Honoring Choices® MASSACHUSETTS

CareDimensions HOSPICE | PALLIATIVE CARE | SUPPORT SERVICES

Massachusetts Health Care Proxy
Instructions and Form

Instructions: To create a valid Massachusetts Health Care Proxy, first, print this document so you have the instructions and the blank form in front of you. You can use the instructions as a checklist as you fill out the form.

- ☐ **On the first part:**
  - Print your full name in the blank space, followed by your address.
- ☐ **My Health Care Agent is:**
  - Print the name and address of the person you are appointing as your Health Care Agent.
    - Remember – your Agent can be any adult you trust to make medical decisions for you based on your choices and preferences for care;
    - But your Agent cannot be a person who is employed in the facility where you are a patient unless they are related to you by blood, marriage or adoption.
  - Then fill in the phone numbers (home, a business, a cell phone) where your Agent can be quickly and easily reached.
- ☐ **My Alternate Health Care Agent:**
  - It's a good idea to appoint an Alternate Health Care Agent in case your Health Care Agent can't be reached in a reasonable amount of time. Here, if you choose to, fill in the Alternate Agent's information just as you did above.
- ☐ **My Health Care Agent's Authority:**
  - Here is where you give your Agent the authority to make decisions for you.
  - If there are certain decisions you don't want your Agent to make, or any instructions you have, list here. If there are no limits or instructions, just leave this area blank so your Agent has full decision making authority for any health care situation that comes up.
- ☐ **SIGNED and Date:**
  - Sign your full name and fill in the date you sign it.
- ☐ **Witness Statement and Signature** (Mandatory)
  - Two adults must be present as witnesses when this document is signed, and they must sign and date this document after you do. Keep in mind that they are not being given any authority at all and are there only to witness you sign the document, or witness another person sign it at your direction;
  - Any adult can be a witness except your Health Care Agent and Alternate Agent;
  - Have Witness One sign, then print his or her name and the date;
  - Then have Witness Two do the same thing in their space.
- ☐ **Health Care Agent Statement:** (Optional)
  - This section isn't required in Massachusetts, but it can be helpful because it lets your care providers know that the Agents you appointed have accepted their roles and responsibilities. If you choose to use this section, have your Agent(s) sign and date in the spaces provided.

That's it! Keep the completed Health Care Proxy and give a copy to your Health Care Agent, and a copy to your doctors & care providers to place in your medical record. For more information, call Care Dimensions at 888-283-1722 or email us at info@CareDimensions.org.

Massachusetts Health Care Proxy

I,_____ Address: _____,

appoint the following person to be my Health Care Agent with the authority to make health care decisions on my behalf. This authority becomes effective if my attending physician determines in writing that I lack the ability to make or communicate health care decisions myself, according to Chapter 201D of the General Laws of Massachusetts.

My Health Care Agent is:

Name: _____ Address: _____

Phone(s): _____; _____; _____

If my Agent is not available, willing or competent to serve and to make a timely decision, I appoint as

My Alternate Health Care Agent:

Name _____ Address: _____

Phone(s): _____; _____; _____

My Health Care Agent's Authority

I give my Health Care Agent the same authority I have to make all health care decisions including end of life care and life-sustaining treatment decisions, except (list limits to authority or give instructions, if any)

_____

_____.

I authorize my Health Care Agent to make health care decisions based on the choices and preferences contained in my personal directive if I have one, and on his or her assessment of my wishes. I give my Health Care Agent the same rights I have to the use and disclosure of my health information and medical records as governed by the Health Insurance Portability and Accountability Act of 1996 (HIPAA), 42 U.S.C. 1320d. Photocopies of this Health Care Proxy have the same force and effect as the original.

I sign my name and date this Health Care Proxy in the presence of two witnesses.

SIGNED:_____ **DATE** _____

Witness Statement and Signature (Mandatory)
We, the undersigned, have witnessed the signing of this document by or at the direction of the signatory above and state the signatory appears to be at least 18 years old, of sound mind and under no constraint or undue influence.

Witness One		***Witness Two***	
Signed:	_____	Signed:	_____
Print Name:	_____	Print Name:	_____
Date:	_____	Date:	_____

Health Care Agent Statement (Optional):
We have read this document carefully and accept the appointment.
Health Care Agent _____ Date _____
Alternate Health Care Agent _____ Date _____