

Advance Planning Resources

About: No matter your age, it is important to know what your wishes are in the event of an emergency. This guide walks you through some of the basics of advance planning and provides resources that can help guide you through having these conversations with family, friends, and care providers.

Although many people think that advance care planning is only for seniors, this is not the case. Everyone over the age of 18 should have a completed advance directive.

Please note that the Generation Patient as an organization is not responsible for the legal accuracy of this document.

If you have any questions, comments, concerns, or a link isn't working, please contact admin@generationpatient.org.

Table of Contents

- Glossary
- Things to Think About
 - Considerations for Advance Directives
 - Talking Points for POLST
 - Considerations for POLST
- Resources
 - American Bar Association Advance Planning Toolkit
 - Samada Advance Directive Guides
 - National POLST Resources
 - Other Resources
- State Resources
 - POLST/MOST Resources
 - Advance Directives
 - Registries

Glossary

From the American Hospital Association's ["Put it in Writing: Questions and Answers on Advance Directives"](#)

Advance Directive	A document in which a person either states choices for medical treatment or designates who should make treatment choices if the person should lose decision-making capacity.
Decision Making Capacity	The ability to make choices that reflect an understanding of the nature and consequences of one's actions.
Durable Power of Attorney for Healthcare	An advance directive in which an individual names someone else (the "agent" or "proxy") to make health care decisions in the event the individual becomes unable to make them. The DPOA can also include instructions about specific possible choices to be made.
Life Sustaining Treatment	A medical intervention administered to a patient that prolongs life and delays death.
Persistent Vegetative State	As defined by the American Academy of Neurology, "a form of eyes-open permanent unconsciousness in which the patient has periods of wakefulness and physiologic sleep/wake cycles but at no time is aware of himself or his environment."
Physician Orders for Life Sustaining Treatment	The POLST form, also known as Medical Orders for Sustaining Treatment (MOST), is a portable, written medical order from a physician, nurse practitioner or physician assistant that helps give people with serious illnesses more control over their own care by specifying the types of medical treatment they want to receive during serious illness. (polst.org)
Proxy	A person appointed to make decisions for someone else, as in a durable power of attorney for health care (also called a surrogate or agent).

Things to Think About

Considerations for Advance Directives

- If your heart stops beating, would you want to be resuscitated?
- If you could no longer breathe on your own, would you want to be put on a ventilator?
- If you were unable to eat, would you want artificial nutrition to be administered?
- If you had a life-limiting illness, would you want to receive antibiotics that might prolong your life?
- Do you want to be an organ donor?

Talking Points for POLST (polst.org)

- Your current medical conditions (diagnosis)
- What is likely to happen as your condition progresses (prognosis)
- Your goals of care, what you want to do, what you enjoy doing
- Treatment options and how they affect what you want to be doing

Considerations for POLST (polst.org)

- Are you okay going to the hospital or would you want to stay where you are?
- Are you okay going into the intensive care unit and potentially being on life support?
- Are you okay having surgery?
- What is your treatment goal?
 - Full Treatment
 - Your treatment goal is to have everything done that is medically appropriate and possible to save your life.
 - You would be okay with going to the hospital, having surgery, and being in the intensive care unit potentially on life support.
 - Selective Treatment
 - Your treatment goal is to treat medical problems that can be reversed.
 - You would be okay with going to the hospital, but you would not want surgery, to be in the intensive care unit, or to be placed on life support.
 - Comfort Focused Treatment
 - Your treatment goal is to make you as comfortable as possible and allow death to happen naturally.
 - You would not want to go to the hospital, have surgery, or be placed in the intensive care unit.

Resources

American Bar Association Advance Planning Toolkit

- How to Select Your Healthcare Agent or Proxy → [tool](#)
- How Do You Weigh Your Odds of Survival → [tool](#)
- Personal Priorities & Spiritual Values Important to Medical Decisions → [tool](#)
- After Death Decisions to Think About Now → [tool](#)
- Conversation Scripts: Getting Past the Resistance → [tool](#)
- The Proxy Quiz for Family or Physician → [tool](#)
- What to Do After Signing Your Healthcare Advance Directive → [tool](#)
- Guide for Healthcare Proxies → [tool](#)
- Health Decisions Resources → [tool](#)

Samada Advance Directive Guides

- What is an Advance Directive (and why do you need one)? → [guide](#)
- How to Make a Living Will → [guide](#)
- How to Create a Healthcare Proxy → [guide](#)

National POLST Resources

- National Website → [resource](#)
- Understanding Advance Care Planning → [guide](#)
- Standard of Care and Advance Care Plan Documents → [guide](#)
- Getting Started with POLST → [guide](#)
- National POLST Form → [guide](#)
- Getting Ready to Talk About POLST → [guide](#)

Other Resources

- What's a POLST → [article](#)
- Questions and Answers on Advance Directives → [guide](#)
- Advance Directive Wallet Card → [resource](#)
- HAS State Specific Advance Planning Forms → [resource](#)

State Resources

POLST/MOST Websites

Alabama	Hawaii	Massachusetts	New Mexico	South Dakota
Alaska	Idaho	Michigan	New York	Tennessee
Arizona	Illinois	Minnesota	North Carolina	Texas
Arkansas	Indiana	Mississippi	North Dakota	Utah
California	Iowa	Missouri	Ohio	Vermont
Colorado	Kansas	Montana	Oklahoma	Virginia
Connecticut	Kentucky	Nebraska	Oregon	Washington
Delaware	Louisiana	Nevada	Pennsylvania	West Virginia
Florida	Maine	New Hampshire	Rhode Island	Wisconsin
Georgia	Maryland	New Jersey	South Carolina	Wyoming
				Washington D.C.

Advance Directives

Alabama	Hawaii	Massachusetts	New Mexico	South Dakota
Alaska	Idaho	Michigan	New York	Tennessee
Arizona	Illinois	Minnesota	North Carolina	Texas
Arkansas	Indiana	Mississippi	North Dakota	Utah
California	Iowa	Missouri	Ohio	Vermont
Colorado	Kansas	Montana	Oklahoma	Virginia
Connecticut	Kentucky	Nebraska	Oregon	Washington
Delaware	Louisiana	Nevada	Pennsylvania	West Virginia
Florida	Maine	New Hampshire	Rhode Island	Wisconsin
Georgia	Maryland	New Jersey	South Carolina	Wyoming
				Washington D.C.

Registries

Alabama	Hawaii	Massachusetts	New Mexico	South Dakota
Alaska	Idaho	Michigan	New York	Tennessee
Arizona	Illinois	Minnesota	North Carolina	Texas
Arkansas	Indiana	Mississippi	North Dakota	Utah
California	Iowa	Missouri	Ohio	Vermont
Colorado	Kansas	Montana	Oklahoma	Virginia
Connecticut	Kentucky	Nebraska	Oregon	Washington
Delaware	Louisiana	Nevada	Pennsylvania	West Virginia
Florida	Maine	New Hampshire	Rhode Island	Wisconsin
Georgia	Maryland	New Jersey	South Carolina	Wyoming
Washington D.C.				

For States without registries, it is recommended that you file your directive at the [US Living Will Registry](#). Some states use this registry as the official registry.