ADVANCE DIRECTIVES

Making things clear

Your family ✓

Your life ✓

Your doctor ✓

Your decision ✓

Your community ✓

Communicate your decisions.

Learn about the options for end-of-life care.

Engage with efforts to improve end-of-life care.

Address any concerns that you may have.

Rest in the confidence that your wishes are known.

KEEPING OPEN COMMUNICATION

As we age and look forward to longer life expectancies, we enjoy more opportunities in life with those that we care about. Making an Advance Directive in case something unexpected occurs is another way to keep open communication and enjoy the time we have without the worry that those that love us would not know what to do or how to honor our desires.

WHAT IS AN ADVANCE DIRECTIVE?

It is a written or oral statement that describes your personal wishes in regards to your medical care that you want (or do not want) if you become unable to make your own decisions.

HOW CAN AN ADVANCE DIRECTIVE HELP?

Advance Directives allows for difficult decisions to be made easier for your family and loved ones. By planning with your family and loved ones letting them know your personal decisions, they are better prepared to make difficult decisions that honor your wishes.

DO I NEED AN ATTORNEY TO VALIDATE MY DOCUMENTS?

No. Directives can be initiated and completed without the assistance of an attorney, although you may retain the service of one. It is advisable to consult with your physician as you consider completing an Advance Directive and discuss your decisions with your family.

TYPES OF ADVANCE DIRECTIVES:

A LIVING WILL

A written or oral statement of the kind of medical care you want (or do not want) if you become unable to make your own decisions. It is called a living will because it takes effect while you are still living.

A HEALTH CARE SURROGATE DESIGNATION

It is a document naming another person as your representative to make medical decisions for you, if you are unable to make them yourself. You can include instructions about any treatment you want, or do not want, as well as assign an alternate surrogate.

AN ANATOMICAL DONATION

It is a document that indicates your wish to donate, at death, all or part of your body.

CHOOSING AN ADVANCE DIRECTIVE

While there are no legal requirements to complete an advance directive, if you are in an unfortunate situation where you cannot speak for yourself, a court-appointed guardian, adult family member or close friend may or may not be aware of your wishes as they make important decisions for you.

When you make an advance directive and discuss it with the significant people in your life, it will better assure that your wishes will be carried out the way you want.

Depending on your individual needs, you may wish to complete any one or a combination of the three types of advance directives.

ADVANTAGES OF HAVING A WRITTEN ADVANCE DIRECTIVE

- You are in CHARGE of making your own decisions.
- Decisions can be changed or updated ANYTIME as per your desire.
- You DO NOT need an attorney.
- It assures that your wishes regarding your personal medical care are respected.
- In the event that family members have to make decisions on whether or not life-prolonging measures should be used, being able to refer to your own wishes can help minimize and reduce unnecessary stress on the family.

THE ROLE OF YOUR HEALTH CARE SURROGATE

In the event you are unable to process information and communicate your health-care wishes, your health care surrogate is empowered to:

- Step into your shoes and speak on your behalf as they make decisions that reflect your wishes.

SELECTING A HEALTH CARE SURROGATE

Health Care Surrogates may function on your behalf for any length of time responding to both life-threatening and non-life-threatening medical conditions.

They should be:

- Someone you trust.
- Someone able to make decisions based on your wishes, and not on their own personal preference or beliefs.

Once you decide on a Health Care Surrogate:

- Be sure to ask them if they agree to take this responsibility.
- Discuss how you would like matters handled.
- Give them a copy of the document.

CONSIDER THESE SITUATIONS:

1. Mr. J., an 84-year-old man living with his loving wife of 50 years requires hospitalization after a sudden fall during a walk down their local street. Mr. J. has no history of any medical complications and was unresponsive to treatment and requires round-the-clock monitoring. 48 hours after his admission, Mr. J. suffers a heart attack and the emergency response team wants to know what does his Advance Directives state.

2. Mrs. S., 54-year-old woman, was accompanying her husband to the hospital to evaluate his concerns of chest pain and severe shortness of breath. They have made multiple trips to the emergency room within the month and are concerned that it might be serious. Mr. S, a heavy smoker for more than 30 years, has been diagnosed with emphysema and was explained by the physician that if he were to be placed on a breathing machine, his lungs will most likely not be strong enough to independently breathe on their own subsequently. Mr. and Mrs. S. had never made any considerations for end of life decisions and are in shock to hear the reality of Mr. S's situation.

A THOUGHT TO CONSIDER

The individuals in both of these situations faced decisions that they had to make during a time of a crisis. Any crisis brings stress onto the individual and their family. Taking the time to discuss your personal wishes with your loved ones, can reduce or even avoid such stress during those sensitive moments.
After speaking with your family, make sure to complete an Advance Directive.

DEFINITIONS

END-STAGE CONDITION

An irreversible condition that is caused by injury, disease, or illness which has resulted in progressively severe and permanent deterioration, and which, to a reasonable degree of medical probability, treatment of the condition would be ineffective.

PERSISTENT VEGETATIVE STATE

A permanent and irreversible condition of unconsciousness in which there is: The absence of voluntary action or cognitive behavior of any kind and an inability to communicate or interact purposefully with the environment.

TERMINAL CONDITION

A condition caused by injury, disease, or illness, from which there is no reasonable medical probability of recovery and which, without treatment, can be expected to cause death.

LIFE PROLONGING

Any medical procedure, treatment, or intervention including artificially provided sustenance and hydration, which sustains, restores, or supplants a spontaneous vital function.

PALLIATIVE/COMFORT CARE

Care which provides for immediate comfort, such as cleanliness, warmth, pain control, food and water, as requested by the individual.

The card below may be used as a convenient method to inform others of your health care advance directives. Complete the card and cut it out. Place in your wallet or purse. You can also make copies and place another one on your refrigerator, in your car glove compartment, or other easy to find place.

HEALTH CARE ADVANCE DIRECTIVES

I, _____

have created the following Advance Directives

- ☐ Living Will
- ☐ Health Care Surrogate Designation
- ☐ Anatomical Donation
- ☐ Other (specify

FOLD

Name _____

Address _____

_____

_____

Telephone _____

Signature _____

cut along dotted line

Agency for Health Care Administration

2727 Mahan Drive, Tallahassee, Florida 32308

1-888-419-3456

www.FloridaHealthFinder.gov

www.MyFloridaRx.com

http://ahca.myflorida.com

04-2006

LIVING WILL

Declaration made this _____ day of _____, 2____, I, _____, willfully and voluntarily make known my desire that my dying not be artificially prolonged under the circumstances set forth below, and I do hereby declare that, if at any time I am mentally or physically incapacitated and
_____ (initial) I have a terminal condition,
or _____ (initial) I have an end-stage condition,
or _____ (initial) I am in a persistent vegetative state,
and if my attending or treating physician and another consulting physician have determined that there is no reasonable medical probability of my recovery from such condition, I direct that life-prolonging procedures be withheld or withdrawn when the application of such procedures would serve only to prolong artificially the process of dying, and that I be permitted to die naturally with only the administration of medication or the performance of any medical procedure deemed necessary to provide me with comfort care or to alleviate pain.

I do ___, I do not ___ desire that nutrition and hydration (food and water) be withheld or withdrawn when the application of such procedures would serve only to prolong artificially the process of dying.

It is my intention that this declaration be honored by my family and physician as the final expression of my legal right to refuse medical or surgical treatment and to accept the consequences for such refusal.

In the event I have been determined to be unable to provide express and informed consent regarding the withholding, withdrawal, or continuation of life-prolonging procedures, I wish to designate, as my surrogate to carry out the provisions of this declaration:

Name _____ Address _____

City _____ State _____ Phone _____

I understand the full import of this declaration, and I am emotionally and mentally competent to make this declaration.

Additional Instructions (optional): _____

_____

_____

Signed _____

Witness _____
Address _____
City _____ State _____
Phone _____

Witness _____
Address _____
City _____ State _____
Phone _____

At least one witness must not be a husband or wife or a blood relative of the principal.

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DESIGNATION OF HEALTH CARE SURROGATE

Name: _____

In the event that I have been determined to be incapacitated to provide informed consent for medical treatment and surgical and diagnostic procedures, I wish to designate as my surrogate for health care decisions:

Name _____

Address _____ City _____ State _____ Phone _____

If my surrogate is unwilling or unable to perform his or her duties, I wish to designate as my alternate surrogate:

Name _____

Address _____ City _____ State _____ Phone _____

I fully understand that this designation will permit my designee to make health care decisions and to provide, withhold, or withdraw consent on my behalf; or apply for public benefits to defray the cost of health care; and to authorize my admission to or transfer from a health care facility.

Additional instructions (optional): _____

_____

I further affirm that this designation is not being made as a condition of treatment or admission to a health care facility. I will notify and send a copy of this document to the following persons other than my surrogate, so they may know who my surrogate is.

Name _____ Signed _____ Date _____

Name _____ Signed _____ Date _____

Witnesses:

1._____

2._____

At least one witness must not be a husband or wife or a blood relative of the principal.

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UNIFORM DONOR FORM

The undersigned hereby makes this anatomical gift, if medically acceptable, to take effect on death. The words and marks below indicate my desires:

I give:

(a) _____ any needed organs or parts

(b) _____ only the following organs or parts for the purpose of transplantation, therapy, medical research, or education: _____

_____

(c) _____ my body for anatomical study if needed. Limitations or special wishes, if any: _____

_____

Signed by the donor and the following witnesses in the presence of each other:

Donor's Signature _____

Donor's Date of Birth _____ Date Signed _____

City and State _____

Witness #1 _____

Street Address _____

City _____ State _____

Witness #2 _____

Street Address _____

City _____ State _____

You can use this form to indicate your choice to be an organ donor. Or you can designate it on your driver's license or state identification card (at your nearest driver's license office).

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Notice of Nondiscrimination: Discrimination is Against the Law

Leon Medical Centers Health Plans complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Leon Medical Centers Health Plans does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Leon Medical Centers Health Plans:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, contact Member Services Department at 1-866-393-5366, 8 a.m.–8 p.m., 7 days a week. If you believe that Leon Medical Centers Health Plans has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with:

Grievance Department, 8600 NW 41st Street, Suite 201, Doral, FL 33166, Phone: 1-866-393-5366, TTY 711, Fax: (305) 642-1144.

You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, Member Services is available to help you. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

U.S. Department of Health and Human Services, 200 Independence Avenue, SW, Room 509F, HHH Building, Washington, D.C. 20201, 1-800-368-1019, 800-537-7697 (TDD)

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

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Notificación Contra la Discriminación: La Discriminación es Contra la Ley

Leon Medical Centers Health Plans cumple con las leyes federales de derechos civiles aplicables y no discrimina por motivos de raza, color, nacionalidad, edad, discapacidad o sexo. Leon Medical Centers Health Plans no excluye a las personas ni las trata de forma diferente debido a su origen étnico, color, nacionalidad, edad, discapacidad o sexo.

Leon Medical Centers Health Plans:

- Proporciona asistencia y servicios gratuitos a las personas con discapacidades para que se comuniquen de manera eficaz con nosotros, como los siguientes:
  - Intérpretes de lenguaje de señas capacitados.
  - Información escrita en otros formatos (letra grande, audio, formatos electrónicos accesibles, otros formatos).
- Proporciona servicios lingüísticos gratuitos a personas cuya lengua materna no es el inglés, como los siguientes:
  - Intérpretes capacitados.
  - Información escrita en otros idiomas.

Si necesita recibir estos servicios, comuníquese con el Departamento de Servicio al Miembro al 1-866-393-5366, 8 a.m. – 8 p.m., 7 días de la semana. Si considera que Leon Medical Centers Health Plans no le proporcionó estos servicios o lo discriminó de otra manera por motivos de origen étnico, color, nacionalidad, edad, discapacidad o sexo, puede presentar un reclamo al:

Departamento de Quejas, 8600 NW 41st Street, Suite 201, Doral, FL 33166, Teléfono: 1-866-393-5366, TTY 711, Fax:(305) 642-1144.

Puede presentar el reclamo en persona o por correo postal, fax o correo electrónico. Si necesita ayuda para hacerlo, el Departamento de Servicio al Miembro está a su disposición para brindársela. También puede presentar un reclamo de derechos civiles ante la Oficina de Derechos Civiles del Departamento de Salud y Servicios Humanos de EE. UU. de manera electrónica a través de Office for Civil Rights Complaint Portal (Oficina de Derechos Civiles portal de quejas), disponible en https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, o bien, por correo postal a la siguiente dirección o por teléfono a los números que figuran a continuación:

U.S. Department of Health and Human Services, 200 Independence Avenue, SW, Room 509F, HHH Building, Washington, D.C. 20201, 1-800-368-1019, 800-537-7697 (TDD) Puede obtener los formularios de reclamo en el sitio.

Multi-language Interpreter Services / Servicios de Intérpretes de Varios Idiomas

English: ATTENTION: If you speak English, language assistance services, free of charge, are available to you. Call 1-866-393-5366 (TTY 711).

Spanish: ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-866-393-5366 (TTY 711).

French (Creole): ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele 1-866-393-5366 (TTY 711).

Vietnamese: CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-866-393-5366 (TTY 711).

Portuguese: ATENÇÃO: Se fala português, encontram-se disponíveis serviços linguísticos, grátis. Ligue para 1-866-393-5366 (TTY 711).

Chinese: 注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-866-393-5366（TTY 711）

French: ATTENTION: Si vous parlez français, des services d'aide linguistique-vous sont proposés gratuitement. Appelez le 1-866-393-5366 (ATS 711).

Tagalog: PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-866-393-5366 (TTY 711).

Russian: ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-866-393-5366 (телетайп: 711).

Arabic:
ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-866-393-5366 (رقم هاتف الصم والبكم711).

Italian: ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 1-866-393-5366 (TTY 711).

German: ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-866-393-5366 (TTY 711).

Korean: 주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-866-393-5366 (TTY 711)번으로 전화해 주십시오.

Polish: UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 1-866-393-5366 (TTY 711).

Gujarati: સુચના: જો તમે ગુજરાતી બોલતા હો, તો નિ:શુલ્ક ભાષા સહાય સેવાઓ તમારા માટે ઉપલબ્ધ છે. ફોન કરો 1-866-393-5366 (TTY 711).

Thai: เรียน: ถ้าคุณพูดภาษาไทยคุณสามารถใช้บริการช่วยเหลือทางภาษาได้ฟรี โทร 1-866-393-5366 (TTY 711).

For more information, please contact
LEON MEDICAL CENTERS CUSTOMER SERVICE
Member services at:
305.642.5366
OR
Talk to your physician regarding your options.

LEON MEDICAL CENTERS
HEALTH PLANS®
Cigna HealthSpring®

Other resources include:
www.agingwithdignity.org | Aging with Dignity (888) 594-7437

www.FloridaHealthFinder.gov | (click Brochures and Guides) | (888) 419-3456

American Association of Retired Persons (AARP) | www.aarp.org
(Type "advance directives" in the website's search engine).