

**MASSACHUSETTS  
Advance Directive  
Planning for Important Health Care Decisions**

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

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800/658-XXXX

CaringInfo, 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 CaringInfo 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. **If you have other questions regarding these documents, we recommend contacting your state attorney general's office.**

## 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 MASSACHUSETTS HEALTH CARE PROXY**

This packet contains a legal document that protects your right to refuse medical treatment you do not want, or to request treatment you do want, by appointing an agent to act on your behalf in the event you lose the ability to make decisions yourself. Massachusetts does not have a statute governing the use of living wills, therefore there is no living will for the state of Massachusetts.

The **Massachusetts Health Care Proxy** lets you name someone to make decisions about your medical care—including decisions about life support—if you can no longer speak for yourself.

Following the Massachusetts Health Care Proxy is an optional organ donation form that allows you to make an anatomical gift of your organs for transplantation, therapy, medical research, or education upon your death. If you do not provide instructions regarding the disposition of your organs after your death, your family or your agent will have the authority to do so on your behalf.

Your Massachusetts Health Care Proxy goes into effect when your doctor determines that you are no longer able to make or communicate your health care decisions.

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.

Note: This document will be legally binding only if the person completing it is a competent adult (at least eighteen years old).

## **COMPLETING YOUR MASSACHUSETTS HEALTH CARE PROXY**

### **Whom should I appoint as my health care agent?**

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

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

### **How do I make my Massachusetts Health Care Proxy legal?**

The law requires that you sign your document, or direct another to sign it, in the presence of two adult witnesses, who must also sign the document to show that they believe you to be at least eighteen years of age, of sound mind, and under no constraint or undue influence. The person you appoint as your agent cannot serve as a witness.

Note: You do not need to notarize your Massachusetts Health Care Proxy.

### **Should I add Instructions to my Massachusetts Health Care Proxy?**

One of the strongest reasons for naming an agent 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 agent carry out your wishes, but be careful that you do not unintentionally restrict your agent's power to act in your best interest. In any event, be sure to talk with your agent 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 Health Care Proxy at any time by:

- notifying your agent or doctor orally or in writing;
- taking any action, such as tearing up or destroying the document that indicates your specific intent to revoke your Proxy; or
- executing another Health Care Proxy.

If you have appointed your spouse as your agent, and your marriage ends, your Health Care Proxy is automatically revoked.

**MASSACHUSETTS HEALTH CARE PROXY**

**APOINTMENT OF AGENT**

PRINT YOUR NAME

(1) I, \_\_\_\_\_, hereby appoint

PRINT THE NAME,  
HOME ADDRESS  
AND TELEPHONE  
NUMBER OF YOUR  
AGENT

\_\_\_\_\_  
\_\_\_\_\_  
(name, home address and telephone number of proxy)

as my health care agent to make any and all health care decisions for me, except to the extent that I state otherwise below.

This Health Care Proxy shall take effect in the event that a determination is made by my attending physician that I lack the capacity to make or to communicate my own health care decisions. My attending physician shall make such determination in writing, and shall include his or her opinion regarding the cause and nature of my incapacity, as well as its extent and probable duration.

(OPTIONAL)

PRINT THE NAME,  
HOME ADDRESS  
AND TELEPHONE  
NUMBER OF YOUR  
ALTERNATE AGENT

(2) Name of alternate agent if the person I appoint above is unable, unwilling, or unavailable to act as my health care agent (optional):

\_\_\_\_\_  
\_\_\_\_\_  
(name, home address and telephone number of alternate agent)

(3) I direct my agent to make health care decisions in accord with my wishes and limitations as may be stated below, or as he or she otherwise knows. If my wishes are unknown, I direct my agent to make health care decisions in accord with what he or she determines to be my best interest.

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Palliative Care  
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**MASSACHUSETTS HEALTH CARE PROXY – PAGE 4 OF 4**

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EXECUTION

SIGN AND DATE  
THE DOCUMENT  
AND PRINT  
YOUR ADDRESS

(5) Signature: \_\_\_\_\_

Name: \_\_\_\_\_

Date: \_\_\_\_\_

Address: \_\_\_\_\_

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**Statement by Witnesses**

I declare that the person who signed this document appears to be at least eighteen years of age, of sound mind, and under no constraint or undue influence. He or she signed (or asked another to sign for him or her) this document in my presence. I am not the person appointed as agent or alternate agent by this document.

Witness 1 Signature: \_\_\_\_\_

Name: \_\_\_\_\_

Address: \_\_\_\_\_

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Date: \_\_\_\_\_

Witness 2 Signature: \_\_\_\_\_

Name: \_\_\_\_\_

Address: \_\_\_\_\_

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Date: \_\_\_\_\_

YOUR WITNESSES  
MUST SIGN AND  
PRINT THEIR  
ADDRESSES

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Hospice and  
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Organization.  
2018 Revised.

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

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

1. Your Massachusetts Health Care Proxy 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 healthcare. 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 Massachusetts document.
7. Be aware that your Massachusetts 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 this form.

**CaringInfo 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 CaringInfo 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 InfoLine
- \$64 helps us provide webinars to hospice

Return to:  
National Hospice Foundation  
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Philadelphia, PA 19182-4401

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