Table of Contents

CAREGIVER NOTEBOOK

Dear Caregiver,

Thank you. That is the first thing that needs to be said as you begin on this journey. Your role as a caregiver is very important and at times will probably feel very overwhelming. We hope that this notebook will help provide some comfort. The goal of the caregiver's notebook is to have a central place to store all the information that is vital to your loved one's care. This includes:

- **A comprehensive mental health section**
- **Housing information**
- **Legal information, specifically "End of Life" forms**
- **Medical information**
- **Daily routine and care information**

This notebook is intended to be comprehensive. Some sections need to be filled out immediately. We recommend photocopying some of the forms and/or writing some information in pencil. This will help because certain information, such as medication, will change.

Since many people may have access to this notebook, we also recommend that the sections marked confidential be removed and stored in a safe place. If you feel that some important papers need to be in the notebook then photocopy them. Put the copy in the notebook and store the original.

You may also consider putting certain pages in a plastic covering. This will protect them even more and make them portable. For example, if you need a certain section for a doctor's appointment you can just grab it and go without having to take the whole notebook.

When you can, involve your loved one in completing the information. This will provide some quality time for discussion and may also help provide a sense of control for your loved one. You may also consider enlisting other family members and close friends of the elder to complete this notebook.

The structure of this notebook is not limited to the way we arranged it. Since it is a three-ring binder you may move things around as you see fit. Customize the book in a manner that works best for you and your loved one.

The first section of this notebook is dedicated to you - the Caregiver. We would recommend keeping this at the front. Please review it often to assess your own needs.

CAREGIVING

"When we do the best that we can, we never know what miracle is wrought in our life, or in the life of another".

~Helen Keller

NOTES

What is Caregiving?

- **Caregiving itself is a multi-dimensional puzzle. For some, it means providing 24-hour care for someone who can't dress, feed, go to the bathroom, or think for himself or herself. For others, caregiving is an emotional roller coaster because a diagnosed condition has not exhibited debilitating symptoms – yet.**

- **Caregiving can go on for a few years or for a lifetime. It means re-evaluating finances, re-evaluating job opportunities and making compromises.**

- **Caregiving is learning how to work with doctors and other healthcare professionals so they treat you as an important member of your loved one's healthcare team.**

- **Caregiving is worrying about what's wrong with dad. Why is he not remembering things anymore? Why is he acting so strangely? And then when you hear the diagnosis, your immediate reaction is you wish you had never asked.**

- **Caregiving includes learning about wheelchairs, and lifts and little gadgets that help you button a shirt.**

- **Caregiving is wondering why no one ever asks how you are.**

- **Caregiving is dreaming about being alone in your own home.**

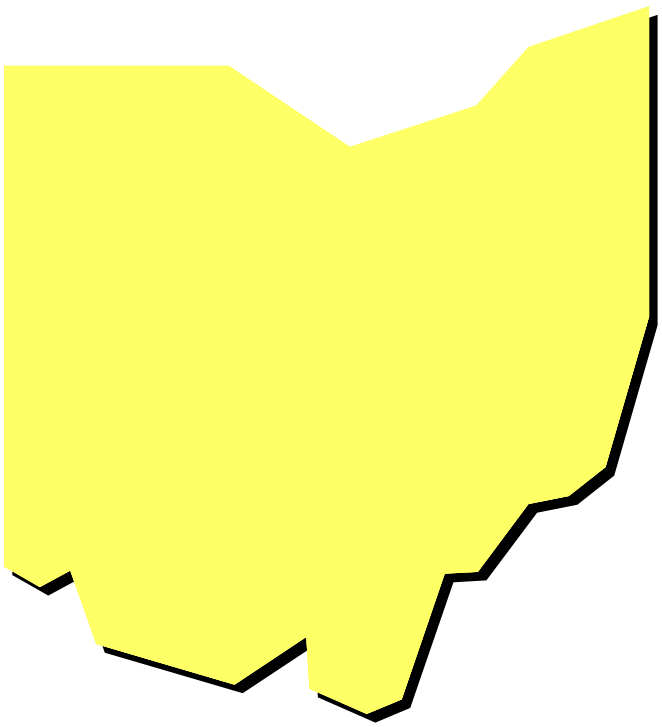
- **Caregiving involves learning about Medicare, Medicaid, Social Security and other public programs.**

- **Caregiving is learning about what it means to die with dignity and making sure that your loved one's wishes will be honored.**

- **Caregiving is the relief you feel when your mother decides its time to move out of the big house and into an assisted living complex.**

- **Caregiving is hard work. Caregiving is pain. Caregiving is loving and giving and sharing. Caregiving is accepting and learning new things and going on, and on, and on. Caregiving is lots of questions and very few answers. Caregiving is being out of the mainstream.**

- **Caregiving is all these things and a whole lot more.**



- **Fifty-seven percent of Ohio caregivers are female, 40 percent are at least 50 years old, and 62 percent are employed.**

- **Eighty percent of care receivers in Ohio are at least age 50, and 70 percent are female. Care receivers live in a variety of settings, from nursing homes to private residences.**

- **On average, a person in Ohio may be in a caregiving role for 4.2 years. However, caregivers of parents and spouses are likely to provide care for 10 years or more. The longer a caregiving relationship exists, the higher the toll it is likely to place on the caregiver physically, emotionally and financially.**

Caregiver Survival Tips

1. **Plan ahead.**
2. **Learn about valuable resources.**
3. **Take one day at a time.**
4. **Develop contingency plans.**
5. **Accept help.**
6. **Make YOUR health a priority.**
7. **Get enough rest and eat properly.**
8. **Make time for leisure.**
9. **Be good to yourself.**
10. **Share your feelings with others.**

Caregiver Bill of Rights

I have the right. . . to take care of myself. This is not an act of selfishness. It will give me the capability of taking better care of my relative.

I have the right. . . to seek help from others even though my relatives may object. I recognize the limits of my own endurance and strength.

I have the right. . . to maintain facets of my own life that do not include the person I care for, just as I would if she or he were healthy. I know that I do everything that I reasonably can for this person, and I have the right to do some things for myself.

I have the right. . . to get angry, depressed, and express other difficult feelings occasionally.

I have the right. . . to reject any attempts by my relative (either conscious or unconscious) to manipulate me through guilt and/or depression.

I have the right. . . to receive consideration, affection, forgiveness, and acceptance from my loved one for what I do, for as long as I offer these qualities in return.

I have the right. . . to take pride in what I am accomplishing and to applaud the courage it has sometimes taken to meet the needs of my relative.

I have the right. . . to protect my individuality and my right to make a life for myself that will sustain me in time when my relative no longer needs my full-time help.

I have the right. . . to expect and demand that as new strides are made in finding resources to aid physically and mentally impaired persons in our country, similar strides will be made towards aiding and supporting caregivers.

AUTHOR UNKNOWN

COUNSELING

"Life is not measured by the breaths we take, but by the moments that take our breath away".

~Unknown

NOTES_____

What is Good Mental Health?

Good mental health means that people have a positive outlook on life. Sadness, crankiness, or anxiety occurs occasionally with everyone, but they should not be permanent states, no matter what our age. The following tips can be useful to both the caregiver and the person receiving care:

- **DO be flexible and learn to adapt to changing circumstances.**
- **DO use your mind and stay active.**
- **DO use caution taking prescription and over-the-counter medications.**
- **DO get regular physical checkups.**
- **DO set goals for yourself and work toward them.**
- **DO check your general attitude. HAVE YOU LAUGHED RECENTLY?**
- **DO get adequate sleep, exercise regularly, eat nutritiously.**
- **DO learn and know signs of depression; it is treatable.**
- **DO avoid isolating yourself; isolation can breed depression.**
- **DO develop and maintain good relationships with others for support.**
- **DO know when to seek treatment and where to find it.**
- **DO know the location of your community Mental Health Providers.**
- **DO know how to refer a person who needs help.**
- **DO know what your rights are and where to get legal advice.**

Experiencing mental health problems or being diagnosed with a mental illness evokes many feeling for the individuals affected, not only for the person with the problems, but for their family, friends, and others associated with them. Mental illness has had a long history of negative associations, and the stigma that remains with mental health disorders continues to affect people negatively. With education and understanding about the facts on mental illness, we can begin to eliminate stigma and increase the quality of life and access to treatment for those who are coping with it. The stigma of mental illness should not prevent people from leading normal lives in the community or getting the treatment they need.

Common Mental Disorders

ALCOHOL and/or MEDICATION ABUSE:

Distress of aging can leave persons especially vulnerable to excessive alcohol consumption. The good news is that older people have the highest success and the greatest sobriety after treatment. Additionally, with an increase in the number of medications and/or dietary supplements people take as they age, it is very important to be aware of drug interactions and appropriate dosages.

ANXIETY:

Anxious or tense feelings that interfere with one's ability to function. These may include feeling tense, nervous, or restless, rapid breathing, unexplainable fears, disturbed sleep and difficulty concentrating.

BI-POLAR DISORDER:

Mood swings between deep depression and euphoric highs marked by spending sprees, rapid speech, irritability, poor judgment or grandiosity.

COMPULSIVE GAMBLING:

While many older people enjoy gambling as a social and recreational activity, it can become an addiction leading to heavy losses, low self-esteem, damaged personal relationships, and even suicide. This disorder is more common among people who abuse alcohol or other substances, and may accompany physical complaints such as digestive problems, insomnia, high blood pressure, or headaches.

DEMENTIA:

A progressive deterioration of the brain that can begin with confusion, memory loss, problems with reasoning, or judgment. More common in people over age eighty-five. It may be confused with other very treatable disorders.

PHOBIAS:

Excessive or unreasonable fears that inhibit daily life or require extreme effort to avoid the feared situation. Examples of phobias are fear of flying, social phobias, obsessive-compulsive disorder or post-traumatic stress disorder.

NONE OF THESE ARE AN INEVITABLE PART OF AGING!!!

DEPRESSION

Depression is a mood disorder that affects the mind and body. People with depression feel sad, helpless and hopeless most of the time. These feelings can be long-lasting and severe.

Causes of Depression:

Depression in an older person can be short lived and could be the result of an inability to cope with multiple stressful situations. For example, extended grief over the loss of a loved one can develop into depression if the grief is not resolved. If an older person has a significant change in lifestyle – loss of financial security, moving to a nursing home, loss of physical independence – he/she may develop depressive symptoms.

Depression can also be an intense, whole-body disorder that occurs for no apparent reason. It can occur without warning, especially if there is a family history of depression, or if a person has had a problem with depression at an earlier age. Chemical changes in the body can also contribute to depression.

For some older adults, depression can be related to a physical illness. Diabetes, thyroid disorders, Alzheimer's disease, stroke, congestive heart failure, cancer, and Parkinson's disease are some examples of physical illness that may trigger depression.

Medications can be responsible for causing depressive symptoms. Some over-the-counter and prescription drugs – including drugs for hypertension, Parkinson's disease, and cancer – can create depressive symptoms. Considering the number of medications the older person may take, it is important to determine whether one, or a combination, may cause the person to feel depressed.

Symptoms of Depression:

When several of the following symptoms happen every day for two weeks or more and negatively affect daily functioning, a depressive illness could be present.

- **A persistent sad, anxious, or "empty" mood.**
- **Loss of interest/pleasure in activities the person usually enjoys.**
- **Decreased energy, fatigue, feeling "slowed down".**
- **Increased agitation.**
- **Changes in eating habits, significant weight gain or loss without dieting.**
- **Changes in sleep patterns; insomnia, oversleeping, early morning wakening.**
- **Difficulty concentrating, remembering, making decisions.**
- **Feelings of inappropriate guilt, worthlessness, helplessness.**
- **Thoughts of death or suicide; a suicide attempt.**
- **Irritability, agitation, restlessness.**
- **Excessive crying.**
- **Unexplained, recurring aches and pains that do not respond to treatment.**

Older adults have a suicide risk almost twice that of the general population. Depression is the most common diagnosis in older adults who commit suicide, so it is critical that depression be recognized and treated as soon as possible. Most older adults who have depression can be treated successfully and start enjoying life again.

Seeking Help

Therapy is helpful for making a difference in the lives of many people. It is a collaborative effort in which you must plan to be involved. Whether you have decided to contact your local mental health center or another mental health provider, the first contact can be confusing and it helps to know what to expect. Make a list of questions and take them with you. Ask about specialized services for seniors.

A mental health professional will gather information about the concerns you have for yourself or for a family member. Be prepared to give information about who made the referral, financial status, insurance coverage, mental health symptoms, and medical concerns.

When you go to your appointment, you will need:

- **Insurance Cards**
- **List of Medications**
- **Information regarding any previous mental health treatment**

What you can expect to do at your visit:

- **Meet with a mental health professional.**
- **Discuss your current mental health concern and reason for coming.**
- **Formulate a plan that may include individual therapy, group therapy and/or family therapy.**
- **Possible discussion of hospitalization if the situation is life threatening.**

Tips for taking charge of your medical care:

- **Write down questions and any observations you or someone else have had before the visit.**
- **Take a support person with you. They are a second set of ears and can help clarify information as needed.**
- **Carry a list of medications at all times (including herbal remedies). Inform your doctors.**
- **Use only one pharmacy. One medication may affect another.**
- **If the cost of medication is an issue, talk about other less expensive alternatives.**

Contacting a private mental health professional:

If you choose to see a private care professional, you will need to determine the nature of his/her practice. To get this information, ask the therapist to tell you about his/her:

- **Training**
- **Experience with older adults and your particular problem.**
- **Certifications or licenses**
- **Method of treatment used**
- **Expected length of treatment**
- **Length of individual sessions**
- **Appointment cancellation policy**
- **Treatment cost, payment plans and insurance coverage.**

Treatment Rights in Ohio

Mental Health Rights:

In the State of Ohio there is an emphasis on people receiving mental health care in a way that honors the rights of every individual. Through the Ohio Administrative Code (OAC), and the Ohio Revised Code (ORC), individuals have a certain set of rights that govern how they are to be treated and how their treatment will be delivered. In addition, the federal Health Insurance Portability and Accountability Act (HIPPA), puts strict emphasis on confidentiality and control of records.

There are mental health laws that govern the right to dignity and respect, rights to informed choice and involvement in creating the treatment plan. People can choose whether to accept medication and treatment services. Furthermore, strict laws surrounding privacy and access to their own records protect individuals. There are also very clear rules as to being informed about rights and how to file a complaint if those rights have been violated.

Each mental health treatment agency has a Clients Rights Officer who is responsible for addressing complaints. In addition, each county has a governing board that employs an Ombudsman or Board Client Rights Officer who assists in the management of grievances. Those individuals should be contacted for further assistance.

Elder Rights:

In addition to these rights, consumers receiving benefits from Medicare, Medicaid, Social Security Disability (SSD) and other sources have similar protections written into legislation. Each program has a specific and detailed process for challenging the denial of assistance, the termination of existing services and other programmatic or operational decisions. It is important to know that most grievances and appeals must be filed in a timely manner. Voicing your grievance may result in scheduling an informal administrative hearing where you, or a representative, may present the reasons why a change or denial of services is not in the best interest of a patient.

All persons, regardless of diagnosis, who receive care and services in a institutional setting such as a group home, assisted living or nursing facility have various rights specific to each venue. For example, residents have the right to receive care in a comfortable, clean and safe environment, the right to be free from abusive treatment, the right to be informed of care decisions and many other specific rights. An Ombudsman can work with you as an advocate to help protect a resident's rights and also to resolve care issues through negotiation. Principles of the program include client confidentiality and following client direction. More information on these rights can be obtained through the Office of the Long-Term Care Ombudsman (1-800-282-1206)**.**

Regulatory organizations, such as the Ohio Department of Health, can also play a role in improving the care delivered to persons living in facilities which they license and inspect. The Ohio Department of Health has the authority to investigate complaints, implement changes and in extreme cases, levy fines and other penalties. The Department operates a 24-hour "Complaint Hotline" (1-800-342-0553)**.**

LEGAL

"Years may wrinkle the skin, but to give up enthusiasm wrinkles the soul".

~Samuel Ullman

NOTES

Choices

Living Well at the End of Life

Advance Directives Packet

Fourth Edition

The Ohio Hospice & Palliative Care Organization expresses deep appreciation and gratitude for the cooperation of the Ohio State Medical Association, the Ohio Hospital Association and the Ohio Osteopathic Association for their efforts in the development and distribution of this Advance Directives Packet: Choices, Living Well at the End of Life. We also thank the Ohio State Bar Association for providing the legal language for the Living Will and Health Care Power of Attorney forms. The packet includes information regarding Hospice and Do-Not-Resuscitate Orders, a Donor Registry Enrollment Form (December 2004) and one copy each of Ohio's Living Will and Health Care Power of Attorney forms. The Living Will and Health Care Power of Attorney forms conform with the requirements of Ohio's Living Will Law, as amended effective December 16, 2004.

Ohio
Hospice &
Palliative Care Organization

Ohio Hospice & Palliative Care Organization
555 Metro Place North, Suite 650
Dublin, Ohio 43017
1 (800) 776-9513
www.ohpco.org

OSMA
Ohio State Medical Association

Ohio State Medical Association
3401 Mill Run Drive
Hilliard, Ohio 43026
www.osma.org

OHIO HOSPITAL ASSOCIATION

Ohio Hospital Association
155 East Broad Street
Columbus, Ohio 43215-3620
www.ohanet.org

OHIO OSTEOPATHIC ASSOCIATION

Ohio Osteopathic Association
53 West Third Avenue
PO Box 8130
Columbus, Ohio 43201-0130
www.ooanet.org

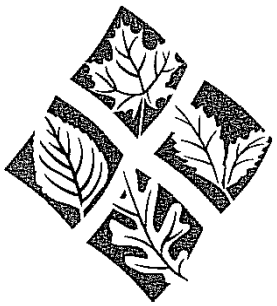
Table of Contents

Ohio Hospice & Palliative Care Organization

OSMA Ohio State Medical Association

Ohio Hospital Association

Ohio Osteopathic Association



Introduction

Today, advances in medicine and medical technology save many lives that only 60 years ago might have been lost. Unfortunately, sometimes this same technology also artificially prolongs life for people who have no reasonable hope of recovery.

No one likes to think about death and dying, but they are inescapable realities of life. Armed with the information and forms in this packet, you can take control of choices regarding your medical future.

In 1991, Ohio recognized your right to have a Living Will. This was in addition to Ohio's other recognized advance directive at that time, the Health Care Power of Attorney. In 1998, Ohio recognized yet another tool to help you and your physician with effective health care planning called a DNR (Do-Not-Resuscitate) Order. All of these measures help put control over future medical choices in your hands.

The Living Will allows you to decide and document, in advance, the type of care you would like to receive if you were to become permanently unconscious or terminally ill and unable to communicate. The Health Care Power of Attorney enables you to select someone to make decisions for you.

A person who does not wish to have Cardiopulmonary Resuscitation (CPR) performed may make this wish known through a doctor's order called a DNR Order. A DNR Order addresses the various methods used to revive people whose hearts have stopped (cardiac arrest) or people who have stopped breathing (respiratory arrest). In 1998, a DNR Law was established to help people communicate their wishes about resuscitation to medical personnel inside or outside a hospital or nursing home setting. It allows emergency medical workers to honor a person's physician-written DNR Order in the home, nursing home or various other settings. The 1998 DNR Law also protects emergency squads and other health care providers from liability if they follow a person's DNR Order.

Following the establishment of the 1998 DNR Law, the Ohio Department of Health established two types of DNR Comfort Care Orders that allow people to choose the extent of the treatment they wish to receive at the end of life. A person with a "DNR Comfort Care Arrest Order" will receive all the appropriate medical treatment, which may include components of CPR, until the person has a cardiac or respiratory arrest, at which point only comfort care will be provided. By requesting the broader "DNR Comfort Care

Order," a person is choosing, from the moment the order is written, to have only comfort care measures provided should an event occur that is life threatening or ending. Your physician or health care provider can explain the differences in DNR Orders.

In addition to the Living Will and Health Care Power of Attorney forms, you will find a copy of the Donor Registry Enrollment Form in this packet. Also included in this packet is information about DNR Orders and the hospice choice, which offers further information about end of life issues and options. The last page offers a convenient wallet card that will provide important information to your health care provider.

It is important to understand what Ohio's laws allow or do not allow in regards to expressing your desires, goals and wishes by using tools such as Ohio's Advance Directives. This packet is meant to educate you about Ohio's Living Will; Health Care Power of Attorney; Anatomical Gifts and the 1998 DNR Law. The goal is to provide you with the information you need to document your future health care decisions. The information and forms in this packet are made available to you through the collaborative effort of the Ohio Hospice & Palliative Care Organization, the Ohio State Medical Association, the Ohio Hospital Association and the Ohio Osteopathic Association. The Ohio State Bar Association prepared the Advance Directive forms.

After reviewing the contents of this packet, you may have additional questions or concerns specific to your personal situation. In such a case, it is important that you discuss your concerns with your family, your physician and your lawyer.

If you choose, you can fill out the Living Will or Health Care Power of Attorney forms by yourself; you are not required to use a lawyer. However, since these are important legal documents, you may wish to consult a lawyer for advice.

In contrast, a DNR Order can only be completed by a physician, certified nurse practitioner or clinical nurse specialist, as appropriate. If you would like to indicate that you do not wish to have CPR, you will need to have a discussion with your physician. Your physician can explain the differences between DNR Orders and their application.

The issues involved in drafting or determining one's wishes regarding a DNR Order, Living Will, Health Care Power of Attorney or Anatomical Gifts are very important. We hope this information and these materials are useful in helping you to make a decision that is comfortable for you and your family.

Your Questions **Answered**

"Living Will and Health Care Power of Attorney"

Q: Aren't Living Wills or Health Care Powers of Attorney just for older people?

A: It is important for anyone over age 18 to think about filling out one or both of these documents. Serious illness or injury can strike at any stage of life. A Living Will or Health Care Power of Attorney will help to ensure that your wishes regarding life-sustaining treatment are followed regardless of your age, and that, when you are no longer able to voice your own wishes, your prior decisions are followed or made for you by the person you choose.

Q: Can I indicate that I wish to donate my organs after death through a Living Will or Health Care Power of Attorney?

A: Ohio law requires that a Living Will created after December 15, 2004, must include a person's preferences about Anatomical gifts (organ and tissue donation). The Living Will form included in this booklet has the required section and also provides instructions regarding how to keep your wishes registered with the Bureau of Motor Vehicles. Living Wills completed before December 15, 2004, that do not include the Anatomical Gifts section are still valid and will be honored in Ohio.

Q: If I state in my Living Will that I don't want to be hooked up to life support equipment, will I still be given medication for pain?

A: Yes. A Living Will affects only care that artificially or technologically postpones death. It does not affect care that eases pain. For example, you would continue to be given pain medication and other treatments necessary to keep you comfortable.

The same is true with a Health Care Power of Attorney. The person you name to make your health care decisions would not be able to order the withholding of treatments that provide you comfort or alleviate pain.

Q: If I have a Living Will, won't my physician be more likely to give up on me if I become really sick?

A: No. Physicians have a duty to maintain life as long as there is hope of recovery. A Living Will simply allows you to determine how much life-sustaining treatment you wish to receive in order to postpone dying once two physicians have determined that you will not recover.

Q: Which is better to have, a Living Will or a Health Care Power of Attorney?

A: Actually, it is a good idea to fill out both documents because they address different aspects of your medical care. A Living Will applies only when you are terminally ill and unable to communicate your wishes or if you are permanently unconscious.

A Health Care Power of Attorney becomes effective even if you are only temporarily unconscious and medical decisions need to be made. For example, if you were to become temporarily unconscious due to an accident or surgery, the person you name in your Health Care Power of Attorney could make medical decisions on your behalf.

If you have both documents and become terminally ill and unable to communicate or become permanently unconscious, the Living Will would be followed since it identifies your wishes in these situations.

Q: When does a Living Will or Health Care Power of Attorney become effective?

A: A Living Will becomes effective when you are terminally ill and unable to express your wishes regarding health care or when you are permanently unconscious. In both cases, two physicians, not just one, must agree that you are beyond medical help and will not recover. If you have indicated that you do not want your dying to be artificially prolonged and two physicians say that there is no reasonable hope of recovery, your wishes will be honored.

A Health Care Power of Attorney becomes effective whenever you lose the ability to make your own decisions, even if only temporarily. At these times, health care decisions will be made by the person you designate.

Q: Can I draft a Living Will or Health Care Power of Attorney that says if I become critically ill, I want everything possible done to keep me alive?

A: Yes, but you can't use the standard forms in this packet. You would need to speak with an attorney about drafting a special document. You also may want to discuss this approach with your personal physician.

Q: If I name someone in my Health Care Power of Attorney to make decisions for me, how much authority does that person have and how can I be certain that he or she is doing what I would like to have done?

A: The person you name as your attorney-in-fact has the authority to make decisions regarding aspects of your medical care if you become unable to express your wishes. For this reason, you should tell the person you name how you feel about life-sustaining treatment, being fed through feeding and fluid tubes, and other important issues.

Also, it is important to remember that a Health Care Power of Attorney document is not the same as a financial Power of Attorney document, which you might use to give someone authority over your financial or business affairs.

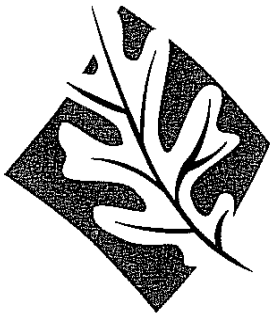
Q: If my condition becomes hopeless, can I specify that I want my feeding and fluid tubes removed?

A: Special instructions are needed to allow for the removal of feeding or fluid tubes if you become permanently unconscious and if the feeding and fluid tubes aren't needed to provide you with comfort.

If you want to make certain that the tubes are removed, should you become permanently unconscious, you need to place your initials on the space provided on the Living Will or Health Care Power of Attorney form. If you don't want the tubes removed when you are permanently unconscious, then don't initial the forms.

Q: Do I have to use the standard forms for a Living Will or Health Care Power of Attorney or can I draw up my own documents?

A: The enclosed forms, which were produced jointly by the Ohio State Bar Association, the Ohio State Medical Association, the Ohio Hospital Association and the Ohio Hospice & Palliative Care Organization, comply with the requirements of Ohio law, but you do not have to use these forms. You may wish to consult an attorney for assistance in drafting a document or you may draft your own. However, in either case, the documents must comply with the specific language spelled out in the Ohio Revised Code.



Ohio's **Living Will**

What you should know about Living Wills:

A **Living Will** is a document that allows you to establish, in advance, the type of medical care you would want to receive if you were to become permanently unconscious, or if you were to become terminally ill and unable to tell your physician or family what kind of life-sustaining treatments you want to receive. In addition, the latest edition of the Living Will allows you to specify your wishes regarding anatomical gifts (organ and tissue donation).

- A **Living Will** is used only in situations where you are unable to tell your physician what kind of health care services you want to receive. Before your **Living Will** goes into effect, you either must be:

  (1) terminally ill (see definition as described in the Living Will Declaration Form) and unable to tell your physician your wishes regarding health-care services;

  OR

  (2) permanently unconscious. To be considered permanently unconscious, two physicians (one of whom must be a medical specialist in an appropriate field) must decide that you have no reasonable possibility of regaining consciousness.

Regardless of your condition, if you were able to speak and tell your physician your wishes about life-prolonging treatments, then the **Living Will** wouldn't be used – your physician would just talk directly with you about your wishes. A **Living Will** is used by the physician only if you are unable to tell him or her what you want to be done.

- A **Living Will** gives your physician the authority to withhold all life-sustaining treatment and permit you to die naturally and take no action to postpone your death, providing you with only that care necessary to make you comfortable and relieve your pain. This may include writing a DNR Order or withdrawing life-sustaining treatment such as CPR.

  Such "comfort care" also may include removing nutrition and hydration (food and water) that is administered through feeding tubes or intravenously. If you wish to give your physician this authority if you become permanently unconscious, there is a space on the **Living Will** form that you must initial. If you want nutrition and hydration to be continued, regardless of the circumstances, don't initial this space.

- A **Living Will** can be honored only if your attending physician and others know about it. It is important to let your physician and your family and friends know that you have a **Living Will** before you become ill. After all, a **Living Will** can't be enforced if people don't know that it exists. In fact, it is a good idea for you to give your attending physician a copy of your **Living Will**. It also is important to give copies to family and friends so that, if necessary, they can advise your physician that you have a **Living Will**. In addition, it is important that you notify a health care facility that you have a **Living Will** when you are admitted as a patient. Please note: You **do not** have to go to court to put your **Living Will** into effect.

- Once the decision to withhold life-sustaining treatment is made, your physician must make a reasonable effort to notify the person or persons you designate in your **Living Will** or your closest family member.

- The law allows your family members to challenge a physician's determination that you have a terminal illness or that you are in a permanently unconscious state. This challenge is limited in nature and may be made only by your closest relatives. The law does not, however, allow your family members to challenge your own legally-documented decision not to be resuscitated.

- If you have both a **Living Will** and a **Health Care Power of Attorney,** the physician must comply with the wishes you state in your **Living Will**. In other words, your **Living Will** takes precedence over your **Health Care Power of Attorney**. There is a space on the **Living Will** form that you may check to let your physician and family and friends know that you have a **Health Care Power of Attorney**.

- You can revoke your **Living Will** at any time. You can do this by simply telling your physician and family that you have changed your mind and wish to revoke your **Living Will**. It is a good idea to ask anyone who has a copy of the document to return it to you.

How to fill out the Living Will form:

You should use this form to let your physician and your family know what kind of life-sustaining treatments you want to receive if you become terminally ill or permanently unconscious and are unable to express your wishes.

NOTE:

1. Read over all information carefully. Definitions are included as part of the form.

2. On the first two lines of the form, print your full name and birth date.

3. On the fourth page of the form, written in bold type face under ***Special Instructions*** is the statement that will give your physician permission to withhold food and fluids in the event you are permanently unconscious. If you want to give your physician permission to withhold food and water in this situation, then you must place your initials on the line indicated in number 3.

4. The next section of the form (immediately below the ***Special Instructions***) provides space for you to list the names, addresses and phone numbers of the contacts (usually family members and close friends) that you want your physician to notify when the **Living Will** goes into effect. **Remember, the Living Will goes into effect only when you are terminally ill or permanently unconscious and you cannot express your own wishes about the health care you receive.**

5. Following the "Anatomical Gift section" is a space to check whether or not you have completed a **Health Care Power of Attorney**. Immediately below this space is a place for you to date and sign the form. **Remember, the Living Will is not considered valid or effective unless you do one of the following:**

> **First Option** – Date and sign the **Living Will** in the presence of two witnesses, who also must sign and include their addresses and indicate the date of their signatures.
>
> OR
>
> **Second Option** – Date and sign the **Living Will** in the presence of a notary public and have the **Living Will** notarized on the appropriate space provided on the form.

The following people may **not** serve as a witness to your **Living Will**:

- Anyone related to you by blood, marriage or adoption (this includes your husband or wife and your children);
- Your attending physician;
- If you are in a nursing home, the administrator of the nursing home.

6. Once you have filled out the **Living Will** and either signed it in the presence of witnesses or in the presence of a notary public, then it is a good idea to give a copy to your personal physician and any contacts you have listed in the **Living Will**. In some Ohio counties, people may be able to register their **Living Wills** with the county recorder. However, it is important to keep in mind that a registered **Living Will** form becomes a public record.

State of Ohio
Living Will Declaration
Notice to Declarant

The purpose of this Living Will Declaration is to document your wish that life-sustaining treatment, including artificially or technologically supplied nutrition and hydration, be withheld or withdrawn if you are unable to make informed medical decisions and are in a terminal condition or in a permanently unconscious state. This Living Will Declaration does not affect the responsibility of health care personnel to provide comfort care to you. Comfort care means any measure taken to diminish pain or discomfort, but not to postpone death.

If you would not choose to limit any or all forms of life-sustaining treatment, including CPR, you have the legal right to so choose and may wish to state your medical treatment preferences in writing in a different document.

Under Ohio law, a Living Will Declaration is applicable only to individuals in a terminal condition or a permanently unconscious state. If you wish to direct medical treatment in other circumstances, you should prepare a Health Care Power of Attorney. If you are in a terminal condition or a permanently unconscious state, this Living Will Declaration controls over a Health Care Power of Attorney.

You should consider completing a new Living Will Declaration if your medical condition changes, or if you later decide to complete a Health Care Power of Attorney. If you have both documents, you should keep copies of both documents together, with your other important papers, and bring copies of both your Living Will and your Health Care Power of Attorney with you whenever you are a patient in a health care facility.

Ohio Hospice & Palliative Care Organization

OSMA Ohio State Medical Association

Ohio Hospital Association

Ohio Osteopathic Association

OSBA Ohio State Bar Association

State of Ohio
Living Will Declaration
of

_____
(Print Full Name)

_____
(Birth Date)

I state that this is my Ohio Living Will Declaration. I am of sound mind and not under or subject to duress, fraud or undue influence. I am a competent adult who understands and accepts the consequences of this action. I voluntarily declare my wish that my dying not be artificially prolonged. If I am unable to give directions regarding the use of life-sustaining treatment when I am in a terminal condition or a permanently unconscious state, I intend that this Living Will Declaration be honored by my family and physicians as the final expression of my legal right to refuse health care.

Definitions. Several legal and medical terms are used in this document. For convenience they are explained below.

Anatomical gift means a donation of all or part of a human body to take effect upon or after death.

Artificially or technologically supplied nutrition or hydration means the providing of food and fluids through intravenous or tube "feedings."

Cardiopulmonary resuscitation or **CPR** means treatment to try to restart breathing or heartbeat. CPR may be done by breathing into the mouth, pushing on the chest, putting a tube through the mouth or nose into the throat, administering medication, giving electric shock to the chest, or by other means.

Declarant means the person signing this document.

Donor Registry Enrollment Form means a form that has been designed to allow individuals to specifically register their wishes regarding organ, tissue and eye donation with the Ohio Bureau of Motor Vehicles Donor Registry.

Do Not Resuscitate or **DNR Order** means a medical order given by my physician and written in my medical records that cardiopulmonary resuscitation or CPR is not to be administered to me.

Health care means any medical (including dental, nursing, psychological, and surgical) procedure, treatment, intervention or other measure used to maintain, diagnose or treat any physical or mental condition.

Health Care Power of Attorney means another document that allows me to name an adult person to act as my agent to make health care decisions for me if I become unable to do so.

Life-sustaining treatment means any health care, including artificially or technologically supplied nutrition and hydration, that will serve mainly to prolong the process of dying.

Living Will Declaration or **Living Will** means this document that lets me specify the health care I want to receive if I become terminally ill or permanently unconscious and cannot make my wishes known.

Permanently unconscious state means an irreversible condition in which I am permanently unaware of myself and my surroundings. My physician and one other physician must examine me and agree that the total loss of higher brain function has left me unable to feel pain or suffering.

Terminal condition or **terminal illness** means an irreversible, incurable and untreatable condition caused by disease, illness or injury. My physician and one other physician will have examined me and believe that I cannot recover and that death is likely to occur within a relatively short time if I do not receive life-sustaining treatment.

[Instructions and other information to assist in completing this document are set forth within brackets and in italic type.]

Health Care if I Am in a Terminal Condition. If I am in a terminal condition and unable to make my own health care decisions, I direct that my physician shall:

1. Administer no life-sustaining treatment, including CPR and artificially or technologically supplied nutrition or hydration; and
2. Withdraw such treatment, including CPR, if such treatment has started; and
3. Issue a DNR Order; and
4. Permit me to die naturally and take no action to postpone my death, providing me with only that care necessary to make me comfortable and to relieve my pain.

Health Care if I Am in a Permanently Unconscious State. If I am in a permanently unconscious state, I direct that my physician shall:

1. Administer no life-sustaining treatment, including CPR, except for the provision of artificially or technologically supplied nutrition or hydration unless, in the following paragraph, I have authorized its withholding or withdrawal; and
2. Withdraw such treatment, including CPR, if such treatment has started; and
3. Issue a DNR Order; and
4. Permit me to die naturally and take no action to postpone my death, providing me with only that care necessary to make me comfortable and to relieve my pain.

Special Instructions. **By placing my initials at number 3 below, I want to specifically authorize my physician to withhold or to withdraw artificially or technologically supplied nutrition or hydration if:**

1. **I am in a permanently unconscious state; and**
2. **My physician and at least one other physician who has examined me have determined, to a reasonable degree of medical certainty, that artificially or technologically supplied nutrition and hydration will not provide comfort to me or relieve my pain; and**
3. **I have placed my initials on this line: _____**

Notifications. *[Note: You do not need to name anyone. If no one is named, the law requires your attending physician to make a reasonable effort to notify one of the following persons in the order named: your guardian, your spouse, your adult children who are available, your parents, or a majority of your adult siblings who are available.]*

In the event my attending physician determines that life-sustaining treatment should be withheld or withdrawn, my physician shall make a reasonable effort to notify one of the persons named below, in the following order of priority:

[Note: If you do not name two contacts, you may wish to cross out the unused lines.]

First Contact:	Second Contact:
Name: _____	Name: _____
Address: _____	Address: _____
_____	_____
Telephone: _____	Telephone: _____

Anatomical Gift (optional)

INSTRUCTIONS: If you elect to make an anatomical gift, please complete and file the attached "Donor Registry Enrollment Form" with the Ohio Bureau of Motor Vehicles to ensure that your wishes will be honored.

____ I wish to make an anatomical gift.

____ I *do not* wish to make an anatomical gift.

Upon my death, the following are my directions regarding donation of all or part of my body:
In the hope that I, _____ (name of donor), may help others upon my death, I hereby give the following body parts: _____
(indicate specific parts or all body parts) for any purpose authorized by law: transplantation, therapy, research or education. *[Cross out any purpose that is unacceptable to you.]*

This is a legal document under the Uniform Anatomical Gift Act or similar laws.

If I do not indicate a desire to donate all or part of my body by filling in the lines above, no presumption is created about my desire to make or refuse to make an anatomical gift.

Donor Registry Enrollment Form. I have completed the Donor Registry Enrollment Form:

_____Yes_____No

NOTE: If you modify or revoke your decision regarding anatomical gifts, please remember to make those changes in your Living Will, Health Care Power of Attorney, and Donor Registry Enrollment Form.

No Expiration Date. This Living Will Declaration will have no expiration date. However, I may revoke it at any time.

Copies the Same as Original. Any person may rely on a copy of this document.

Out of State Application. I intend that this document be honored in any jurisdiction to the extent allowed by law.

Health Care Power of Attorney. I have completed a Health Care Power of Attorney:

_____ Yes _____ No

SIGNATURE

[See below for witness or notary requirements.]

I understand the purpose and effect of this document and sign my name to this Living Will Declaration on _____, 20 _____, at _____, Ohio.

_____

DECLARANT

[You are responsible for telling members of your family, the agent named in your Health Care Power of Attorney (if you have one), and your physician about this document. You also may wish to tell your religious advisor and your lawyer that you have signed a Living Will Declaration. You may wish to give a copy to each person notified.]

[You may choose to file a copy of this Living Will Declaration with your county recorder for safekeeping.]

WITNESSES OR NOTARY ACKNOWLEDGMENT

[Choose one.]

*[This Living Will Declaration will not be valid unless it either is signed by two eligible witnesses who are present when you sign or are present when you acknowledge your signature, **or** it is acknowledged before a Notary Public.]*

*[The following persons **cannot** serve as a witness to this Living Will Declaration: the agent or*

any successor agent named in your Health Care Power of Attorney; your spouse; your children; anyone else related to you by blood, marriage or adoption; your attending physician; or, if you are in a nursing home, the administrator of the nursing home.]

Witnesses. I attest that the Declarant signed or acknowledged this Living Will Declaration in my presence, and that the Declarant appears to be of sound mind and not under or subject to duress, fraud or undue influence. I further attest that I am not an agent designated in the Declarant's Health Care Power of Attorney, I am not the attending physician of the Declarant, I am not the administrator of a nursing home in which the Declarant is receiving care, and I am an adult not related to the Declarant by blood, marriage or adoption.

_____ residing at _____
Signature

_____ _____ , _____
Print Name

Dated: _____ , 20_____

_____ residing at _____
Signature

_____ _____ , _____
Print Name

Dated: _____ , 20_____

OR

Notary Acknowledgment.
State of Ohio
County of _____ ss.

On _____, 20_____, before me, the undersigned Notary Public, personally appeared _____, known to me or satisfactorily proven to be the person whose name is subscribed to the above Living Will Declaration as the Declarant, and who has acknowledged that (s)he executed the same for the purposes expressed therein. I attest that the Declarant appears to be of sound mind and not under or subject to duress, fraud or undue influence.

_____
Notary Public

My Commission Expires: _____

DONOR REGISTRY ENROLLMENT FORM (OPTIONAL)

_____

(name of donor)

INSTRUCTIONS: In addition to completing the references to Anatomical Gifts in your Living Will and Ohio Health Care Power of Attorney you should also complete and file the "Donor Registry Enrollment Form" with the Ohio Bureau of Motor Vehicles to ensure that your wishes concerning organ and tissue donation will be honored. This document will serve as your consent to recover the organ and/or tissues indicated at the time of your death, if medically possible. In completing this form, your wishes will be recorded in the Ohio Donor Registry and will be accessible only to the appropriate organ, tissue or eye recovery organizations. Be sure to share your wishes in this area with loved ones and friends so they are aware of your intentions.

To register for the Donor Registry, please complete this form, detach and send the original to:

Ohio Bureau of Motor Vehicles
ATTN: Record Clearance Unit
P.O. Box 16784
Columbus, Ohio 43216-6784

Make a copy of this form and retain it as part of your Living Will Declaration.

[This form must be signed by two witnesses. If the donor is under the age of 18, a parent or legal guardian must sign as one of the two witnesses.]

[This form should be used to state your intentions to be included in or removed from the Ohio Bureau of Motor Vehicles Donor Registry.]

Please indicate below:

____Please include me in the Donor Registry

____Please remove me from the Donor Registry

Ohio Hospice & Palliative Care Organization

OSMA Ohio State Medical Association

OHIO HOSPITAL ASSOCIATION

OHIO OSTEOPATHIC ASSOCIATION

OSBA Ohio State Bar Association

Print or type full name of living donor _____

Mailing Address _____

City _____ State _____ Zip _____

Phone ( ) _____ Date of Birth _____

Driver's License or ID Card Number _____

Social Security Number _____

In the hope that I, _____ (name of donor), may help others upon my death, the following are my directions regarding donation of all or part of my body.

___ On my death, I make an anatomical gift of my organs, tissues, and eyes for any purpose authorized by law.

OR

___ On my death, I make an anatomical gift of the following specified organ, tissues, or eyes for any purposes indicated below:

☐ Any or all	☐ Liver	☐ Bone/ligament	☐ Heart valves
☐ Heart	☐ Kidneys	☐ Veins	☐ Skin
☐ Lung	☐ Pancreas	☐ Eyes	☐ Other

☐ Any purpose authorized by law or, specifically as indicated below:

- ☐ Transplantation
- ☐ Therapy
- ☐ Research
- ☐ Education
- ☐ Advancement of medical science
- ☐ Advancement of dental science

_____

Signature of Donor

_____

Date of Birth of Donor Date Signed

_____

Witness Date

_____

Witness Date

Ohio's
Health Care
Power of Attorney

What you should know about a Health Care Power of Attorney:

A **Health Care Power of Attorney** is a document that allows you to name a person to act on your behalf to make health care decisions for you if you become unable to make them for yourself. **This person becomes an attorney-in-fact for you.**

- A **Health Care Power of Attorney** is different from a financial power of attorney that you use to give someone authority over your financial matters.
- The person you appoint as your **attorney-in-fact,** by completing the **Health Care Power of Attorney** form, has the power to authorize and refuse medical treatment for you. **This authority is recognized in all medical situations when you are unable to express your own wishes.** Unlike a **Living Will**, it is not limited to situations in which you are terminally ill or permanently unconscious. For example, your physician or the hospital may consult with your attorney-in-fact should you be injured in a car accident and become temporarily unconscious.

- There are **five <u>limitations</u>** on the authority of your attorney-in-fact:

1. **An attorney-in-fact has limited authority to order that life-sustaining treatment be withdrawn from you.** Your attorney-in-fact may order that life-sustaining treatment be refused or withdrawn only if you have a terminal condition or if you are in a permanently unconscious state. And even then, the attending physician and, if applicable, the consulting physician, must confirm that diagnosis, and your attending physician(s) must determine that you have no reasonable possibility of regaining decision-making ability.

2. **Your attorney-in-fact does not have the authority to order the withdrawal of "comfort care."** Comfort care is any type of medical or nursing care that would provide you with comfort or relief from pain.

3. **If you are pregnant, your attorney-in-fact cannot order the withdrawal of life-sustaining treatment unless certain conditions are met.** Life-sustaining treatment cannot be withdrawn if doing so would terminate the pregnancy unless there is substantial risk to your life or two physicians determine that the fetus would not be born alive.

4. **Your attorney-in-fact may order that nutrition and hydration be withdrawn only if you are in a terminal condition or permanently unconscious state and two physicians agree that nutrition and hydration will no longer provide comfort or alleviate pain.** If you want to give your attorney-in-fact the authority to withhold nutrition and hydration if you were to become permanently unconscious, you must indicate this in the appropriate section of the **Health Care Power of Attorney** form. If you also have a **Living Will**, it should be consistent with your **Health Care Power of Attorney** regarding the withholding of nutrition and hydration. In other words, if you indicate in your **Health Care Power of Attorney** that it is permissible for your attorney-in-fact to order that nutrition and hydration be withheld, then you also should indicate in your **Living Will** that it is permissible for your physician to withhold nutrition and hydration.

5. **If you previously have given consent for treatment (before becoming unable to communicate), your attorney-in-fact cannot withdraw your consent unless certain conditions are met.** Either your physical condition must have changed and/or the treatment you approved is no longer of benefit or the treatment has not been proven effective.

If you have a **Health Care Power of Attorney** and a **Living Will**, health care workers must follow the wishes you state in your **Living Will**, once the **Living Will** becomes effective. In other words, your **Living Will** takes precedence over your **Health Care Power of Attorney.**

You can change your mind and revoke your **Health Care Power of Attorney** at any time. You can do this simply by telling your attorney-in-fact, your physician and your family that you have changed your mind and wish to revoke your **Health Care Power of Attorney**. In this case, it is probably a good idea to ask for a copy of the document back from anyone to whom you may have given it.

How to fill out the Health Care Power of Attorney form:

You should use this form to appoint someone to make health care decisions for you if you should become unable to make them for yourself.

NOTE:

1. Read over all information carefully. Definitions are included as part of the form.

2. On the first two lines of the form, print your full name and birth date.

3. Under, "Naming of My Agent," fill in the name of the person you are appointing as your attorney-in-fact, the agent's current address and telephone number. You may name alternate agents on the indicated spaces, if you choose not to name alternate agents, you may wish to cross out the unused lines. You may not name your attending physician or the administrator of any nursing home where you are receiving care as your attorney-in-fact.

4. On the fifth page of the form, written in bold face type under ***Special Instructions,*** is the statement that will give your physician permission to withhold food and water in the event you are permanently unconscious. If you want to give your physician permission to withhold food and water in this situation, then you must place your initials on the line indicated in number three.

5. The form provides a section where you may write additional instructions and impose additional limitations that you may consider appropriate to document. You may attach additional pages if needed. You should include all attached pages with any copy(ies) you make and you should note the attached pages on the form itself in the related area.

6. Following "Additional Instructions or Limitations" is a section where you indicate whether or not you have a **Living Will**. Immediately below this area are spaces to date and sign the form. Remember, the **Health Care Power of Attorney** is not considered valid or effective unless you do one of the following:

> **First Option** – Date and sign the **Health Care Power of Attorney** in the presence of two witnesses, who also must sign and include their addresses and indicate the date of their signatures.
>
> OR
>
> **Second Option** – Date and sign the **Health Care Power of Attorney** in the presence of a notary public and have the **Health Care Power of Attorney** notarized on the appropriate space provided on the form.

The following people may **not** serve as a witness to your **Health Care Power of Attorney**:

- The Agent and any successor agent named in this document;
- Anyone related to you by blood, marriage, or adoption, including your spouse and your children;
- Your attending physician or, if you are in a nursing home, the administrator of the nursing home.

7. NOTE: The section titled NOTICE TO ADULT EXECUTING THIS DOCUMENT is required by law to be part of the document and must accompany it and any copies distributed.

State of Ohio
Health Care Power of Attorney
of

_____

(Print Full Name)

_____

(Birth Date)

I state that this is my Health Care Power of Attorney and I revoke any prior Health Care Power of Attorney signed by me. I understand the nature and purpose of this document. If any provision is found to be invalid or unenforceable, it will not affect the rest of this document.

This Health Care Power of Attorney is in effect only when I cannot make health care decisions for myself. However, this does not require or imply that a court must declare me incompetent.

Definitions. Several legal and medical terms are used in this document. For convenience they are explained below.

Agent or **attorney-in-fact** means the adult I name in this Health Care Power of Attorney to make health care decisions for me.

Anatomical gift means a donation of all or part of a human body to take effect upon or after death.

Artificially or technologically supplied nutrition or hydration means the providing of food and fluids through intravenous or tube "feedings."

Cardiopulmonary resuscitation or **CPR** means treatment to try to restart breathing or heartbeat. CPR may be done by breathing into the mouth, pushing on the chest, putting a tube through the mouth or nose into the throat, administering medication, giving electric shock to the chest, or by other means.

Comfort care means any measure taken to diminish pain or discomfort, but not to postpone death.

Donor Registry Enrollment Form means a form that has been designed to allow individuals to specifically register their wishes regarding organ, tissue and eye donation with the Ohio Bureau of Motor Vehicles Donor Registry.

Do Not Resuscitate or **DNR Order** means a medical order given by my physician and written in my medical records that cardiopulmonary resuscitation or CPR is not to be administered to me.

Health care means any medical (including dental, nursing, psychological, and surgical) procedure, treatment, intervention or other measure used to maintain, diagnose or treat any physical or mental condition.

Health Care Power of Attorney means this document that allows me to name an adult person to act as my agent to make health care decisions for me if I become unable to do so.

Life-sustaining treatment means any health care, including artificially or technologically supplied nutrition and hydration, that will serve mainly to prolong the process of dying.

Living Will Declaration or **Living Will** means another document that lets me specify the health care I want to receive if I become terminally ill or permanently unconscious and cannot make my wishes known.

Permanently unconscious state means an irreversible condition in which I am permanently unaware of myself and surroundings. My physician and one other physician must examine me and agree that the total loss of higher brain function has left me unable to feel pain or suffering.

Principal means the person signing this document.

Terminal condition or **terminal illness** means an irreversible, incurable and untreatable condition caused by disease, illness or injury. My physician and one other physician will have examined me and believe that I cannot recover and that death is likely to occur within a relatively short time if I do not receive life-sustaining treatment.

[Instructions and other information to assist in completing this document are set forth within brackets and in italic type.]

Naming of My Agent. The person named below is my agent who will make health care decisions for me as authorized in this document.

Agent's Name: _____

Agent's Current Address: _____

Agent's Current Telephone Number: _____

Naming of Alternate Agents. *[Note: You do not need to name alternate agents. You also may name just one alternate agent. If you do not name alternate agents or name just one alternate agent, you may wish to cross out the unused lines.]*

Should my agent named above not be immediately available or be unwilling or unable to make decisions for me, then I name, in the following order of priority, the following persons as my alternate agents:

First Alternate Agent:

Name: _____

Address: _____

_____

Telephone:_____

Second Alternate Agent:

Name: _____

Address: _____

_____

Telephone:_____

Any person can rely on a statement by any alternate agent named above that he or she is properly acting under this document and such person does not have to make any further investigation or inquiry.

Guidance to Agent. My agent will make health care decisions for me based on the instructions that I give in this document and on my wishes otherwise known to my agent. If my agent believes that my wishes as made known to my agent conflict with what is in this document, this document will control. If my wishes are unclear or unknown, my agent will make health care decisions in my best interests. My agent will determine my best interests after considering the benefits, the burdens, and the risks that might result from a given decision. If no agent is available, this document will guide decisions about my health care.

Authority of Agent. My agent has full and complete authority to make all health care decisions for me whenever I cannot make such decisions, unless I have otherwise indicated below. This authority includes, but is not limited to, the following: *[Note: Cross out any authority that you do* ***not*** *want your agent to have.]*

1. To consent to the administration of pain-relieving drugs or treatment or procedures (including surgery) that my agent, upon medical advice, believes may provide comfort to me, even though such drugs, treatment or procedures may hasten my death. My comfort and freedom from pain are important to me and should be protected by my agent and physician.

2. If I am in a terminal condition, to give, to withdraw or to refuse to give informed consent to life-sustaining treatment, including artificially or technologically supplied nutrition or hydration.

3. To give, withdraw or refuse to give informed consent to any health care procedure, treatment, intervention or other measure.

4. To request, review, and receive any information, verbal or written, regarding my physical or mental health, including, but not limited to, all my medical and health care records.

5. To consent to further disclosure of information, and to disclose medical and related information concerning my condition and treatment to other persons.

6. To execute for me any releases or other documents that may be required in order to obtain medical and related information.

7. To execute consents, waivers, and releases of liability for me and for my estate to all persons who comply with my agent's instructions and decisions. To indemnify and hold harmless, at my expense, any third party who acts under this Health Care Power of Attorney. I will be bound by such indemnity entered into by my agent.

8. To select, employ, and discharge health care personnel and services providing home health care and the like.

9. To select, contract for my admission to, transfer me to, or authorize my discharge from any medical or health care facility, including, but not limited to, hospitals, nursing homes, assisted living facilities, hospices, adult homes and the like.

10. To transport me or arrange for my transportation to a place where this Health Care Power of Attorney is honored, should I become unable to make health care decisions for myself in a place where this document is not enforced.

11. To complete and sign for me the following:

(a) Consents to health care treatment, or the issuance of Do Not Resuscitate (DNR) Orders or other similar orders; and

(b) Requests for my transfer to another facility, to be discharged against health care advice, or other similar requests; and

(c) Any other document desirable to implement health care decisions that my agent is authorized to make pursuant to this document.

Special Instructions. **By placing my initials at number 3 below, I want to specifically authorize my agent to refuse, or if treatment has commenced, to withdraw consent to, the provision of artificially or technologically supplied nutrition or hydration if:**

1. **I am in a permanently unconscious state; and**

2. **My physician and at least one other physician who has examined me have determined, to a reasonable degree of medical certainty, that artificially or technologically supplied nutrition and hydration will not provide comfort to me or relieve my pain; and**

3. **I have placed my initials on this line: _____**

Limitations of Agent's Authority. I understand that under Ohio law, there are five limitations to the authority of my agent:

1. My agent cannot order the withdrawal of life-sustaining treatment unless I am in a terminal condition or a permanently unconscious state, and two physicians have confirmed the diagnosis and have determined that I have no reasonable possibility of regaining the ability to make decisions; and

2. My agent cannot order the withdrawal of any treatment given to provide comfort care or to relieve pain; and

3. If I am pregnant, my agent cannot refuse or withdraw informed consent to health care if the refusal or withdrawal would end my pregnancy, unless the pregnancy or health care would create a substantial risk to my life or two physicians determine that the fetus would not be born alive; and

4. My agent cannot order the withdrawal of artificially or technologically supplied nutrition or hydration unless I am terminally ill or permanently unconscious and two physicians agree that nutrition or hydration will no longer provide comfort or relieve pain and, in the event that I am permanently unconscious, I have given a specific direction to withdraw nutrition or hydration elsewhere in this document; and

5. If I previously consented to any health care, my agent cannot withdraw that treatment unless my condition has significantly changed so that the health care is significantly less beneficial to me, or unless the health care is not achieving the purpose for which I chose the health care.

Additional Instructions or Limitations. I may give additional instructions or impose additional limitations on the authority of my agent. *[Note: On the lines below you may write in additional instructions or limitations. Here you may include any specific instructions or limitations you consider appropriate, such as instructions to refuse specific types of treatment that are inconsistent with your religious beliefs or unacceptable to you for any other reason. If the space below is not sufficient, you may attach additional pages. If you include additional instructions or limitations here and your wishes change, you should complete a new Health Care Power of Attorney and tell your agent about the changes. If you do not have any additional instructions or limitations, you may wish to write "None" below or cross out the unused lines.]*

No Expiration Date. This Health Care Power of Attorney will have no expiration date and will not be affected by my disability or by the passage of time.

Guardian. I intend that the authority given to my agent will eliminate the need for any court to appoint a guardian of my person. However, should such proceedings start, I nominate my agent to serve as the guardian of my person, without bond.

Enforcement by Agent. My agent may take for me, at my expense, any action my agent considers advisable to enforce my wishes under this document.

Release of Agent's Personal Liability. My agent will not incur any personal liability to me or my estate for making reasonable choices in good faith concerning my health care.

Copies the Same as Original. Any person may rely on a copy of this document.

Out of State Application. I intend that this document be honored in any jurisdiction to the extent allowed by law.

Living Will. I have completed a Living Will:_____ Yes _____ No

Anatomical Gift(s). I have made my wishes known regarding organ and tissue donation in my Living Will:_____Yes _____ No

Donor Registry Enrollment Form. I have completed the Donor Registry Enrollment Form: _____ Yes _____ No

SIGNATURE

[See next page for witness or notary requirements.]

I understand the purpose and effect of this document and sign my name to this Health Care Power of Attorney on _____, 20_____, at _____, Ohio.

_____

PRINCIPAL

[You are responsible for telling members of your family and your physician about this document and the name of your agent. You also may wish, but are not required to tell your religious advisor and your lawyer that you have signed a Health Care Power of Attorney. You may wish to give a copy to each person notified.]

[You may choose to file a copy of this Health Care Power of Attorney with your county recorder for safekeeping.]

WITNESSES OR NOTARY ACKNOWLEDGMENT

[Choose one.]

[This Health Care Power of Attorney will not be valid unless it either is signed by two eligible witnesses who are present when you sign or are present when you acknowledge your signature, ***or*** *it is acknowledged before a Notary Public.]*

[The following persons ***cannot*** *serve as a witness to this Health Care Power of Attorney: the agent; any successor agent named in this document; your spouse; your children; anyone else related to you by blood, marriage or adoption; your attending physician; or, if you are in a nursing home, the administrator of the nursing home.]*

Witnesses. I attest that the Principal signed or acknowledged this Health Care Power of Attorney in my presence, that the Principal appears to be of sound mind and not under or subject to duress, fraud or undue influence. I further attest that I am not an agent designated in this document, I am not the attending physician of the Principal, I am not the administrator of a nursing home in which the Principal is receiving care, and I am an adult not related to the Principal by blood, marriage or adoption.

_____ residing at _____
Signature

_____ _____ , _____
Print Name

Dated: _____ , 20_____

_____ residing at _____
Signature

_____ _____ , _____
Print Name

Dated: _____ , 20_____

OR

Notary Acknowledgment.
State of Ohio
County of _____ ss.

On _____, 20_____, before me, the undersigned Notary Public, personally appeared _____, known to me or satisfactorily proven to be the person whose name is subscribed to the above Health Care Power of Attorney as the Principal, and who has acknowledged that (s)he executed the same for the purposes expressed therein. I attest that the Principal appears to be of sound mind and not under or subject to duress, fraud or undue influence.

_____
Notary Public

My Commission Expires: _____

[This notice is included in this printed form as required by Ohio Revised Code § 1337.17.]

NOTICE TO ADULT EXECUTING THIS DOCUMENT

This is an important legal document. Before executing this document, you should know these facts:

This document gives the person you designate (the attorney in fact) the power to make MOST health care decisions for you if you lose the capacity to make informed health care decisions for yourself. This power is effective only when your attending physician determines that you have lost the capacity to make informed health care decisions for yourself and, notwithstanding this document, as long as you have the capacity to make informed health care decisions for yourself, you retain the right to make all medical and other health care decisions for yourself.

You may include specific limitations in this document on the authority of the attorney in fact to make health care decisions for you.

Subject to any specific limitations you include in this document, if your attending physician determines that you have lost the capacity to make an informed decision on a health care matter, the attorney in fact GENERALLY will be authorized by this document to make health care decisions for you to the same extent as you could make those decisions yourself, if you had the capacity to do so. The authority of the attorney in fact to make health care decisions for you GENERALLY will include the authority to give informed consent, to refuse to give informed consent, or to withdraw informed consent to any care, treatment, service, or procedure to maintain, diagnose, or treat a physical or mental condition.

HOWEVER, even if the attorney in fact has general authority to make health care decisions for you under this document, the attorney in fact NEVER will be authorized to do any of the following:

(1) Refuse or withdraw informed consent to life-sustaining treatment (unless your attending physician and one other physician who examines you determine, to a reasonable degree of medical certainty and in accordance with reasonable medical standards, that either of the following applies:

(a) You are suffering from an irreversible, incurable and untreatable condition caused by disease, illness, or injury from which (i) there can be no recovery and (ii) your death is likely to occur within a relatively short time if life-sustaining treatment is not administered, and your attending physician additionally determines, to a reasonable degree of medical certainty and in accordance with reasonable medical standards, that there is no reasonable possibility that you will regain the capacity to make informed health care decisions for yourself.

[This notice is included in this printed form as required by Ohio Revised Code § 1337.17.]

(b) You are in a state of permanent unconsciousness that is characterized by you being irreversibly unaware of yourself and your environment and by a total loss of cerebral cortical functioning, resulting in you having no capacity to experience pain or suffering, and your attending physician additionally determines, to a reasonable degree of medical certainty and in accordance with reasonable medical standards, that there is no reasonable possibility that you will regain the capacity to make informed health care decisions for yourself);

(2) Refuse or withdraw informed consent to health care necessary to provide you with comfort care (except that, if the attorney in fact is not prohibited from doing so under (4) below, the attorney in fact could refuse or withdraw informed consent to the provision of nutrition or hydration to you as described under (4) below). **(You should understand that comfort care is defined in Ohio law to mean artificially or technologically administered sustenance (nutrition) or fluids (hydration) when administered to diminish your pain or discomfort, not to postpone your death, and any other medical or nursing procedure, treatment, intervention, or other measure that would be taken to diminish your pain or discomfort, not to postpone your death. Consequently, if your attending physician were to determine that a previously described medical or nursing procedure, treatment, intervention, or other measure will not or no longer will serve to provide comfort to you or alleviate your pain, then, subject to (4) below, your attorney in fact would be authorized to refuse or withdraw informed consent to the procedure, treatment, intervention, or other measure.);**

(3) Refuse or withdraw informed consent to health care for you if you are pregnant and if the refusal or withdrawal would terminate the pregnancy (unless the pregnancy or health care would pose a substantial risk to your life, or unless your attending physician and at least one other physician who examines you determine, to a reasonable degree of medical certainty and in accordance with reasonable medical standards, that the fetus would not be born alive);

(4) Refuse or withdraw informed consent to the provision of artificially or technologically administered sustenance (nutrition) or fluids (hydration) to you, unless:

(a) You are in a terminal condition or in a permanently unconscious state.

[This notice is included in this printed form as required by Ohio Revised Code § 1337.17.]

(b) Your attending physician and at least one other physician who has examined you determine, to a reasonable degree of medical certainty and in accordance with reasonable medical standards, that nutrition or hydration will not or no longer will serve to provide comfort to you or alleviate your pain.

(c) If, but only if, you are in a permanently unconscious state, you authorize the attorney in fact to refuse or withdraw informed consent to the provision of nutrition or hydration to you by doing both of the following in this document:

(i) Including a statement in capital letters or other conspicuous type, including, but not limited to, a different font, bigger type, or boldface type, that the attorney in fact may refuse or withdraw informed consent to the provision of nutrition or hydration to you if you are in a permanently unconscious state and if the determination that nutrition or hydration will not or no longer will serve to provide comfort to you or alleviate your pain is made, or checking or otherwise marking a box or line (if any) that is adjacent to a similar statement on this document;

(ii) Placing your initials or signature underneath or adjacent to the statement, check, or other mark previously described.

(d) Your attending physician determines, in good faith, that you authorized the attorney in fact to refuse or withdraw informed consent to the provision of nutrition or hydration to you if you are in a permanently unconscious state by complying with the above requirements of (4)(c)(i) and (ii) above.

(5) Withdraw informed consent to any health care to which you previously consented, unless a change in your physical condition has significantly decreased the benefit of that health care to you, or unless the health care is not, or is no longer, significantly effective in achieving the purposes for which you consented to its use.

Additionally, when exercising authority to make health care decisions for you, the attorney in fact will have to act consistently with your desires or, if your desires are unknown, to act in your best interest. You may express your desires to the attorney in fact by including them in this document or by making them known to the attorney in fact in another manner.

When acting pursuant to this document, the attorney in fact GENERALLY will have the same rights that you have to receive information about proposed health care, to review health care records, and to consent to the disclosure of health care records. You can limit that right in this document if you so choose.

[This notice is included in this printed form as required by Ohio Revised Code § 1337.17.]

Generally, you may designate any competent adult as the attorney in fact under this document. However, you CANNOT designate your attending physician or the administrator of any nursing home in which you are receiving care as the attorney in fact under this document. Additionally, you CANNOT designate an employee or agent of your attending physician, or an employee or agent of a health care facility at which you are being treated, as the attorney in fact under this document, unless either type of employee or agent is a competent adult and related to you by blood, marriage, or adoption, or unless either type of employee or agent is a competent adult and you and the employee or agent are members of the same religious order.

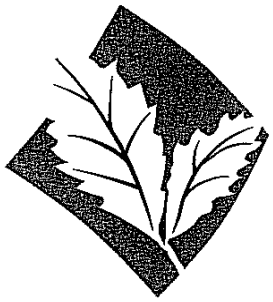
This document has no expiration date under Ohio law, but you may choose to specify a date upon which your durable power of attorney for health care will expire. However, if you specify an expiration date and then lack the capacity to make informed health care decisions for yourself on that date, the document and the power it grants to your attorney in fact will continue in effect until you regain the capacity to make informed health care decisions for yourself.

You have the right to revoke the designation of the attorney in fact and the right to revoke this entire document at any time and in any manner. Any such revocation generally will be effective when you express your intention to make the revocation. However, if you made your attending physician aware of this document, any such revocation will be effective only when you communicate it to your attending physician, or when a witness to the revocation or other health care personnel to whom the revocation is communicated by such a witness communicates it to your attending physician.

If you execute this document and create a valid durable power of attorney for health care with it, it will revoke any prior, valid durable power of attorney for health care that you created, unless you indicate otherwise in this document.

This document is not valid as a durable power of attorney for health care unless it is acknowledged before a notary public or is signed by at least two adult witnesses who are present when you sign or acknowledge your signature. No person who is related to you by blood, marriage, or adoption may be a witness. The attorney in fact, your attending physician, and the administrator of any nursing home in which you are receiving care also are ineligible to be witnesses.

If there is anything in this document that you do not understand, you should ask your lawyer to explain it to you.



Ohio's **Do-Not-Resuscitate** Law

Ohio's Do-Not-Resuscitate (DNR) Law gives individuals the opportunity to exercise their right to limit care received in emergency situations in special circumstances. "Special circumstances" include care received from emergency personnel when 911 is dialed. The law authorizes a physician to write an order letting health care personnel know that a patient does not wish to be resuscitated in the event of a cardiac arrest (no palpable pulse) or respiratory arrest (no spontaneous respirations or the presence of labored breathing).

The following information is included as a brief overview of some of the more common questions, issues and concerns regarding Ohio's Do-Not-Resuscitate Law. It is not meant to provide all information needed to make the decision to have a Do-Not-Resuscitate Order written. An individual is enrolled in the DNR Comfort Care (DNRCC) Program after **consultation** with his or her physician regarding end of life issues. Upon enrollment, the individual will receive a special identification form. Other DNRCC identifications, such as a wallet identification card, also may be used, but must include the Ohio State DNR logo to be valid.

The DNR Comfort Care Protocol allows the DNR Comfort Care Order to be used in multiple settings and practice areas including, but not limited to, nursing facilities, residential care facilities, hospitals, outpatient areas, home, and public places. For a DNR Comfort Care Order to be useful in multiple settings, it must be recognizable by health care workers. The Ohio Department of Health has developed a standard order form that is generally recognized.

Unlike a Living Will and Health Care Power of Attorney, a DNR Order must be written and signed by a physician, an advanced-practice nurse or a certified nurse practicioner after consultation with the patient.

DNR Comfort Care is a legally-sanctioned program that is implemented according to a standardized protocol. The DNRCC Order is implemented at different points, depending upon the patient's wishes and must be consistent with reasonable medical standards.

The two options within the DNR Comfort Care Protocol are the DNR Comfort Care (DNRCC) Order and the DNR Comfort Care-Arrest (DNRCC-Arrest) Order. With a DNRCC Order, a person receives any care that eases pain and suffering, but no resuscitative measures to save or sustain life from the moment the order is signed by the physician. With a DNRCC-Arrest Order, a person receives standard medical care that may include some components of resuscitation until he or she experiences a cardiac or respiratory arrest.

DNR Comfort Care: The Facts

Cardiopulmonary Resuscitation (CPR) has a broad meaning. It includes any or all of the following:

- Administration of chest compressions;
- Insertion of an artificial airway;
- Administration of resuscitation drugs;
- Defibrillation or cardioversion;
- Provision of respiratory assistance;
- Initiation of a resuscitative intravenous line; or
- Initiation of cardiac monitoring.

CPR is a life-saver, but some people may not want it to be administered in certain cases.
In some cases, CPR saves lives. In other cases, it is not effective. Many people overestimate the success of CPR. A person who is revived can be left with permanent or painful injury. Resuscitation also can include other treatment, such as drugs, tubes and electric shock. People with terminal illnesses or other serious medical conditions may prefer to focus on comfort care at the end of life rather than receiving CPR when the time comes. For more information about the pros and cons of CPR and whether it is right for you, ask your physician.

It is easy to make your wishes about CPR known.
If you want to receive CPR when appropriate, you do not need to do anything. Health care providers are required to perform CPR when necessary. If you **do not** want CPR, you need to discuss your wishes with your physician and ask your physician to write a DNR Order. If your physician agrees that you should not get CPR, he or she can fill out the required form to make your wishes known in case of an emergency.

Even if you are healthy now, you may want to state that you do not want to receive CPR if you ever become terminally ill.
Ohio has a standard Living Will Declaration form. This form specifically allows you to direct your physician not to administer life-sustaining treatments, including CPR, and to issue a DNR Order if two physicians have agreed that you are either terminally ill or permanently unconscious.

DNR Comfort Care does NOT mean "Do Not Treat."
The DNR Comfort Care Protocol is very specific in terms of what treatment is to be given and what treatment is to be withheld. Only those items listed on the "will not" list are to be withheld. The items listed on the "will" list, along with any other treatment that may be needed for the patient's condition, may be provided as appropriate.

DNR Orders may be revoked.
You always have the right to change your mind and request CPR. If you do change your mind, you should speak with your physician right away about revoking your DNR Order. You also should tell your family and caregivers about your decision and throw away any DNR identification items you might have.

If you have a DNR Order or identification, your family cannot demand that CPR be provided.
You have the right to make your own decisions about your health care. You should make sure your family knows your desires about CPR.

Does Ohio have a law concerning Do Not Resuscitate (DNR) Orders?

Yes. Ohio adopted a law concerning DNR Orders in 1998.

Can I sign my own (DNR) Order?

No. Unlike Living Wills and Health Care Powers of Attorney, DNR Orders must be written and signed by a physician, advanced practice nurse or certified nurse practicioner after consultation with the patient.

Where should my Living Will, Health Care Power of Attorney and DNR be kept?

Copies of these forms should be kept in easily accessible places where others can find them. You also should give copies of your Living Will, Health Care Power of Attorney and/or DNR Order to your physician, family members and any close friends who might serve as caretakers.

What does DNR mean?

DNR stands for "do not resuscitate." A person who does not wish to have cardiopulmonary resuscitation (CPR) performed may make this wish known through a physician's order called a DNR Order. A DNR Order addresses the various methods used to revive people whose hearts have stopped functioning or who have stopped breathing. Examples of these treatments include chest compressions, electric heart shock, artificial breathing tubes, and special drugs.

Under its DNR Comfort Care Protocol, the Ohio Department of Health has established two standardized DNR Orders. When completed by a physician (certified nurse practitioner or advance practice nurse, as appropriate), these standardized DNR Orders allow patients to choose the extent of the treatment they wish to receive at the end of life. A patient with a "DNR Comfort Care-Arrest Order" will receive all the appropriate medical treatment, including resuscitation, until the patient has a cardiac or pulmonary arrest, at which point only comfort care will be provided. By requesting the broader "DNR Comfort Care Order," a patient may reject other life-sustaining measures such as drugs to correct abnormal heart rhythms. With this order, only comfort care is provided at a point even before the heart or breathing stops. Your physician can explain the differences in DNR Orders.

Can anyone else override my wishes about CPR?

In certain medical situations, your physician and agent may make decisions regarding your care based upon new medical information. This could include decisions related to CPR. You should make sure these individuals know your desires about CPR.

What if I change my mind after my physician writes a DNR Order?

You always have the right to change your mind and request CPR. If you **do** change your mind, you should talk with your physician right away about revoking your DNR Order. You should also tell your family and caregivers about your decision, mark "cancelled" on the actual DNR Order, and destroy any DNR wallet cards or other identification items you may have.

DNR COMFORT CARE

DNR IDENTIFICATION FORM

☐ **DNRCC**
(If this box is checked the DNR Comcort Care Protocol is activated immediately.)

☐ **DNRCC—Arrest**
(If this box is checked, the DNR Comfort Care Protocol is implemented in the event of a cardiac arrest or a respiratory arrest.)

Patient Name:_____

Address:_____

City_____ State_____ Zip_____

Birthdate_____ Gender ☐ M ☐ F

Signature_____ (optional)

Certification of DNR Comfort Care Status (to be completed by the physician)*

(Check only one box)
☐ **Do-Not-Resuscitate Order**—My signature below constitutes and confirms a formal order to emergency medical services and other health care personnel that the person identified above is to be treated under the State of Ohio DNR Protocol. I affirm that this order is not contrary to reasonable medical standards or, to the best of my knowledge, contrary to the wishes of the person or of another person who is lawfully authorized to make informed medical decisions on the person's behalf. I also affirm that I have documented the grounds for this order in the person's medical record.

☐ **Living Will (Declaration) and Qualifying Condition**—The person identified above has a valid Ohio Living will (declaration) and has been certified by two physicians in accordance with Ohio law as being terminal or in a permanent unconscious state, or both.

Printed name of physician*:_____

Signature_____ Date_____

Address:_____ Phone_____

City/State_____ Zip_____

* A DNA order may be issued by a certified nurse practitioner or clinical nurse specialist when authorized by section 2133.211 of the Ohio Revised Code.

See reverse side for DNR Protocol

DO NOT RESUSCITATE COMFORT CARE PROTOCOL

After the State of Ohio DNR Protocol has been activated for a specific DNR Comfort Care patient, the Protocol specifies that emergency medical services and other health care workers are to do the following:

WILL:

- Suction the airway
- Administer oxygen
- Position for comfort
- Splint or immobilize
- Control bleeding
- Provide pain medication
- Provide emotional support
- Contact other appropriate health care providers such as hospice, home health, attending physician/CNS/CNP

WILL NOT:

- Administer chest compressions
- Insert artificial air way
- Administer resuscitative drugs
- Defibrillate or cardiovert
- Provide respiratory assistance (other than that listed above)
- Initiate resuscitative IV
- Initiate cardiac monitoring

If you have responded to an emergency situation by initiating any of the **WILL NOT** actions prior to confirming that the DNR Comfort Care Protocol should be activated, discontinue them when you activate the Protocol. You may continue respiratory assistance, IV medications, etc., that have been part of the patient's ongoing course of treatment for an underlying disease.

The Hospice Choice

When choices seem few and unpleasant...

Life is full of choices. We all want to be in control, capable of making our own decisions, determining how we live our lives. When confronting a life-threatening illness and cure no longer is possible, we experience fear, frustration and confusion. We can feel as if we have lost control of our lives. Hospice restores our ability to make decisions, to put life back on track by offering positive choices as we confront life's end.

What assurances do I have if I choose hospice?

You can be assured that your wishes will be respected and that you will be allowed to die, pain free, surrounded by those who love you, and with the utmost respect and dignity. Hospice will focus on comfort measures and quality of life needs and allow you to die naturally rather than prolong your life beyond its natural ability to continue.

When does hospice become a part of my choice?

People who choose hospice have medical conditions that no longer can be cured. Hospice, with more than 30 years of experience in caring for the terminally ill, offers tremendous advances in pain management that dramatically improve quality of life. As one of the most life-affirming forms of health care, hospice provides comfort, support and respect for the patient, the family and friends. Traditional medical care focuses almost solely on patients' physical needs. Hospice addresses the physical, emotional and spiritual needs of patients facing the end of life, along with the needs of their caregivers.

By making the hospice choice, what can I expect?

Hospice caregivers and volunteers join together, around the clock if necessary, to provide hospice care for patients, family and friends. Physicians, nurses, home health aides, social workers, bereavement counselors, chaplains and volunteers collaborate to assure the physical, emotional, mental and spiritual needs, that are especially important at the end of life, are met. Hospice caregivers realize how deeply family members and friends are affected by a terminal illness.

How does hospice impact the quality of my life?

A significant reassurance is that hospice services are provided in the soothing, familiar surroundings of your home where you are most comfortable and where loved ones can be involved more easily. And, if you live in a nursing home or assisted living facility, hospice care is provided in those locations as well.

If I choose hospice care, how will I pay for the services?

Medicare, Medicaid and most private insurance companies recognize hospice care, which generally is a cost savings in health care. Care is most often provided in the home, with the family helping as caregivers, and there is less expensive high-tech equipment to escalate your health care costs. Hospice care need not be a financial burden to anyone. Local hospices will work closely with you to identify possible sources of payment. Hospice, the ultimate expression of caring, support and love, has served millions of people of all income levels, races, creeds, ages and medical circumstances. Hospice is here to help you when needed.

Can a hospice patient who shows signs of recovery be returned to regular medical treatment?

Certainly. If improvement in the condition occurs and the disease seems to be in remission, the patient can be discharged from hospice and return to aggressive therapy or go on about his or her daily life. If a discharged patient should later need to return to hospice care, Medicare and most private insurance policies allow additional coverage for this purpose.

What does the hospice admission process involve?

One of the first things hospice will do is to contact the patient's physician to make sure he or she agrees that hospice care is appropriate for this patient at this time. (Hospices may have medical staff available to help patients who have no physician.) Once a patient is identified as appropriate for hospice care, he or she will be asked to sign consent and insurance forms. These are similar to the forms patients sign when they enter a hospital.

Isn't hospice care just for people who have cancer?

No. Hospice care is available for patients with many terminal illnesses such as amyotrophic lateral sclerosis (ALS), dementia, heart disease, HIV/AIDS, liver disease, pulmonary disease, stroke, coma and other conditions. Inquire at your local hospice to learn more.

What specific assistance does hospice provide to home-based patients?

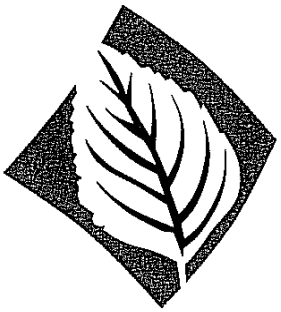
Hospice patients are cared for by a team of physicians, nurses, social workers, counselors, home health aides, clergy, therapists, and volunteers, all of whom provide assistance based on their areas of expertise. In addition, hospices help provide medications, supplies, equipment, hospital services and additional helpers in the home, as appropriate.

How do I make the hospice choice?

Speak to your physician, clergy, hospital discharge planner, social worker, nurse or local/state hospice organization. When you and your family realize that care, instead of cure, is most important to you, that is when to ask for hospice.

If I make the hospice choice and need more information about Ohio's hospices, who can help me?

The Ohio Hospice & Palliative Care Organization, whose mission is to promote the development and delivery of highest quality, end of life care through advocacy of hospice philosophy and standards, can provide this information.



Anatomical Gifts

Registering to become an Organ, Tissue and Eye Donor

Anatomical Gifts

Ohio law requires that Living Wills created after December 15, 2004, must include a person's preferences about Anatomical Gifts (organ and tissue donation). The Living Will form included in this booklet has the required section and also provides instructions for registering your wishes with the Bureau of Motor Vehicles. Living Wills completed before December 16, 2004, that do not include the Anatomical Gifts (organ and tissue donation) section are still valid and will be honored in Ohio. If you have previously completed an approved Donor Registry Enrollment Form or made the affirmation when renewing your driver license or state identification card, then you have given consent for your organs, tissue, and/or eyes, if usable, to be removed upon your death. The revised Living Will form allows you to be specific regarding the type(s) of organ/tissue you wish to donate and for what purposes.

How Do I Register to Become a Donor?

There are two ways to register:
1) When you obtain or renew your Ohio Driver License or State I.D. Card, you will be asked, "Do you want to make an anatomical gift?" By answering "yes," your name will be added to Ohio's Donor Registry. This authorizes the use of any of your usable organs, tissues or eyes for any purposes authorized by law; you are not agreeing to donate your entire body. If your name is in the registry, donation will move forward at the time of your death.
2) If you wish to join the registry at a time other than when you renew your license or State I.D. Card, or if you wish to refine or change your donation consent, you must complete the Donor Registry Enrollment Form that is attached to the Ohio Living Will form and return it to Ohio Bureau of Motor Vehicles, ATTN: Record Clearance Unit, P.O. Box 16784, Columbus, OH 43216-6784. Through the enrollment form, you can specify the organs or tissues you wish to donate, and the specific purposes for which they can be used. Each time your license or I.D. Card comes up for renewal, if you have a Donor Registry Enrollment Form with restrictions on file, you will need to complete and submit a new enrollment form. You can use the enrollment form to become a donor, even if you have neither a driver's license nor a state issued identification card, by providing your social security number on the enrollment form.

In addition to registering your intent to become a donor, you should discuss your wishes with your family.

How Do I Remove My Name from the Registry?

If you want to remove your name from the Donor Registry, you can complete the section of the Donor Registry Enrollment Form that states, "Please remove me from the Donor Registry." Send the form to the Bureau of Motor Vehicles and update your Living Will and Health Care Power of Attorney forms.

What Can be Donated?

Page two of two of the form welcomes donations "of all or part of my body." Organs including heart, lungs, liver, kidneys and pancreas; tissues including skin, bone, ligaments, heart valves, veins and eyes. If you wish to donate your entire body, you must contact the medical school of your choice to declare your intent.

How Are Donated Organs or Tissues Used?

Under Ohio law, an anatomical gift may be used for transplantation, therapy, research, education or advancement of medical or dental science. The Ohio Donor Registry Enrollment Form lists each of these possible uses. You should check either all **or** the appropriate box(es) next to your specific choice(s) for both anatomical gifts and the purposes authorized by law. After completing the Ohio Donor Registry Enrollment Form, make a copy for your records and send the original to the Bureau of Motor Vehicles at the address provided on the form.

Important Donation Facts:

- Anatomical gifts donation information provided through the Ohio Donor Registry can be accessed and used only by authorized organ, tissue and eye recovery agencies in Ohio.
- Your status as an anatomical gifts donor is considered only ***after*** every effort has been made to save your life and you have been declared legally dead.
- The recovery of organs and tissues is a surgical procedure that ensures the donor's body is treated with dignity and respect. An open casket is still possible.
- All costs associated with organ and tissue donation are paid for by the organ procurement organization.
- You can change your mind or refine your intent at any time, but only by completing a new Donor Registry Enrollment Form and sending it to the Burear of Motor Vehicles.
- If you are under 18 years of age and wish to be a registered donor, one of the witnesses on your Donor Registry Enrollment Form must be your parent or legal guardian.
- Organ donation is an anonymous process that ensures your gift will go to the person who needs it most.

For more information about organ and tissue donation, please contact www.donatelifeohio.org or your local organ procurement organization.

Lifeline of Ohio
770 Kinnear Road, Suite 200
Columbus, OH 43212
(614) 291-5667
(800) 525-5667
www.lifelineofohio.org

LifeBanc
20600 Chagrin Boulevard, Suite 350
Cleveland, OH 44122-5343
(216) 752-5433
(800) 558-5433
www.lifebanc.org

Life Center Organ Donor Network
2925 Vernon Place, Suite 300
Cincinnati, OH 45219-2425
(513) 558-5555
(800) 981-5433
www.lifecnt.org

Life Connection of Ohio
Dayton Regional Office
40 Wyoming Street
Dayton, OH 45409
(937) 223-8223
(800) 535-9206
www.lifeconnectionofohio.org

Life Connection of Ohio
Toledo Regional Office
3661 Briarfield Boulevard, Suite 105
Maumee, OH 43537-9102
(419) 893-1618
(800) 262-3443
www.lifeconnectionofohio.org

It is important to let your loved ones know that you have Advance Directives. This card is provided for your use. Please complete the card and place it in your wallet or purse so your wishes will be known to medical professionals.

Forms located: _____

My Healthcare Power of Attorney(s)/Agent(s):

Primary
Name: _____
Phone: _____

Secondary
Name: _____
Phone: _____

❑ I have a Living Will.
❑ I have a Healthcare Power of Attorney Form.
❑ I am an Anatomical Gifts Donor and have registered with the Bureau of Motor Vehicles.

Name: _____
Address: _____
City: _____
State: _____ Zip: _____ Phone: _____

MEDICAL

"We make a living by what we get, but we make a life by what we give".

~Sir Winston Churchill

NOTES

Health Insurance

MEDICARE:

- **Health insurance program funded by the federal government.**
- **Offers health care benefits to people 65 or older, and to anyone under 65 who has been collecting Social Security disability for at least 2 years or has a serious disability, such as kidney failure.**
- **Most Seniors are covered under the Original Medicare Plan. That plan requires them to pay for some of their health care in addition to their monthly Part B and D premiums. Those additional amounts are called deductibles and coinsurance. All premiums, deductibles and coinsurance amounts change every year on January 1st.**
- **Medicare currently has four parts.**
  - **Part A helps pay for inpatient hospital care, some skilled nursing facilities, hospice care, and some home health care. Part A is premium-free for most people.**
  - **Part B helps pay for doctors, outpatient hospital care and tests, lab services and home health care. There is a monthly charge to the patient for coverage from Part B, and a deductible is also applied.**
  - **Part C allows various HMOs, PPOs, and similar health care organizations to offer health insurance plans to Medicare beneficiaries. At a minimum, they must provide the same basic benefits that the Original Medicare Plan provides under Parts A and B. Part C organizations are allowed to offer additional benefits such as dental and vision care. To help control costs, Part C plans are allowed to limit a patient's choice of doctor's, hospitals, etc., to just those who are members of their networks. This can be a major disadvantage is a patient's favorite doctor or hospital is not a member of their networks.**
  - **Part D provides prescription drug benefits through various private insurance companies. Like Part B, most people have to pay extra premiums each month to be covered. Premiums vary for Part D from state-to-state and company-to-company.**

MEDIGAP;

- **Private health insurance policy offered to people who are eligible for Medicare. Also referred to as Supplemental Medicare Insurance.**
- **Helps pay for services that are not covered by Medicare, such as deductibles, co-payments, and prescriptions. Twelve standardized plans have been defined by federal law, but not all states allow all 12, and not all companies offer all twelve.**

Health Insurance

MEDICAID:

- **Health insurance program funded by federal and state governments.**
- **Offers health care benefits to those with low income, such as those who are collecting SSI, welfare, or public assistance.**
- **Eligibility depends on monthly income, personal assets, and state regulations.**
- **Covers most medical care and nursing home costs, but is not accepted by all hospitals/doctors.**

PRIVATE INSURANCE:

- **Insurance that is covered under a group plan from an employer or purchased by an individual.**
- **There are basically two types of private insurance:**
  - **Fee for Service Plans require you to pay premiums and a deductible, then you (or the doctor's billing office) submit a claim to obtain reimbursement for the cost of care.**
  - **Managed Care Plans (HMO/PPO) are prepaid health insurance plans that cover the cost of services within a network of health care providers. Patients choose a primary care physician who they must see for referrals to other specialists. These plans do not usually have a deductible for in-network visits, but do charge a small co-payment for doctor's visits and prescriptions.**

For More Information:

Medicare Hotline: (800) Medicare (633-4227)

Medicare Rights Center: (800) 333-4114

American Association of Retired Persons (AARP): (800) 424-3410

National Insurance Consumer Help Line: (800) 942-4242

Managing Medical Care at Home

Medical Emergencies:

When caring for someone who is ill, it is vital to know how to handle a medical emergency. Though it is possible to avoid many medical emergencies by closely observing the patient for health changes, calling a doctor for advice, and keeping the home safe, emergencies can still arise. Having a plan to follow will help you remain calm if an emergency does occur. It can also aid those who assist you in caring for the patient when you are not at home.

To start, make sure you have an Emergency Information form filled out. This information should be photocopied and put in places that are easily accessible, such as next to the telephone and on the refrigerator.

Know When to Call for an Ambulance:

There are certain instances in which recognizing an emergency and calling 911 can save a person's life. However, since ambulance service can be extremely expensive when not covered by insurance, it is important to know exactly when it is necessary. Always call for an ambulance if a person. . .

- **is unconscious**
- **has chest pain or pressure**
- **has trouble breathing or is not breathing**
- **has no pulse**
- **is bleeding severely**
- **is vomiting blood or is bleeding from the rectum**
- **has fallen and may have broken bones**
- **has had a seizure**
- **has a severe headache and slurred speech**
- **has pressure or severe pain in the abdomen that does not go away**
  -OR-
- **moving the person could cause further injury**
- **traffic or distance would cause a life-threatening delay in getting to the hospital**
- **the person is too heavy for you to lift or help**

If you know CPR or other emergency procedures, you should call for an ambulance before doing anything else. Once you make the call, you can care for the patient until help arrives.

Going to the Emergency Room (ER):

Most people try to avoid going to the ER at all costs. However, there are times when the patient's need for care is urgent, and you must take him/her to the emergency room. The following suggestions may help during this stressful time.

* **If you think that the patient's condition may lead you to the ER, pack a bag in advance so that you are ready to go if/when the time comes. Comfortable clothing that is free of any metal fasteners should be included as well as any assistive devices.**
* **Keep a list of friends and family members to notify.**
* **If the patient will be in the hospital for awhile, you may want to suspend services such as newspaper, home health care, food delivery, etc.**
* **Make sure you are familiar with the patient's medical history, in case the patient cannot speak for him/herself. Keep a list of important information, such as past health problems, allergies, and current medications and dosages.**
* **Be able to describe exactly what the patient's problem is, when it started, what may have caused it, and if the patient was given any medication or other treatments.**
* **Know the patient's legal rights and responsibilities while in the hospital.**
* **Use good communication skills. Though the ER can be a frustrating place, it will not serve you well to take your anger out on the staff. Try to be understanding and patient, while being assertive. To do this, follow these tips for better communication:**
  - **Don't be afraid to speak up if you feel that the patient's rights are being violated or if you are not satisfied with the patient's care.**
  - **Tell the health care professional about your dissatisfaction with care in a direct way that is not demanding or disrespectful.**
  - **Speak in a meaningful way to the health care professional, such as, "I don't like that my mother is in so much pain," rather than, "Why won't you do something about my mother's pain?" This sounds less accusatory, and expresses how you are feeling to the other person.**
  - **Be clear about what you and/or the patient need in order to feel comfortable and content with the care.**
  - **Listen carefully to what the health care professional has to say and ask for clarification to make sure that you fully understand what is being said before responding.**
  - **Be sensitive to the health care professional's limitations in his/her ability to help you and the patient. ER staff members are usually very busy, over-worked and tired. Don't assume that they are just unpleasant or unwilling to help.**
* **For patient's who go the ER frequently (e.g. sufferers of sickle cell disease), try to develop good relationships with familiar ER staff members. If you are friendly and treat them with respect, you are more likely to receive the same treatment in return.**
* **Know the ER chain of command.**

Learn First Aid and Basic Emergency Procedures:

If you are not familiar with CPR or other emergency procedures, and would like to learn, you can take a course from the American Red Cross. The following are some basic tips about first aid and emergencies. You should always call 911 or an ambulance before performing CPR or First Aid.

Ashland Red Cross 419-289-3535
www.redcross.org

1) **Check if the patient is conscious. Ask the person a question and gently shake his/her shoulders. If there is no response, the person is unconscious.**

2) **Open the airway. Place two fingers under the point of the patient's chin and lift the jaw. At the same time, place your other hand on the patient's forehead and tilt the head back.**
3) **Check if the patient is breathing. Listen and look at the chest to check for breathing. Feel for breath coming out of the mouth on your cheek for 5 seconds. If you do not hear, see, or feel anything, the patient is not breathing.**
4) **Check for a pulse. Place two fingers over the patient's Adam's apple and slide the fingers toward you in the groove of the neck. Feel the pulse for 5-10 seconds.**

5) **Give "Rescue Breathing". Remove any material from the patient's mouth or throat. Tilt the head back (see opening the airway), rest your hand on the patient's forehead and pinch their nose closed with your thumb and index finger. Take a full breath, place your lips around the patient's mouth and blow into his/her mouth until the chest rises. Remove your mouth and allow the chest to fall fully. Continue providing 1 breath every 5-6 seconds.**

6) **Give CPR. Place the heel of one hand over the lower 1/3 of the breastbone (where the ribs meet the breastbone). Place the heel of the other hand on top of the hand on the breastbone and intertwine your fingers. Lean over the patient with your arms straight and begin to press down on the chest about 1-1/2 to 2 inches. Complete 15 chest compressions, at a rate of about 80-100 per minute. Give 2 rescue breaths (see "Give Rescue Breathing" above). Continue alternating 15 chest compressions with 2 rescue breaths.**

Treat Choking:

Ask the patient if he/she can speak or cough. If the person cannot speak, give the Heimlich Maneuver. Stand behind the patient, place your fist just above the navel, clasp your fist with the other hand, and give quick, upward thrusts until the object is removed or the person becomes unconscious.

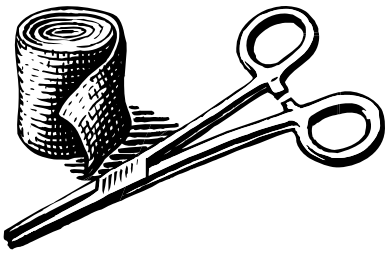
If the person becomes unconscious, give two rescue breaths. If they do not go in, sweep the mouth with your finger, then give abdominal thrusts by straddling the person's legs, placing the heel of your hand (one on top of the other) directly above the navel and give inward, upward thrusts. If breathing starts, lay the person on his/her side with the head tilted back and the top knee bent to prevent rolling forward.

Treat Burns:

Pour cold water on the burned area for 2-3 minutes. Remove any clothing or jewelry that is on or around the burned area, unless they are sticking to the burned area. Cover the burn with a sterile dressing. Do not apply lotions, ointments, or fat (e.g. butter) to the burn. Do not touch the burned area or burst any blisters. Do not cover a facial burn.

Treat Severe Bleeding:

If you have either latex or non-latex gloves, these should be worn at all times while in contact with blood. If not, you can use plastic wrap or layers of cloth. Using a clean pad or dressing, apply direct pressure to the wound for 10 minutes. If no bones are broken, raise an injured limb to above the level of the patient's heart. Lay the patient down to reduce the chance of shock and minimize blood flow. Apply a bandage over the original pad or dressing. Wash your hands thoroughly with soap and water after providing care.



Troubleshooting: What to do if…

The person is injured, but conscious

1. **Assess injuries**
2. **Call an ambulance (if necessary)**
3. **Treat injuries (see First Aid)**

REMINDER:
If the patient has signed a Do Not Resuscitate (DNR) Order, you must show it to the paramedics immediately. Otherwise they are required to perform CPR and other life-saving procedures. The DNR order must be kept with the patient at all times.

The person is unconscious

1. **Call an ambulance**
2. **Open airway and check breathing**

The person is breathing

1. **Place the patient on his/her side or stomach –**
   (only if spinal injury is not suspected)
2. **Wait for the ambulance to arrive**

The person is NOT breathing

1. **Give "Rescue Breathing"**
2. **Check pulse**

There is a pulse present

Continue "Rescue Breathing" and keep checking the pulse until the ambulance arrives

There is NO pulse present

Perform CPR until the ambulance arrives

What is Hospice Care?

- Hospice is a service that provides palliative care to any terminally ill patient with a limited life expectancy of months rather than years.
- Palliative care is aimed at pain relief and symptom control rather than curative treatment.
- Hospice provides comfort and compassion when they are needed most.
- Hospice care enables a person to retain his or her dignity and maintain quality of life during the end of life.
- Hospice care encompasses the support given to the patient and the family during the illness and through their bereavement.

Hospice Philosophy

The national Hospice and Palliative Care Organization defines the Hospice philosophy as:

> "Hospice provides support and care for persons in the last phases of incurable disease so that they may live as fully and as comfortable as possible. Hospice exists in the hope and belief that through appropriate care, and the promotion of a caring community sensitive to their needs, patients and their families may be free to attain a degree of mental and spiritual preparation for death that is satisfactory to them. Hospice offers palliative care to terminally ill people and their families without regard for age, gender, nationality, race, creed, sexual orientation, disability, diagnosis, availability of a primary care giver, or ability to pay."

Hospice of North Central Ohio Mission Statement

In order to affirm life and recognize death as a natural process, Hospice will care for patients and their loved ones, empower them to cope with terminal illness, enhance the quality of life as they prepare for a peaceful, dignified death, and continuously improve the delivery of quality care. We will assist and serve as a resource in the areas of death, dying, grief, and bereavement.

Although end-of-life care may be difficult to discuss, it is best for family members to share their wishes long before it becomes a concern. This can greatly reduce stress when the time for hospice becomes apparent. By having these discussions in advance, patients are not forced into uncomfortable situations. Instead, they can make an educated decision that includes the advice and input of family and friends.

If you have any questions regarding the services of Hospice of North Central Ohio, Inc. please call 1-800-952-2207

When is it Time to Call Hospice?

Many terminally ill people and their families, "ask how will I know when it is the right time to call Hospice"? Of course, there is no single or simple answer to that question. It all depends upon individual circumstances.

A good rule of thumb however is a call sooner rather than later. The Hospice admissions team can assist you in determining if a patient is appropriate in meeting the criteria to become a Hospice patient. Your physician must write the order for Hospice care, and again our Hospice team can assist you with contacting your doctor.

The Hospice team can assist patients and family members in many ways - medically, psychologically, and spiritually, and much more effectively when there is time.

The team can certainly help if they are called in during the last few days of a person's life, but early intervention allows us to provide for full benefits. Typically after the death of a patient our families are likely to say we wish we would have had Hospice sooner.

Hospice care can be provided at home, or in a skilled nursing facility or residential care facility.

Some signs that indicate it is appropriate to call Hospice:

- Life expectancy is six months or less. (Any patient living longer may be recertified by their physician for additional hospice care. Patients may also stabilize, and choose to discontinue Hospice care.)
- There are no more options for curative treatment and/or the individual does not wish to pursue further curative treatment.
- Pain and symptoms have begun to interfere with the quality of life.
- Someone in the family wants to explore spiritual issues that occur at the end of life.
- Information is needed about Living Wills or Advanced Care Directives.

Please call us if you have any questions about hospice care, or if you wish to discuss care for your loved one.

Hospice of North Central Ohio
800-952-2207 Daytime Hours
800-257-9917 After Hours
419-281-7101 Local or
www.hospiceofnorthcentralohio.org

What to do as Death Approaches

This particular phase of caregiving is likely one of the most difficult life experiences that you will have. This is an extremely emotional and overwhelming time. You may find it helpful to identify additional individuals you can call for support. It also helps to be informed about what to expect at the end of life so that you can be prepared when the time comes. Although it is difficult to predict exactly when a terminally ill person will die, a combination of signs and symptoms can signal that the time is getting close. Not all symptoms will appear at the same time, and some may never appear. However, all of the following symptoms are normal and expected at the time of death. If you have any questions or concerns, do not hesitate to call your Hospice office.

Signs and Symptoms of Approaching Death:

- **Decreases in the need for food and fluids may occur. Your loved one will probably say that he/she doesn't have an appetite and isn't hungry. The body naturally begins to conserve energy and requires less nourishment. This is the body's natural response to the dying process. It is telling you that eating and drinking are no longer helpful and that the body can no longer use food and fluid properly.**

  ### What to do:

  - **Contact the Hospice nurse (if you are using one) so that he/she can suggest alternative ways to give medications.**
  - **Offer fluids in small sips, but do not force.**
  - **Allow your loved one to choose when and what to eat or drink, even if this means little or nothing will be eaten or drunk.**
  - **Offer food or drink, but do not force.**
  - **Nutritional supplements may be indicated in some cases but, again, do not force.**
  - **Discuss alternatives with the Hospice nurse (if you are using one).**

- **Hands, arms, feet, and legs may become cool to the touch. You may notice the underside of the body becoming much darker in color. The skin may turn a bluish color with purplish splotches. This is the result of blood circulation slowing down.**

  ### What to do:

  - **Use blankets for warmth to prevent the feeling of being cold.**
  - **Do not use an electric blanket or heating pad.**
  - **Be aware that occasionally arms and legs may be cool to touch, but the patient may state that he/she is hot and kick off the blankets.**

- **Your loved one will gradually spend more time sleeping during the day and may be difficult to arouse at times. This is the result of a change in the body's metabolism.**

  ## What to do:

  - **Plan time and activities with your family member for those occasions when he/she seems most alert.**
  - **Don't confuse withdrawal with rejection. Your loved one may not wish to carry on a conversation much of the time, but may be comforted by your voice talking or reading from a favorite book or verse.**
  - **Soft, quiet music may be comforting at this time.**

- **The patient may become increasingly confused about what time it is, where he/she is, and the identity of close and familiar people. The patient may also become restless, see things that are not there, or pull at the bed linen. This is caused by decreases in oxygen circulation to the brain and changes in the body's metabolism.**

  ## What to do:

  - **Remind the patient of the day and time, and who is there with him/her.**
  - **Talk to the patient calmly and reassuringly.**
  - **Sit next to the bed and hold the patient's hand to provide comfort.**
  - **React calmly and behave with confidence, so as not to startle the patient further.**
  - **Always talk as if the patient can hear you, even if he/she appears to be unconscious.**
  - **When providing care, explain what you are doing.**
  - **Keep a light on in the room (soft lighting without shadows) to decrease some of the confusion.**

- **There may be a change in bowel or bladder habits. Loss of control of bowel and/or bladder may occur. If there is a bladder catheter (Foley) in place, you will notice the urine becoming dark, with the amount decreasing as death comes closer.**

  ## What to do:

  - **Ask the Hospice nurse (if you are using one) for pads to put on the bed to protect the linen.**
  - **Change pads as needed to keep the bed as clean and dry as possible.**
  - **Ask the Hospice nurse (if you are using one) to show you how to place pads under the patient and other ways to keep the skin clean, warm, and dry.**

- **Changes in breathing patterns may be noticed. Irregular breathing may occur and there may be a pause for 10-30 seconds where there is no breathing at all. This is called apnea. You may also notice that there are oral secretions that will collect in the back of the throat and cause a noisy breathing called a "death rattle". This happens when a person is too weak to cough or swallow. This symptom is common and indicative of a decrease in circulation and a building up of waste products in the body.**

What to do:

- **Changing the patient's position may help the breathing, but don't become alarmed if it doesn't. A change in breathing pattern is normal and expected.**
- **When oral secretions build up, elevating the head off the bed with pillows or obtaining a hospital bed will make breathing easier.**
- **Use a cool mist humidifier in the room.**
- **Use a moist washcloth to relieve a dry mouth.**
- **Chapstick or Vaseline to the lips may provide comfort.**
- **Try turning the patient on his/her side to keep secretions from getting caught in the throat.**
- **Call the Hospice nurse (if you are using one) for further advice if the patient becomes distressed with these symptoms.**

- **Hearing and vision ability may decrease slightly.**

What to do:

- **Maintain a peaceful, quiet atmosphere.**
- **Keep soft lights on in the room when vision decreases.**
- **Soft music may be comforting.**
- **Be calm and reassuring.**
- **Never assume that the patient cannot hear you when talking to others in the room. Hearing is the last of the five senses to be lost.**

What to do at the time of death:

- **Call the Hospice (if you are using them). Be sure to keep all numbers for the Hospice in an accessible location, so you can refer to them quickly.**
- **DO NOT CALL 911 OR THE PARAMEDICS.**
- **If you are alone, call a friend or family member to be with you.**
- **Note the time that your loved one stopped breathing.**
- **Call the funeral home. They will send someone to the house to take the body directly to the funeral home. You may instruct the funeral home to contact the Hospice.**

End of Life Summary

One to Three Months	One to Two Weeks	Days or Hours	Minutes
• Withdrawal from the world & people • Decreased food intake • Increase in sleep • Going inside of self • Less communication	• Disorientation • Agitation • Talking with the unseen • Confusion • Picking of clothes • Decreased blood pressure • Pulse increase or decrease • Color changes, pale, bluish • Increased perspiration • Respiration irregularities • Congestion • Sleeping but responding • Complaints of body tired & heavy • Not eating, taking little fluids • Body temperature, hot/cold	• Intensification of one to two week signs • Surge of energy • Decrease in blood pressure • Eyes glassy, tearing, half open • Irregular breathing, stop/start • Restlessness or no activity • Purplish knees, feet, hands, blotchy • Pulse weak and hard to find • Decreased urine output • May wet or stool the bed	• "Fish out of water" breathing • Cannot be awakened

Forms

WHEN I'M AN OLD LADY
By Joanne Bailey Baxter, Lorain, OH

When I'm an old lady, I'll live with my kids, and make their life happy and filled with such fun. I want to pay back all the joy they've provided, returning each deed. Oh, they'll be so excited. When I'm an old lady and live with my kids.

I'll write on the wall with red, white, and blue; and bounce on the furniture wearing my shoes. I'll drink from the carton and then leave it out. I'll stuff all the toilets and oh, they'll shout. When I'm an old lady and live with my kids.

When they're on the phone and just out of reach, I'll get into things like sugar and bleach. Oh, they'll snap their fingers and then shake their head, and when that is done I'll hide under the bed. When I'm an old lady and live with my kids.

When they cook dinner and call me to meals, I'll not eat my green beans or salads congealed. I'll gag on my okra, spill milk on the table, and when they get angry, run fast as I'm able. When I'm an old lady and live with my kids.

I'll sit close to the TV, through the channels I'll click. I'll cross both my eyes to see if they stick. I'll take off my socks and throw one away, and play in the mud until the end of the day. When I'm an old lady and live with my kids.

And later in bed, I'll lay back and sigh, and thank God in prayer and then close my eyes; and my kids will look down with a smile slowly creeping, and say with a groan, "she's so sweet when she's sleeping." when I'm an old lady and live with my kids.

Emergency Information

Personal Information

Name_____ **Date of Birth**_____

Address_____

Phone_____

SS#_____ **Insurance#**_____

Medicaid#_____ **Medicare#**_____

List of Medical Conditions_____

_____

Is there an active Do Not Resuscitate (DNR)?	**YES**	**NO**
Do you have an Advanced Health Directive?	**YES**	**NO**
Are you an organ donor?	**YES**	**NO**

Important Numbers

*For all EMERGENCY calls dial 911, for all NON-EMERGENCY calls dial the number provided.

Primary Doctor_____ **Pharmacy**_____

Home Health Care Agency_____

Medical Equipment Provider_____

Family Member's #_____ **Friend/Neighbor**_____

FIRE	**419-289-6511**
POLICE	**419-289-1911**
OHIO STATE HIGHWAY PATROL	**419-289-0911**
SAMARITAN HOSPITAL	**419-289-0491**
POISON CONTROL	**1-800-222-1222**
APPLESEED COMMUNITY MENTAL HEALTH CENTER	**419-289-6111 OR 1-800-400-8500**
MENTAL HEALTH AND RECOVERY BOARD OF ASHLAND COUNTY	**419-281-3139**
OHIO DISTRICT 5 AREA AGENCY ON AGING	**419-524-4144 OR 1-800-860-5799**
ASHLAND COUNTY COUNCIL ON AGING	**419-281-1477**
MEDICAID	**419-282-5000**
MEDICARE	**1-800-633-4227**

Name:____

Date:____________________________

Emergency Contact:____

Medication Records

Medication	
For what condition	
Physician	
Physician's Phone #	
Prescription number	
Pharmacy	
Pharmacy Phone #	

Medication	
For what condition	
Physician	
Physician's Phone #	
Prescription number	
Pharmacy	
Pharmacy Phone #	

Medication	
For what condition	
Physician	
Physician's Phone #	
Prescription number	
Pharmacy	
Pharmacy Phone #	

Medication	
For what condition	
Physician	
Physician's Phone #	
Prescription number	
Pharmacy	
Pharmacy Phone #	

Medication	
For what condition	
Physician	
Physician's Phone #	
Prescription number	
Pharmacy	

CAREGIVER LIST

List all caregivers' names and the special skills that they provide for your loved one.

NAME_________________________ **ADDRESS** _____________________ ______________________________ **PHONE #** ______________________ **CELL #**________________________ **HELPS BY**_____________________ ______________________________	**NAME**_________________________ **ADDRESS** _____________________ ______________________________ **PHONE #** ______________________ **CELL #**________________________ **HELPS BY**_____________________ ______________________________
NAME_________________________ **ADDRESS** _____________________ ______________________________ **PHONE #** ______________________ **CELL #**________________________ **HELPS BY**_____________________ ______________________________	**NAME**_________________________ **ADDRESS** _____________________ ______________________________ **PHONE #** ______________________ **CELL #**________________________ **HELPS BY**_____________________ ______________________________
NAME_________________________ **ADDRESS** _____________________ ______________________________ **PHONE #** ______________________ **CELL #**________________________ **HELPS BY**_____________________ ______________________________	**NAME**_________________________ **ADDRESS** _____________________ ______________________________ **PHONE #** ______________________ **CELL #**________________________ **HELPS BY**_____________________ ______________________________

"One person caring about another represents life's greatest value".
~Jim Rohn

DAILY ACTIVITIES

Preferred Items:

	FOOD	ROUTINE
BREAKFAST (usually at ____a.m.)		
LUNCH (usually at ____a.m./p.m)		
DINNER (usually at ____p.m.)		
BEDTIME (usually at ____p.m.)		

Dislikes:

	FOOD	ROUTINE
BREAKFAST		
LUNCH		
DINNER		
BEDTIME		

Keeping a routine is often comforting for your loved one and helps others in your time of absence. Preferred items can include food, TV programs, music, hobbies, games, etc. Disliked foods can include items that your loved one is allergic to; however, make sure you note that for any other caregivers.

Weekly Activity Log

Week of _____

Personal Care	**N**	**M**	**T**	**W**	**R**	**F**	**S**	**Mobility**	**N**	**M**	**T**	**W**	**R**	**F**	**S**
Bed Bath								Assistive Devices							
Shower/Chair								Ambulation							
Sink Bath								Cane/Walker/ WC							
Tub Bath								Complete Bed Rest							
Perineal Care								Hoyer Lift							
Comb/Brush Hair								Position/Side Rails							
Shampoo/Set								ROM							
Skin Care								Transfers							
Lotion/Powder								Turn/Position							
Nail Care								**Homemaking**							
Foot Care/Soak								Bathroom							
Elevate Feet								Bedroom							
Shave								Kitchen							
Oral/Denture Care								Living Room							
Dressing								Garbage							
Incontinence Care								Errands							
Empty Urine/BSC															
Commode/Bedpan								**Nutrition**							
Toilet Assist								Meal Prep B/L/D							
Medication Reminder								Feeding Assistance							

Notes: _____

_____

_____

CAREGIVING LOG

This may include any concerns, questions or comments that you and the other caregivers have. It may also include phone calls to physicians or any other health care providers.

DATE/ TIME	CONCERNS, QUESTIONS, COMMENTS, etc. (If you spoke with a health care provider, you may also want to note what they suggested.)

MEDICAL HISTORY

This can include any medical conditions, hospitalizations, surgeries, tests, etc.

DATE	DESCRIPTION OF EVENT	PHYSICIAN	HOSPITAL	RESULTS/NOTES

QUESTIONS FOR NEXT MEDICAL VISIT

Appointment Date and Time_____

Will be seeing Dr. _____for _____

Has been experiencing _____

_____

QUESTION	RESPONSE
1.	**1.**
2.	**2.**
3.	**3.**
4.	**4.**

Results of Visit (any changes to medication, tests ordered, etc.)_____

_____

_____

Next Appointment _____

Comments_____

_____

_____

_____

_____

_____

Geriatric Depression Scale (GDS) Short Form

Choose the best answer for how you have felt over the past week:

1. Are you basically satisfied with you life?	YES	**NO**
2. Have you dropped many of your activities and interests?	**YES**	NO
3. Do you feel that your life is empty?	**YES**	NO
4. Do you often get bored?	**YES**	NO
5. Are you in good spirits most of the time?	YES	**NO**
6. Are you afraid that something bad is going to happen to you?	**YES**	NO
7. Do you feel happy most of the time?	YES	**NO**
8. Do you often feel helpless?	**YES**	NO
9. Do you prefer to stay at home, rather than going out and doing new things?	**YES**	NO
10. Do you feel you have more problems with memory than most?	**YES**	NO
11. Do you think it is wonderful to be alive now?	YES	**NO**
12. Do you feel pretty worthless the way you are now?	**YES**	NO
13. Do you feel full of energy?	YES	**NO**
14. Do you feel that your situation is hopeless?	**YES**	NO
15. Do you think that most people are better off than you are?	**YES**	NO

Answers in **bold** indicate depression, and each of these answers counts as one point. A score greater than 5 suggests depression and warrants further evaluation. Scores greater than 10 are almost always depression.

Short Michigan Alcoholism Screening Test-- Geriatric Version (short MAST-G)

Choose the best answer for how you have felt over the last year:

1. When talking with others, do you ever underestimate how much you actually drink?	YES	NO
2. After a few drinks, have you sometimes not eaten or been able to skip a meal because you didn't feel hungry?	YES	NO
3. Does having a few drinks help decrease your shakiness or tremors?	YES	NO
4. Does alcohol sometimes make it hard for you to remember parts of the day or night?	YES	NO
5. Do you usually take a drink to relax or calm your nerves?	YES	NO
6. Do you drink to take your mind off your problems?	YES	NO
7. Have you ever increased your drinking after experiencing a loss in your life?	YES	NO
8. Has a doctor or nurse ever said they were worried or concerned about your drinking?	YES	NO
9. Have you ever made rules to manage your drinking?	YES	NO
10. When you feel lonely, does having a drink help?	YES	NO

If the person answered **YES** to two or more questions, encourage them to have a talk with the doctor.

This test is courtesy of the University of Michigan Alcohol Research Center. For further information about this test you may contact Fredric C. Blow, Ph.D., at University of Michigan Alcohol Research Center, 400 E. Eisenhower Parkway, Suite A, Ann Arbor, MI 48108; (734) 998-7952.

Caregiver self-assessment questionnaire
How are YOU?

Caregivers are often so concerned with caring for their relative's needs that they lose sight of their own well-being. Please take just a moment to answer the following questions. Once you have answered the questions, turn the page to do a self-evaluation.

During the past week or so, I have ...

1. Had trouble keeping my mind on what I was doing ..... ☐ Yes ☐ No
2. Felt that I couldn't leave my relative alone ..... ☐ Yes ☐ No
3. Had difficulty making decisions ..... ☐ Yes ☐ No
4. Felt completely overwhelmed ..... ☐ Yes ☐ No
5. Felt useful and needed ..... ☐ Yes ☐ No
6. Felt lonely ..... ☐ Yes ☐ No
7. Been upset that my relative has changed so much from his/her former self ..... ☐ Yes ☐ No
8. Felt a loss of privacy and/or personal time ..... ☐ Yes ☐ No
9. Been edgy or irritable ..... ☐ Yes ☐ No
10. Had sleep disturbed because of caring for my relative ..... ☐ Yes ☐ No
11. Had a crying spell(s) ..... ☐ Yes ☐ No
12. Felt strained between work and family responsibilities ..... ☐ Yes ☐ No
13. Had back pain ..... ☐ Yes ☐ No
14. Felt ill *(headaches, stomach problems or common cold)* ..... ☐ Yes ☐ No
15. Been satisfied with the support my family has given me ..... ☐ Yes ☐ No
16. Found my relative's living situation to be inconvenient or a barrier to care ..... ☐ Yes ☐ No
17. On a scale of 1 to 10, with 1 being "not stressful" to 10 being "extremely stressful," please rate your current level of stress. _____
18. On a scale of 1 to 10, with 1 being "very healthy" to 10 being "very ill," please rate your current health compared to what it was this time last year. _____

AMA
AMERICAN MEDICAL ASSOCIATION

Self-evaluation

To determine the score:

1. Reverse score questions 5 and 15. *(For example, a "No" response should be counted as "Yes" and a "Yes" response should be counted as "No.")*
2. Total the number of "yes" responses.

To interpret the score

Chances are that you are experiencing a high degree of distress:

- If you answered "Yes" to either or both questions 4 and 11; or
- If your total "Yes" score = 10 or more; or
- If your score on question 17 is 6 or higher; or
- If your score on question 18 is 6 or higher

Next steps

- Consider seeing a doctor for a check-up for yourself
- Consider having some relief from caregiving (Discuss with the doctor or a social worker the resources available in your community.)
- Consider joining a support group

FINANCIAL, LEGAL & MEDICAL AGENTS

	NAME	ADDRESS/PHONE	NOTES
ACCOUNTANT			
BANKER			
INSURANCE			
LAWYER			
CONSERVATOR/ REPRESENTATIVE PAYEE			
GUARDIAN			
HEALTH CARE POWER OF ATTORNEY			
POWER OF ATTORNEY			

Conservator is a court appointed person that handles the financial affairs of someone deemed mentally incompetent.
Representative Payee is the person authorized to receive the elder's Social Security check in order to pay bills.
Guardian is a court appointed person that handles both personal and financial matters for someone deemed mentally incompetent.
Health Care Power of Attorney is authorized to make medical decisions in case of mental incapacity.
Power of Attorney is the legal authorization to handle both personal and financial matters for the elder.
Durable Power of Attorney stays in effect if the person becomes mentally incapacitated.

BANKING & INSURANCE INFORMATION

(CONFIDENTIAL)

Bank_____ **Phone #**_____
Address _____
Checking Acct. #_____ **Other Name on Acct.** _____
Savings Acct # _____ **Other Name on Acct.** _____
Additional Acct # _____ **Other Name on Acct.** _____
Notes _____
_____

Bank_____ **Phone #**_____
Address _____
Checking Acct. #_____ **Other Name on Acct.** _____
Savings Acct # _____ **Other Name on Acct.** _____
Additional Acct # _____ **Other Name on Acct.** _____
Notes _____
_____

Insurance

	Agent/Company Information	**Policy #**	**Notes**
Automobile			
Automobile			
Disability			
Home			
Life			
Other			
Other			

Personal Monthly Budget

PROJECTED MONTHLY INCOME	
	Income 1
	Extra income
	Total monthly income

PROJECTED BALANCE
(Projected income minus expenses)

ACTUAL BALANCE
(Actual income minus expenses)

ACTUAL MONTHLY INCOME	
	Income 1
	Extra income
	Total monthly income

DIFFERENCE
(Actual minus projected)

HOUSING	Projected Cost	Actual Cost
Mortgage or rent		
Electricity		
Water and sewer		
Waste removal		
Maintenance or repairs		
Supplies		
Other		
Subtotals		

TRANSPORTATION	Projected Cost	Actual Cost
Bus/taxi fare		
Insurance		
Licensing		
Fuel		
Maintenance		
Other		
Subtotals		

INSURANCE	Projected Cost	Actual Cost
Home		
Health		
Life		
Other		
Subtotals		

FOOD	Projected Cost	Actual Cost
Groceries		
Dining out		
Other		
Subtotals		

PETS	Projected Cost	Actual Cost
Food		
Medical		
Grooming		

ENTERTAINMENT	Projected Cost	Actual Cost
Video/DVD		
Movies		
Sporting events		
Other		
Other		
Other		
Subtotals		

LOANS	Projected Cost	Actual Cost
Personal		
Credit card		
Credit card		
Credit card		
Other		
Subtotals		

TAXES	Projected Cost	Actual Cost
Federal		
State		
Local		
Other		
Subtotals		

SAVINGS OR INVESTMENTS	Projected Cost	Actual Cost
Retirement account		
Investment account		
Other		
Subtotals		

GIFTS AND DONATIONS	Projected Cost	Actual Cost
Charity 1		
Charity 2		
Charity 3		
Subtotals		

Toys			**LEGAL**	Projected Cost	Actual Cost
Other			Attorney		
			Other		
PERSONAL CARE	Projected Cost	Actual Cost	Other		
Medical			***Subtotals***		
Hair/nails					
Clothing			**TOTAL PROJECTED COST**		
Dry cleaning					
Health club			**TOTAL ACTUAL COST**		
Organization dues or fees					
Other			**TOTAL DIFFERENCE**		
Subtotals					

QUARTERLY BILLS

EXPENSE	COMPANY	ACCOUNT #	DUE DATE	AMOUNT
Income Tax				
Property Tax				

CONFIDENTIAL

Net Worth Worksheet

Estimated Net Worth:

Date_____

Assets	
Personal Items	**Estimated Value**
Home	
Vehicles	
Jewelry	
Artwork	
Furniture	
Electronics	
Antiques	
Other	
Cash or Cash Equivalent	
Checking account	
Savings account	
Certificates of deposit	
Money market account	
Life insurance (cash value)	
Other	
Investments	
Retirement account	
Bonds	
Mutual funds	
Individual stock shares	
Real estate other than home	
Other	
Assets Total	

Liabilities	
Loan Balances	**Estimated Value**
Mortgage loan	
Home equity loan	
Car loans	
Real estate loans	
Student loans	
Other loans	
Other Outstanding Debt	
Credit card debt	
Other debt	
Liabilities Total	

MY INFORMATION

Suggested Instructions:

1. Fill out pages in pencil on all information that is subject to change or needs to be updated. Fill out rest of information with black pen.
2. Some of your important papers should be kept in a safe place, but not in your Safety Deposit Box because when you need to get them you may not be able to retrieve it..
3. These papers should be kept at home.
4. Chose who you would want to take care of your private matters now and give them a copy after filling them out.
5. Keep these papers safe by placing them in a fire proof box. If you do not have one you can place them in your "freezer" after it has been securely wrapped in a freezer ziplock bag and sealed properly. This keeps them from being destroyed by fire.
6. It will be necessary for you to update this information from time to time.
7. You may consider having a house key made and give to your trusted family member or friend so they will be available to you in case of injury, illness or death.

List of Names, Addresses, Phone Numbers and relationship of people I would want to be contacted right away in case of emergency.

_____

_____

_____

_____

PLEASE KEEP ALL OF THIS INFORMATION GIVEN TO YOU PRIVATE

Name of person(s) and phone number given a copy of "My Information"

_____

_____

FROM _____ DATE _____

PRESENTED TO:_____

It is my hope that I may be spared from anxiety at the time of my death by knowing that I have tried to be prepared for this event.

Enclosed is the information which I have recorded to help with the arrangements necessary at that time. This also contains vital statistics and many other types of information you will need.

MY INFORMATION:

NAME _____
(birth name, married name(s)

Address _____zip_____

Date of Birth _____ Social Security Number _____
Birthplace _____
state city county
Education (School, degrees, year)
_____
_____
_____

Occupation _____ Workplace _____
Workplace address _____Year begun _____
Prior Employment (places & dates)
_____
_____
_____

Mother's Maiden Name _____
Birthplace _____ Date of Birth _____

Father's Name _____
Birthplace _____ Date of Birth_____

Your Marital Status : ____ single ____ married ____widowed ____divorced

Name of Spouse _____ Date of Birth _____
Date Married _____ Date of Death / Divorce _____

Name of Spouse _____ Date of Birth _____
Date Married _____ Date of Death / Divorce _____

Civic Activities _____

Military Service _____

Church Affiliation(s)_____

Church Activities _____

Citations, Awards _____

Hobbies _____

State Resident Since (month & year)_____

Previous Residence (city & years) _____

Unusual Background Interest or Activities _____

_____

_____

_____

Medical Information
(You may need to know before my death)

Allergies to drugs, certain conditions

_____

Name and type of Doctor & Phone Number _____
Name and type of Doctor & Phone Number _____

Family or Friends I want notified in case of illness or hospitalization: (Name & Phone Numbers)

_____

_____

_____

Funeral Home
(Name, address, phone number)

_____

_____

Cemetery

Name of Cemetery_____
Address & phone_____
Deed Information_____
_____

MEMORIAL INSTRUCTIONS

Place of Service _____

Name of Church _____ Phone_____
Church Address _____

Participating Organization (Military or Fraternal)
_____

Type of Service _____open _____closed

Casket ___Metal ___Wood ___Fiberglass, Color (ext) _____ Color (int) _____
Vault/Memorial ___Bronze, ___Granite, ___Other_____ Flowers ___yes ___no,
Flowers color and type preferred _____
Some of flowers, plants taken to after funeral_____

Flag __yes ___no, Fold, Place at Head of Casket __yes __no, To Drape Casket ___yes ___no

Clothing used: ___Current Wardrobe, ___New, ___Other, _____
Jewelry __on __off, if on, which ones _____
If off, give jewelry to who and which ones _____
Glasses ___on ___off, if off what to do with them _____
Music __yes __no, organist___, tape/DVD___, soloist___ Name _____
Music selections: _____
_____
_____
_____

Favorite Bible verses you want read_____
_____
_____
Other Literature you want read _____
_____
_____

Special instructions_____
_____
_____
_____

Pall Bearers _____
_____
_____

Grave Stone ___not purchased, type desired_____
Inscription, picture, etc. wanted on stone_____
_____
_____
Purchased when and where _____

Suggested Memorial(s) Name & Addresses _____

Preceded in Death are:

Name	Relationship	Date of Death

Surviving are: (Parents, spouse, children, brothers, sisters)

Name	Relationship	Residence (city,state)

_____Number of Grandchildren _____Number of Great Grandchildren

WHOM TO CONTACT

Name	Address	Phone	Relationship

List of Credit Cards--Name and Account Numbers

_____

_____

Mortgage Lender

_____

Landlord's Name, Address, Phone Number _____

_____

Receive Social Security ____yes ____no
Receive Pension (name, address, phone) _____
Name of Power of Attorney _____
Address, Phone Number of POA _____
Copy of Living Will / Power of Attorney (POA) at hospital ____yes ____no

Newspapers for Obituary notices:
1. _____ 2._____
3._____ 4._____

Electric Company _____
Water & Sewer Company _____
Heating Company _____
Phone Company _____
Newspaper _____

Other important bills need information on

_____

_____

_____

Employer--name of company, who to contact, address and phone number

_____

_____

Florist--name, address, phone number

_____

If necessary which nursing home I prefer -- name, address, phone number

_____

Any other important information not asked already_____

_____

_____

_____

_____

Important Information: **Social Security and Veternan's Benefits**--You may be entitled to some type of benefits. These **benefits must be applied for: they are not paid automatically.** Contact the local Social Security office and Department of Veteran's Affairs.

WEBSITES

Caregiving

AARP Webplace
http://www.aarp.org/family/caregiving
1-888-687-2277
"This site has a caregiving section that discusses caregiving options and includes information on caregiver support, long-term care financing, help with home care, housing options, assistive devices, and caregiving for adult children. Click on Family on the main page to access caregiving information".

Aging Parents and Elder Care
http://www.aging-parents-and-elder-care.com/
"Helping people overcome the challenges of elder care".

AgingPro
http://www.agingpro.com
"Online directory of aging and caregiver support services. Offers access to professionals in aging, resources, educational articles, virtual classroom, ask the expert, and support groups".

AGIS
http://www.agis.com/
"Provides information and planning tips about long-term care and caregiving. Its website helps consumers find long-term care housing, caregiver support, hospice and palliative care programs and other aging services".

Caregiving.com
http://www.caregiving.com
773-343-6341
"This site is useful for family members and professional health care providers. The site offers weekly and monthly tips as well as a support center that is full of stories written and sent in by caregivers".

Caring.com
http://www.caring.com
"Provides expert advice, practical information, easy to use tools, and person-to-person support you will need to make the caregiving journey easier".

Children of Aging Parents
http://www.caps4caregivers.org
1-800-227-7294
"A non-profit, charitable organization that strives to assist caregivers of the elderly or chronically ill with information, referrals, and support".

Family Caregiver Alliance
http://www.caregiver.org/
1-800-445-8106
"This website has an excellent series of caregiver fact sheets, a statistics and research section with several research articles of interest to caregivers, and the links to other useful resources".

CAREGIVING cont.

National Family Caregivers Association (NFCA)
http://www.thefamilycaregiver.org/ or http://www.nfcacares.org/
1-800-896-3650
"The NFCA site provides caregivers with tips, advocacy updates, as well as information on communicating effectively with healthcare professionals. The site also offers a section on sharing your caregiving story".

National Alliance for Caregiving
http://www.caregiving.org
"The Alliance supports family caregivers and the professionals who help them and works to increase public awareness of issues facing family caregivers. The website features peer-reviewed links to other resources for family caregivers".

ShirleyBoard
http://www.shirleyboard.com
"ShirleyBoard is an online community for people that are caring for aging loved ones".

Strength for Caring Resource Center
http://www.strengthforcaring.com
1-866-466-3458
"Is a comprehensive website designed to provide family caregivers with a broad range of expert content and information, an emerging on-line community, daily inspiration, and much needed support".

The Well Spouse Association
http://www.wellspouse.org/
1-800-838-0879
"The Association is a national, non-profit organization that provides support to husbands, wives, and partners of chronically ill and/or disabled people".

Counseling

Mental Health America
http://www.mentalhealthamerica.net
1-800-969-6642
Mental Health America's programs help it to fulfill its mission of "promoting mental health, preventing mental disorders and achieving victory over mental illness through advocacy, education, research and services."

Mental Health and Recovery Board of Ashland County
http://www.ashlandmhrb.org
419-281-3139
"The Network of Care Web Site provides our community with access to the latest information and resources available for health and social services. The web site has been customized for Ashland County".

National Alliance for Mental Illness (NAMI)
http://www.nami.org/ Nationwide
http://www.namiohio.org/ Statewide
http://www.ashlandmhrb.org Locally
419-281-3139 ext. 227
NAMI is the nation's largest grassroots organization for people with mental illness and their families. NAMI members and friends work to fulfill their mission by providing support, education, and advocacy.

The National Institute for Mental Health (NIMH)
http://www.nimh.nih.gov
1-866-615-6464
The National Institute of Mental Health is the largest scientific organization in the world dedicated to research focused on the understanding, treatment, and prevention of mental disorders and the promotion of mental health.

Ohio Advocates for Mental Health
http://www.ohioadvocates.org/
1-800-589-2603
The mission of Ohio Advocates for Mental Health is to enhance the quality of life for people labeled with mental illness. Their vision is that people labeled with mental illness will live, work, and thrive in their communities.

Substance Abuse and Mental Health Services Administration (SAMSHA)
http://www.samsha.gov/
1-877-726-4727
SAMSHA wants a life in the community for everyone. Its' mission is on building resilience and facilitating recovery for people with or at risk for mental or substance abuse disorders.

FINANCIAL

Benefits Checkup
http://www.benefitscheckup.org
"Developed and maintained by the National Council on Aging, this site is the nation's most comprehensive Web-based service to screen for benefits programs for seniors with limited income and resources".

Eldercare Locator
http://www.eldercare.gov
1-800-677-1116
"A free national service of the Administration of Aging, U.S. Department of Health and Human Services, in partnership with the National Association of State Units on Aging. This nationwide service helps identify local resources for seniors".

Government Benefits
http://www.govbenefits.gov
1-800-333-4636
"Find out about government benefit eligibility information through a free, confidential and easy-to-use online tool. Answer some basic questions and receive a customized report listing the benefit programs for which you or your loved one in eligible".

National Association of County Veteran Service Officers (NACVSO)
http://www.nacvso.org
419-282-4225 Jane Roland
"Provides assistance in obtaining veterans' benefits and answers questions regarding rules and regulations concerning veterans. Website provides directory of Veteran Service Officers across the country".

Ohio Veteran's Affairs Office
http://veteransaffairs.ohio.gov/
1-614-644-0898
"Provides aged or disabled veterans with rehabilitative, residential and medical care and services. The VA also helps veterans and their families to present claims for veterans' benefits to the federal government and offers veterans low-cost loans to acquire farms and homes".

FINANCIAL cont.

Social Security Administration
http://www.ssa.gov
1-800-772-1213
1-800-325-0778 TTY
"This site has an online screening tool to identify eligibility for Social Security programs and an online application for benefits".

U.S. Department of Veteran Affairs
http://www.va.gov
1-800-827-1000
"Provides veterans with information on health care and other benefits they are entitled to receive".

HOUSING

Alzheimer's Association CareSource
http://www.alz.org/caresource
1-800-272-3900
1-866-403-3073 TTY
"This suite of online programs helps caregivers find useful tools for decision making and care".

Consumer Consortium on Assisted Living
http://www.ccal.org
1-703-533-8121
"Nationwide consumer organization focused on the needs, rights and protection of assisted living consumers, their caregivers and loved ones".

Medicare's Nursing Home Compare
http://medicare.gov/NHcompare/home.asp
1-800-633-4227
"Get detailed information about the past performance of every Medicare and Medicaid certified nursing home in the country. Search by city, state, zip code or name".

National Citizens' Coalition for Nursing Home Reform
http://www.nccnhr.org
1-202-332-2276
"An advocacy group that works to protect the rights of those living in a nursing home".

A Place for Mom
http://www.aplaceformom.com
1-877-666-3239
"A Place for Mom is a free referral service dedicated to helping families find safe, affordable – and wonderful- senior care for their loved ones".

SNAP for Seniors
http://www.snapforseniors.com
1-888-651-7627
"SNAP for Seniors simplifies your search for senior housing".

LEGAL

National Academy of Elder Law Attorneys
http://www.naela.org
1-520-881-4005
"Consumers are provided with information about elder law and how to contact elder law attorneys in their area".

Ohio State Legal Services Association
http://www.ohiolegalservices.org
1-866-529-6446
"Offers an online public law library and a list of Ohio organizations that provide free or low-cost legal services or referrals".

Pro Seniors
http://www.proseniors.org
1-800-488-6070
"Provides free legal services and referrals to older adults".

MEDICAL

Administration on Aging
http://www.aoa.gov
1-202-619-0724
"The site is designed to provide a comprehensive overview of a wide variety of topics, programs and services related to aging".

Area Agency on Aging
http://www.agingnorthcentralohio.org
1-800-860-5799
"Within this web site you will find useful information on services, programs and options for caregivers and older consumers".

Government website for Seniors
http://www.seniors.gov
1-800-333-4636
"The website provides official information and services from the U.S. government for seniors".

Medicaid
http://www.cms.hhs.gov/home/medicaid.asp
"The website provides information about the Medicaid program. You can also find healthcare providers or search lists of special topics".

Medicare
http://www.medicare.gov
1-800-633-4227
"The official U.S. government website for people with Medicare. Online tools help you learn about the many Medicare plans available".

NeedyMeds
http://www.needymeds.org
"The website assists people with finding help for the cost of medicine".

Ohio Department of Aging
http://www.aging.ohio.gov
1-800-266-4346
"The Ohio Department of Aging serves more than 2 million older Ohioans. They help mature adults live active, healthy and independent lives through programs like their well-known Golden Buckeye Card".

Ohio Senior Health Insurance Information Program
http://www.ohioinsurance.gov
1-800-686-1578
"OSHIIP staff educate consumers about Medicare, certain Medicaid issues, long-term care insurance and other health insurance matters".

Partnership for Prescription Assistance Program
http://www.pparx.org
1-888-477-2669
"Helps consumers access various prescription assistance programs. Ohio's Best Rx is an example of this program. You can access Ohio's Best Rx directly by calling 1-866-923-7879.

RxHope
http://www.rxhope.com
1-732-507-7400
"RxHope is exactly what its name implies...a helping hand to people in need of obtaining critical medications that they would normally have trouble affording".

TogetherRx
http://www.togetherrxaccess.com
1-800-444-4106
"The card provides prescription medicine discounts. You must not be eligible for Medicare to enroll".

Old Age Alphabet

- **A for arthritis,**
- **B for bad back,**
- **C is for chest pains. Perhaps cardiac?**
- **D is for dental decay and decline,**
- **E is for eyesight--can't read that top line.**
- **F is for fissures and fluid retention**
- **G is for gas (which I'd rather not mention**
- **H high blood pressure (I'd rather have low)**
- **I is for incisions with scars you can show.**
- **J is for joints, that now fail to flex**
- **L for libido--what happened to sex?**
- **Wait! I forgot about K!**
- **K is for my knees that crack when they're bent**
- **M is for my memory which ain't worth a cent**
- **N for neurosis, pinched nerves and stiff neck**
- **O is for osteo- and all bones that crack**
- **P for prescriptions, I have quite a few**
- **Give me another pill; I'll be good as new!**
- **Q is for queasiness. Fatal or flu?**
- **R is for reflux--one meal turns into two**
- **S is for sleepless nights, counting my fears**
- **T for tinnitus--I hear bells in my ears**
- **U is for urinary: difficulties with flow**
- **V is for vertigo, that's "dizzy", you know.**
- **W is worry, now what's going 'round?**
- **X is for X ray--and what might be found.**
- **Y for another year I've left behind**
- **Z is for zest that I still have my mind,**

I have survived all the symptoms my body's deployed and kept twenty-six doctors gainfully employed!!!

~Author Unknown

Older Than Dirt Quiz :

Count all the ones that you remember not the ones you were told about

Ratings at the bottom.

1 Blackjack chewing gum
2. Wax Coke-shaped bottles with colored sugar water
3. Candy cigarettes
4. Soda pop machines that dispensed glass bottles
5. Coffee shops or diners with table side juke boxes
6 . Home milk delivery in glass bottles with cardboard stoppers
7. Party lines on the telephone
8. Newsreels before the movie
9. P.F. Flyers
10. Butch wax
11. TV test patterns that came on at night after the last show and were there until TV shows started again in the morning. (there were only 3 channels, if you were fortunate)
12. Peashooters
13. Howdy Doody
14. 45 RPM records
15. S & H green stamps
16. Hi-fi's
17. Metal ice trays with lever
18. Mimeograph paper
19 Blue flashbulbs
20. Packards
21. Roller skate keys
22. Cork popguns
23. Drive-ins
24. Studebakers
25. Wash tub wringers
26. Smelling salts
If you remembered 0-5 = You're still young
If you remembered 6-10 = You are getting older
If you remembered 11-15 = Don't tell your age,
If you remembered 16-25 = You're older than dirt!