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ANNUAL DOCUMENT DAY
Monday, June 12, 2023

Health Care Proxy
Power of Attorney

On Monday, June 12, Attorney Vera Ochea of Metrowest Legal Services will execute Health Care Proxy and Power of Attorney documents at the COA by appointment only. There is no charge.

- Please complete the intake form(s) for the documents you are requesting, and return to the COA on or before **May 30.** This date allows MetroWest Legal Services sufficient time to create an official document with your data for your scheduled appointment on June 12 at the COA office. If we do not receive your intake forms by May 30, we will need to cancel your appointment with the attorney.

- Couples may share one appointment with the attorney, but each person needs to complete and return their own intake forms for the documents requested.

- When you arrive for your 15-minute appointment on June 12, the documents requested will be pre-printed with your data. The lawyer will explain the document(s) and answer questions. If you are comfortable with everything, she will sign and notarize. Staff will serve as your witnesses. Your original document and copies will be provided to you when you leave.

Name(s): _____

Appointment time at the COA: Monday, June 12: _____

HEALTH CARE PROXY

WHAT IS A HEALTH CARE PROXY?

A Health Care Proxy is a legal document that allows you to name someone you know and trust to make health care decisions for you if you become unable to make or communicate those decisions yourself. In Massachusetts any competent adult 18 years of age or over may execute a Health Care Proxy document. The person you name in the document is called "agent". You can name as your agent any adult except the administrator, operator, or employee of a health care facility such as a hospital or nursing home where you are a patient or resident.

WHEN CAN MY AGENT ACT?

Your agent will only act when your attending doctor determines in writing that you do not have capacity to make or communicate health care decisions yourself. This means that your agent will be able to act if you are temporarily unconscious, in a coma, or have some other medical condition in which you cannot make or communicate health care decisions yourself.

WHAT CAN MY AGENT DO?

Your agent will make health care decisions for you according to your wishes, including your religious or moral beliefs. If your wishes are not known in a particular situation, then your agent will decide based on what he or she thinks would be in your best interest. In order to follow your wishes, your agent needs to know exactly how you feel. The more specific and firm you are, the more likely your wishes will be honored.

You can grant broad grant of authority to your agent without any indication of preferences. Alternatively, you can express your preferences but still leave the final decision in the agent's hands. In addition, you may insert any limits you want to put on your agent's authority. The agent cannot act in any way not authorized. For example, you may limit the Agent's authority by stating, "I do not authorize the Agent to allow the administration of a feeding tube." The agent then has no right to consent to the use of a feeding tube, no matter what the circumstances. Many people use a feeding tube during a severe illness and then recover. Eliminating the use of a specific treatment can create problems later on. Moreover, as technology advances, new treatments you never knew about may be prohibited by the language in your Proxy. We therefore advise great care in limiting the agent's authority.

HOW WILL I DRAFT SUCH A DOCUMENT?

An attorney from Metrowest Legal Services will draft a Health Care Proxy free of charge at the Wayland Senior Center. Please contact the Sudbury Senior Center for details and to complete an intake.

MWLS - HEALTH CARE PROXY INTAKE

I. PERSONAL INFORMATION

NAME: _____

ADDRESS: _____ PHONE NUMBER: _____

DATE OF BIRTH: _____ MARITAL STATUS: _____ DISABILITY: _____

ETHNICITY: _____ CITIZENSHIP: _____ LANGUAGE: _____

II. HEALTH CARE AGENT AND ALTERNATE SELECTION

IF I AM NO LONGER ABLE TO MAKE OR COMMUNICATE MY OWN HEALTH DECISIONS, I CHOOSE THE FOLLOWING PERSON TO MAKE DECISIONS FOR ME:

NAME: _____

ADDRESS: _____ PHONE NUMBER: _____

IF THE ABOVE NAMED PERSON IS NOT ABLE, WILLING, HAS DIED OR IS DIVORCED OR LEGALLY SEPARATED FROM ME, THEN I CHOOSE THE FOLLOWING ALTERNATE:

NAME: _____

ADDRESS: _____ PHONE NUMBER: _____

III. AGENT'S AUTHORITY AND WISHES

PLEASE CROSS OUT ANYTHING YOU DO NOT WANT YOUR HEALTH CARE AGENT TO DO LISTED BELOW:

1. To examine and copy all my medical records, x-rays, test results, and hospital, doctors, and other medical bills;

2. To discuss my diagnosis; prognosis; condition; past, present and future treatment; and alternative forms of care with any and all medical, administrative, and insurance personnel who have had any contact with me or who are responsible for my care;

3. To authorize my admission to a medical, nursing, residential, or similar facility and to enter into agreements for my care; to retain and discharge physicians, nurses, therapists and any other medical or psychosocial personnel; to authorize all medical, therapeutic, and surgical procedures, and the administration of drugs, including psychotropic drugs; to decide which form of treatment will be most in keeping with my wishes.

4. To withhold treatment if I have a medical condition that in the opinion of my physician and several consultants cannot be reversed and which significantly limits my capacity to function independently and significantly limits my ability to enjoy life.

5. In the event that my illness, disease, or declining health condition does not require hospitalization, it is my preference to receive home health care rather than institutional care, if possible. I am fully aware of the increased risk of accidental injury associated with remaining in my home and willingly assume that risk.

6. In the situation described above I do not wish to have withheld comfort care such as pain medication, even if it dulls my mind and indirectly shortens my life.

7. The treatment I authorize to be withheld includes but is not limited to artificial nutrition and hydration, cardiopulmonary resuscitation, mechanical breathing, antibiotics, major or minor surgery, diagnostic testing, the transfusion of blood or blood products, and chemotherapy.

DURABLE POWER OF ATTORNEY

WHAT IS A POWER OF ATTORNEY?

A power of attorney is a document which gives to another person, called an "attorney-in-fact," the power to act on your behalf. It can be written to give the attorney-in-fact very broad powers over large areas of your life. Alternatively, it can be written narrowly to give the attorney-in-fact a specific duty or area of authority. Signing, or "executing," such a power of attorney does not lessen your rights to do the things your attorney-in-fact can do. For example, you may write a power of attorney allowing your attorney-in-fact to write checks against your account, but still retain the right to write checks yourself. Your attorney-in-fact has an obligation to use his power in your best interest, ignoring his own interest and desires.

WHY DURABLE?

Previously a power of attorney was not valid after you became mentally incompetent. As a practical matter, powers of attorney were not very useful to elders who wanted their relatives or friends to handle their affairs when they were no longer able to do so themselves. The Legislature passed a law which allows you to designate your power of attorney as "durable," or lasting beyond the onset of any mental impairment. Durable does not mean irrevocable, however. While you are still mentally capable, you retain the right to revoke any power of attorney.

HOW WILL I DRAFT SUCH A DOCUMENT?

An attorney from Metrowest Legal Services will draft a Power of Attorney document free of charge at the Wayland Senior Center. Please contact the Sudbury Senior Center for details and to complete an intake.

MWLS –DURABLE POWER OF ATTORNEY INTAKE

I. PERSONAL INFORMATION

NAME: _____

ADDRESS: _____ PHONE NUMBER: _____

DATE OF BIRTH: _____ MARITAL STATUS: _____ DISABILITY: _____

ETHNICITY: _____ CITIZENSHIP: _____ LANGUAGE: _____

II. AGENT AND ALTERNATE SELECTION

IF I AM NOT ABLE TO HANDLE MY FINANCIAL AND PERSONAL MATTERS, I CHOOSE THE FOLLOWING PERSON TO DO IT FOR ME:

NAME: _____

ADDRESS: _____ PHONE NUMBER: _____

IF THE ABOVE NAMED PERSON IS NOT ABLE, WILLING, HAS DIED OR IS DIVORCED OR LEGALLY SEPARATED FROM ME, THEN I CHOOSE THE FOLLOWING ALTERNATE:

NAME: _____

ADDRESS: _____ PHONE NUMBER: _____

III. GUARDIAN AND CONSERVATOR NOMINATION

I NOMINATE _____ as Conservator of my Estate and as Guardian of my Person, for consideration by the Court, should protective proceedings be commenced against my person or my estate.