage in personal or community efforts to improve end-of-life care

**Note:** The following is not a substitute for legal advice. While Caring Info updates the following information and form to keep them up-to-date, changes in the underlying law can affect how the form will operate in the event you lose the ability to make decisions for yourself. If you have any questions about how the form will help ensure your wishes are carried out, or if your wishes do not seem to fit with the form, you may wish to talk to your health care provider or an attorney with experience in drafting advance directives.

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## Using these Materials

### BEFORE YOU BEGIN

1. Check to be sure that you have the materials for each state in which you may receive health care.
2. These materials include:
  - Instructions for preparing your advance directive, please read all the instructions.
  - Your state-specific advance directive forms, which are the pages with the gray instruction bar on the left side.

### ACTION STEPS

1. You may want to photocopy or print a second set of these forms before you start so you will have a clean copy if you need to start over.
2. When you begin to fill out the forms, refer to the gray instruction bars — they will guide you through the process.
3. Talk with your family, friends, and physicians about your advance directive. Be sure the person you appoint to make decisions on your behalf understands your wishes.
4. Once the form is completed and signed, photocopy the form and give it to the person you have appointed to make decisions on your behalf, your family, friends, health care providers and/or faith leaders so that the form is available in the event of an emergency.
5. You may also want to save a copy of your form in an online personal health records application, program, or service that allows you to share your medical documents with your physicians, family, and others who you want to take an active role in your advance care planning.

## Introduction to Your Connecticut Advance Directive

This packet contains a **Connecticut Advance Directive**, which is a legal document that protects your right to refuse medical treatment you do not want or to request treatment you do want in the event you lose the ability to make decisions yourself. You can complete any or all of the first four parts of this document, depending on your advance planning needs.

**Part One** is your **Living Will**. This part lets you state your wishes about medical care in the event that you are terminally ill and cannot make your own health care decisions, or are permanently unconscious.

**Part Two** is your **Appointment of a Health Care Representative**. This part allows you to appoint a person to make health care decisions for you in the event you can no longer make your own health care decisions.

Your Living Will and Appointment of a Health Care Representative go into effect when this document is provided to your attending physician and your attending physician determines that you are unable to understand and appreciate the nature and consequences of health care decisions, including the benefits and disadvantages of such treatment, and you are unable to reach and communicate an informed decision regarding treatment. However, if your attending physician has not determined that you are terminally ill or permanently unconscious, you must be given beneficial medical treatment, including nutrition and hydration.

**Part Three, Designation of a Conservator**, allows you to designate someone as your conservator in the event a court determines that one should be appointed for you. You may also designate, and the court may appoint, a successor conservator who will assume conservator duties if the original conservator resigns or is otherwise removed.

Unlike a healthcare representative, your conservator must comply with your properly-executed healthcare instructions. Your conservator may also carry out your wishes regarding cremation or other direction as to the disposal of your body after death, although further information and forms for this are not included in this packet. It is possible for the same person to serve as both your health care representative and conservator. In general, the decisions of a health care representative will override the decisions of a conservator, although some exceptions apply.

**Part Four, Document of Anatomical Gift**, allows you to document your organ donation wishes.

**Part Five** contains required signature and witnessing provisions.

**Part Six** is an optional **Witness Affidavit** section, which can be useful in the event your advance directive is challenged in court.

This form does not expressly address mental illness. If you would like to make advance care plans involving mental illness, you should talk to your physician and an attorney about a durable power of attorney tailored to your needs.

*Note: These documents will be legally binding only if the person completing them is a competent adult (at least 18 years old).*

## **Completing Your Connecticut Advance Directive**

### **How do I make my Connecticut Advance Directive legal?**

The law requires that you sign and date your document in the presence of two adult witnesses. The person you appoint as your health care representative cannot serve as a witness or sign the document. Each of your witnesses must also sign the document in the presence of the other witness.

If you are a resident of a facility operated or licensed by the Department of Mental Health and Addiction Services:

- at least one witness must be an individual who is not affiliated with your health care facility, and
- at least one witness must be a physician or clinical psychologist with specialized training in treating mental illness.

If you are a resident of a facility operated or licensed by the Department of Developmental Services:

- at least one witness must be an individual who is not affiliated with your treating health care facility, and
- at least one witness must be a physician or clinical psychologist with specialized training in developmental disabilities.

You may also ask your witnesses to complete the optional Witness Affidavit on the last page of the form. This must be signed in front of a notary public or other officer authorized to administer oaths. If your advance directive were ever challenged legally, the witness affidavit would be accepted by a court as evidence of the document's validity.

### **Whom should I appoint as my Health Care Representative?**

Your health care representative is the person you appoint to make decisions about your health care if you become unable to make those decisions yourself. Your health care representative may be a family member or a close friend whom you trust to make serious decisions. The person you name as your health care representative should clearly understand your wishes and be willing to accept the responsibility of making health care decisions for you.

## **Completing Your Connecticut Advance Directive (continued)**

The person you appoint as your health care representative **cannot** be:

- your attending physician,
- an operator, administrator, or employee of a health care facility in which you are a patient or resident or to which you have applied for admission, unless he or she is related to you by blood, marriage, or adoption, or
- an administrator or employee of a government agency that is financially responsible for your medical care, unless he or she is related to you by blood, marriage, or adoption.

You can appoint a second person as your alternate representative. The alternate will step in if the first person you name as Health Care Representative is unable, unwilling or unavailable to act for you.

### **Should I add personal instructions to my Connecticut Advance Directive?**

One of the strongest reasons for naming a health care representative is to have someone who can respond flexibly as your medical situation changes and deal with situations that you did not foresee. If you add instructions to this document it may help your health care representative carry out your wishes, but be careful that you do not unintentionally restrict your health care representative's power to act in your best interest. In any event, be sure to talk with your health care representative about your future medical care and describe what you consider to be an acceptable "quality of life."

### **What if I change my mind?**

You may revoke your Part One of your advance directive, the Living Will, at any time and in any manner, regardless of your mental or physical condition. You should be sure to notify your health care provider and health care representative of your revocation in order to ensure that your revocation is effective.

You may revoke Part Two of your advance directive, the appointment of your health care representative, only in a writing signed by you and two witnesses. You should be sure to notify your health care provider and health care representative of your revocation in order to ensure that your revocation is effective.

Unless you specify otherwise in the additional instructions portion of Part Two, page 4 of your advance directive, appointment of your spouse as your health care representative is automatically revoked if you are divorced or legally separated or upon the dissolution or annulment of your marriage.

## **Completing Your Connecticut Advance Directives (continued)**

### **What other important facts should I know?**

Due to restrictions in the state law, a pregnant patient's Advance Directive will not be honored.

## CONNECTICUT ADVANCE DIRECTIVE

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### **THESE ARE MY HEALTH CARE INSTRUCTIONS, INCLUDING MY LIVING WILL, MY APPOINTMENT OF A HEALTH CARE REPRESENTATIVE, THE DESIGNATION OF MY CONSERVATOR OF THE PERSON FOR MY FUTURE INCAPACITY AND MY DOCUMENT OF ANATOMICAL GIFT**

To any physician who is treating me: These are my health care instructions including those concerning the withholding or withdrawal of life support systems, together with the appointment of my health care representative, the designation of my conservator of the person for future incapacity and my document of anatomical gift. If the time comes when I am incapacitated to the point when I can no longer actively take part in decisions for my own life, and am unable to direct my physician as to my own medical care, I wish this statement to stand as a testament of my wishes. As my physician, you may rely on any decision made by my health care representative, or conservator of my person, if I am unable to make a decision for myself.

#### **Part One. LIVING WILL**

PRINT YOUR NAME

I, \_\_\_\_\_,  
(Name)

the author of this document, request that, if my condition is deemed terminal or if I am determined to be permanently unconscious, I be allowed to die and not be kept alive through life support systems. By terminal condition, I mean that I have an incurable or irreversible medical condition which, without the administration of life support systems, will, in the opinion of my attending physician, result in death within a relatively short time. By permanently unconscious I mean that I am in a permanent coma or persistent vegetative state or other irreversible condition in which I am at no time aware of myself or the environment and show no behavioral response to the environment.

## CONNECTICUT ADVANCE DIRECTIVE

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### **Specific Instructions:**

Listed below are my instructions regarding particular types of life support systems. This list is not all-inclusive. My general statement that I not be kept alive through life support systems provided to me is limited only where I have indicated that I desire a particular treatment to be provided.

(Initial your wishes below)

	Provide	Withhold
Cardiopulmonary Resuscitation	_____	_____
Artificial Respiration (including a respirator)	_____	_____
Artificial means of providing nutrition and hydration	_____	_____

I further direct that:

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I do want sufficient pain medication to maintain my physical comfort. I do not intend any direct taking of my life, but only that my dying not be unreasonably prolonged.

INITIAL THE  
OPTIONS THAT  
REFLECT YOUR  
WISHES

ADD OTHER  
INSTRUCTIONS, IF  
ANY, REGARDING  
YOUR ADVANCE  
CARE PLANS

THESE  
INSTRUCTIONS CAN  
FURTHER ADDRESS  
YOUR HEALTH CARE  
PLANS, SUCH AS  
YOUR WISHES  
REGARDING  
HOSPICE  
TREATMENT, BUT  
CAN ALSO ADDRESS  
OTHER ADVANCE  
PLANNING ISSUES,  
SUCH AS YOUR  
BURIAL WISHES

ATTACH  
ADDITIONAL PAGES  
IF NEEDED

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**Part Two. APPOINTMENT OF HEALTH CARE REPRESENTATIVE**

PRINT THE NAME,  
PHONE NUMBER  
AND ADDRESS OF  
YOUR HEALTH CARE  
REPRESENTATIVE

I appoint \_\_\_\_\_,  
(Health care representative)

\_\_\_\_\_, \_\_\_\_\_  
(Telephone number) (Address)

to be my health care representative.

If my attending physician determines that I am unable to understand and appreciate the nature and consequences of health care decisions and unable to reach and communicate an informed decision regarding treatment, my health care representative is authorized to make any and all health care decisions for me, including:

- (1) The decision to accept or refuse any treatment, service or procedure used to diagnose or treat my physical or mental condition, except as otherwise provided for by law such as for psychosurgery or shock therapy;
- (2) The decision to provide, withhold or withdraw life support systems;

I direct my health care representative to make decisions on my behalf in accordance with my wishes, as stated in this document or as otherwise known to my health care representative. In the event my wishes are not clear or a situation arises that I did not anticipate, my health care representative may make a decision in my best interests, based upon what is known of my wishes

PRINT THE NAME  
AND PHONE  
NUMBER OF YOUR  
ALTERNATE  
REPRESENTATIVE

If the person I have named above as my health care representative is unwilling or unable to serve as my health care representative,

I appoint \_\_\_\_\_,  
(Health care representative)

\_\_\_\_\_, \_\_\_\_\_  
(Telephone number) (Address)

to be my alternate health care representative.

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**Part Three. DESIGNATION OF A CONSERVATOR OF THE PERSON**

If a conservator of my person should need to be appointed, I designate

\_\_\_\_\_  
(Conservator)

\_\_\_\_\_  
(Phone number)

\_\_\_\_\_  
(Address)

to be appointed my conservator.

If the person above is unwilling or unable to serve as my conservator,

I designate \_\_\_\_\_,  
(Alternate conservator)

\_\_\_\_\_  
(Phone number)

\_\_\_\_\_  
(Address)

I designate \_\_\_\_\_,  
(Successor conservator)

\_\_\_\_\_  
(Phone number)

\_\_\_\_\_  
(Address)

to be my successor conservator.

No bond shall be required of either of them in any jurisdiction.

PRINT THE NAME,  
PHONE NUMBER,  
AND ADDRESS OF  
YOUR  
CONSERVATOR

PRINT THE NAME,  
PHONE NUMBER,  
AND ADDRESS OF  
YOUR ALTERNATE  
CONSERVATOR

PRINT THE NAME,  
PHONE NUMBER,  
AND ADDRESS OF  
YOUR SUCCESSOR  
CONSERVATOR

**CONNECTICUT ADVANCE DIRECTIVE - PAGE 7 OF 9**

**Part Four. DOCUMENT OF ANATOMICAL GIFT**

INITIAL ONLY ONE CHOICE

I make no anatomical gift at this time.

\_\_\_\_\_  
(Initial here)

I hereby make this anatomical gift, if medically acceptable, to take effect upon my death.

\_\_\_\_\_  
(Initial here)

I give: (initial one)

\_\_\_\_\_ (1) any needed organs or parts

\_\_\_\_\_ (2) only the following organs or parts

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

INITIAL YOUR CHOICE HERE

PRINT THE ORGANS YOU WANT TO DONATE

INITIAL YOUR CHOICE HERE

to be donated for: (initial one)

\_\_\_\_\_ (1) any of the purposes stated in subsection (a) of section 19a-289j of the general statutes

\_\_\_\_\_ (2) these limited purposes

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

PRINT THE PURPOSES FOR WHICH YOU ARE WILLING TO DONATE YOUR ORGANS

**Part Five. EXECUTION**

These requests, appointments, and designations are made after careful reflection, while I am of sound mind. Any party receiving a duly executed copy or facsimile of this document may rely upon it unless such party has received actual notice of my revocation of it.

Signature \_\_\_\_\_

Print Name \_\_\_\_\_

Date \_\_\_\_\_

**WITNESSES' STATEMENTS**

This document was signed in our presence by \_\_\_\_\_

\_\_\_\_\_, the author of this document, who appeared to be eighteen years of age or older, of sound mind and able to understand the nature and consequences of health care decisions at the time this document was signed. The author appeared to be under no improper influence. We have subscribed this document in the author's presence and at the author's request and in the presence of each other.

Witness \_\_\_\_\_

Printed Name \_\_\_\_\_

Address \_\_\_\_\_

\_\_\_\_\_

Witness \_\_\_\_\_

Printed Name \_\_\_\_\_

Address \_\_\_\_\_

\_\_\_\_\_

SIGN, DATE, AND  
PRINT YOUR NAME

TWO WITNESSES  
SIGN BELOW AND  
PRINT THEIR  
NAMES AND  
ADDRESSES

WITNESS # 1

WITNESS #2

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**CONNECTICUT ADVANCE DIRECTIVE - PAGE 9 OF 9**

**WITNESS AFFIDAVIT**

STATE OF CONNECTICUT )  
 : ss. \_\_\_\_\_ )  
COUNTY OF \_\_\_\_\_ ) (Town/City)

We, the subscribing witnesses, being duly sworn, say that we witnessed the execution of these health care instructions, the appointments of a health care representative, the designation of a conservator for future incapacity and a document of anatomical gift by the author of this document; that the author subscribed, published, and declared the same to be the author's instructions, appointments, and designation in our presence; that we thereafter subscribed the document as witnesses in the author's presence, at the author's request, and in the presence of each other; that at the time of the execution of said document the author appeared to us to be eighteen years of age or older, of sound mind, able to understand the nature and consequences of said document, and under no improper influence, and we make this affidavit at the author's request this \_\_\_\_\_ day of \_\_\_\_\_ 20\_\_\_\_\_ .

Witness \_\_\_\_\_

Printed Name \_\_\_\_\_

Witness \_\_\_\_\_

Printed Name \_\_\_\_\_

Subscribed and sworn to before me this \_\_\_\_\_ day of \_\_\_\_\_ 20\_\_\_\_\_.

\_\_\_\_\_  
Commissioner of the Superior Court Notary Public

My commission expires: \_\_\_\_\_

*Courtesy of Caring Info*  
1731 King St., Suite 100, Alexandria, VA 22314  
www.caringinfo.org, 800/658-8898

THIS AFFIDAVIT IS  
OPTIONAL

YOUR WITNESSES  
MUST SIGN AND  
PRINT THEIR  
NAMES

A NOTARY PUBLIC  
FILLS THIS PART  
OUT

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## **You Have Filled Out Your Health Care Directive, Now What?**

1. Your *Connecticut Advance Directive* is an important legal document. Keep the original signed document in a secure but accessible place. Do not put the original document in a safe deposit box or any other security box that would keep others from having access to it.
2. Give photocopies of the signed original to your agent and alternate agent, doctor(s), family, close friends, clergy, and anyone else who might become involved in your health care. If you enter a nursing home or hospital, have photocopies of your document placed in your medical records.
3. Be sure to talk to your agent(s), doctor(s), clergy, family, and friends about your wishes concerning medical treatment. Discuss your wishes with them often, particularly if your medical condition changes.
4. You may also want to save a copy of your form in an online personal health records application, program, or service that allows you to share your medical documents with your physicians, family, and others who you want to take an active role in your advance care planning.
5. If you want to make changes to your documents after they have been signed and witnessed, you must complete a new document.
6. Remember, you can always revoke your Connecticut document.
7. Be aware that your Connecticut document will not be effective in the event of a medical emergency. Ambulance and hospital emergency department personnel are required to provide cardiopulmonary resuscitation (CPR) unless they are given a separate directive that states otherwise. These directives called "prehospital medical care directives" or "do not resuscitate orders" are designed for people whose poor health gives them little chance of benefiting from CPR. These directives instruct ambulance and hospital emergency personnel not to attempt CPR if your heart or breathing should stop.

Currently not all states have laws authorizing non-hospital do-not-resuscitate orders. We suggest you speak to your physician if you are interested in obtaining one. **Caring Info does not distribute these forms.**

## Congratulations!

You've downloaded **your free, state specific advance directive.**

You are taking important steps to make sure your wishes are known. Help us keep this free.

Your generous support of the National Hospice Foundation and Caring Info allows us to continue to provide these FREE resources, tools, and information to educate and empower individuals to access advance care planning, caregiving, hospice and grief services, and information.

**I hope you will show your support for our mission and make a tax-deductible gift today.**

Since 1992, the National Hospice Foundation has been dedicated to creating FREE resources for individuals and families facing a life-limiting illness, raising awareness for the need for hospice care, and providing ongoing professional education and skills development to hospice professionals across the nation.

Your gift strengthens the Foundation's ability to provide FREE caregiver and family resources.

Support your National Hospice Foundation by returning a **generous tax-deductible gift of \$23, \$47, \$64**, or the most generous amount you can send.

**You can help** us provide resources like this advance directive FREE by sending in your gift to help others.

**Please help to make this possible with your contribution! Cut along the dotted line and use the coupon below to return a check contribution of the most generous amount you can send. Thank you.**



**YES!** I want to support the important work of the National Hospice Foundation.

**\$23**

helps us provide free advance directives

**\$47**

helps us maintain our free HelpLine

**\$64**

helps us provide webinars to hospice professionals

Return to:

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PO Box 824401  
Philadelphia, PA 19182-4401

AD\_2018



OR donate online today: [www.caringinfo.org/donate](http://www.caringinfo.org/donate)