Hall of the House of Representatives

89th General Assembly - Regular Session, 2013

Amendment Form

Subtitle of Senate Bill No. 1013

TO CREATE THE ARKANSAS HEALTH CARE DECISIONS ACT.

Amendment No. 1 to Senate Bill No. 1013

Amend Senate Bill No. 1013 as originally introduced:

Page 7, delete lines 1 through 36

AND

Page 8, delete lines 1 through 36

AND

Page 9, line 1, delete "20-6-107" and substitute "20-6-105"

AND

Page 11, line 20, delete "20-6-108" and substitute "20-6-106"

AND

Page 12, delete lines 7 through 36

AND

Page 13, line 2, delete "20-6-110" and substitute "20-6-107"

AND

Page 13, line 10, delete "20-6-111" and substitute "20-6-108"

AND

Page 13, line 21, delete "20-6-112" and substitute "20-6-109"

AND

Page 14, line 23, delete "20-6-113" and substitute "20-6-110"

AND

Page 14, line 29, delete "20-6-114" and substitute "20-6-111"

AND

Page 15, line 14, delete "20-6-115" and substitute "20-6-112"

AND

Page 15, line 21, delete "20-6-116" and substitute "20-6-113"

AND

Page 15, line 26, delete "20-6-117" and substitute "20-6-114"

AND

Page 16, line 4, delete "20-6-118" and substitute "20-6-115"

AND

Page 16, line 11, delete "§ 20-6-106(c)(5)." and substitute "§ 20-6-107(c)."

AND

Page 16, line 15, delete "20-6-119" and substitute "20-6-116"

AND

Page 16, line 25, delete "20-6-120" and substitute "20-6-117"

AND

Page 16, line 32, delete "20134" and substitute "2013"

AND

Page 16, line 36, delete "20-6-121" and substitute "20-6-118"

AND

Page 17, delete line 1 and substitute "A law or part of law in conflict with this subchapter is repealed.

SECTION 2. DO NOT CODIFY. Forms.
The State Board of Health shall adopt the following forms and may by

rule revise the forms so long as the revisions are consistent with the intent of this act.

FORMS

ADVANCE CARE PLAN

Instructions: Competent adults and emancipated minors may give advance instructions using this form or any form of their own choosing. To be legally binding, the Advance Care Plan must be signed and either witnessed or notarized.

I, _____, hereby give these advance instructions on how I want to be treated by my doctors and other health care providers when I can no longer make those treatment decisions myself.

Agent: I want the following person to make health care decisions for me:

Name: _____ Phone #: _____ Relation: _____
Address: _____

Alternate Agent: If the person named above is unable or unwilling to make health care decisions for me, I appoint as alternate:

Name: _____ Phone #: _____ Relation: _____
Address: _____

Quality of Life:

I want my doctors to help me maintain an acceptable quality of life including adequate pain management. A quality of life that is unacceptable to me means when I have any of the following conditions **(you can check as many of these items as you want)**:

- ☐ **Permanent Unconscious Condition:** I become totally unaware of people or surroundings with little chance of ever waking up from the coma.
- ☐ **Permanent Confusion:** I become unable to remember, understand or make decisions. I do not recognize loved ones or cannot have a clear conversation with them.
- ☐ **Dependent in all Activities of Daily Living:** I am no longer able to talk clearly or move by myself. I depend on others for feeding, bathing, dressing and walking. Rehabilitation or any other restorative treatment will not help.
- ☐ **End-Stage Illnesses:** I have an illness that has reached its final stages in spite of full treatment. Examples: Widespread cancer that does not respond anymore to treatment; chronic and/or damaged heart and lungs, where oxygen needed most of the time and activities are limited due to the feeling of suffocation.

Treatment:

If my quality of life becomes unacceptable to me and my condition is irreversible (that is, it will not improve), I direct that medically appropriate treatment be provided as follows. **Checking "yes" means I WANT the treatment. Checking "no" means I DO NOT want the treatment.**

☐ Yes ☐ No	**CPR (Cardiopulmonary Resuscitation):** To make the heart beat again and restore breathing after it has stopped. Usually this involves electric shock, chest compressions, and breathing assistance.
☐ Yes ☐ No	**Life Support / Other Artificial Support:** Continuous use of breathing machine, IV fluids, medications, and other equipment that helps the lungs, heart, kidneys and other organs to continue to work.
☐ Yes ☐ No	**Treatment of New Conditions:** Use of surgery, blood transfusions, or antibiotics that will deal with a new condition but will not help the main illness.
☐ Yes ☐ No	**Tube feeding/IV fluids:** Use of tubes to deliver food and water to patient's stomach or use of IV fluids into a vein which would include artificially delivered nutrition and hydration.

PLEASE SIGN ON PAGE 2

Other instructions, such as burial arrangements, hospice care, etc.: _____

_____

_____

_____

_____

(Attach additional pages if necessary)

Organ donation (optional): Upon my death, I wish to make the following anatomical gift (please mark one):

☐ Any organ/tissue ☐ My entire body ☐ Only the following organs/tissues: _____

_____

_____

SIGNATURE

Your signature should either be witnessed by two competent adults or notarized. If witnessed, neither witness should be the person you appointed as your agent, and at least one of the witnesses should be someone who is not related to you or entitled to any part of your estate.

Signature: _____ DATE: _____
(Patient)

Witnesses:

1. I am a competent adult who is not named as the agent. I witnessed the patient's signature on this form.

_____
Signature of witness number 1

2. I am a competent adult who is not named as the agent. I am not related to the patient by blood, marriage, or adoption and I would not be entitled to any portion of the patient's estate upon his or her death under any existing will or codicil or by operation of law. I witnessed the patient's signature on this form.

_____
Signature of witness number 2

This document may be notarized instead of witnessed:

STATE OF ARKANSAS
COUNTY OF _____

I am a Notary Public in and for the State and County named above. The person who signed this instrument is personally known to me (or proved to me on the basis of satisfactory evidence) to be the person who signed as the "patient". The patient personally appeared before me and signed above or acknowledged the signature above as his or her own. I declare under penalty of perjury that the patient appears to be of sound mind and under no duress, fraud, or undue influence.

My commission expires: _____ _____
Signature of Notary Public

WHAT TO DO WITH THIS ADVANCE DIRECTIVE

- Provide a copy to your physician(s)
- Keep a copy in your personal files where it is accessible to others
- Tell your closest relatives and friends what is in the document
- Provide a copy to the person(s) you named as your health care agent

APPOINTMENT OF HEALTH CARE AGENT

(ARKANSAS)

I, _____, give my agent named below permission to make health care decisions for me if I cannot make decisions for myself, including any health care decision that I could have made for myself if able. If my agent is unavailable or is unable or unwilling to serve, the alternate named below will take the agent's place.

Agent:	Alternate:
_____ Name	_____ Name
_____ Address	_____ Address
_____ City State Zip Code	_____ City State Zip Code
(____) _____ Area Code Home Phone Number	(____) _____ Area Code Home Phone Number
(____) _____ Area Code Work Phone Number	(____) _____ Area Code Work Phone Number
(____) _____ Area Code Mobile Phone Number	(____) _____ Area Code Mobile Phone Number
_____ Patient's name (please print or type) Date	_____ Signature of patient (must be at least 18 or emancipated minor)

To be legally valid, **either** block A **or** block B must be properly completed and signed.

Block A Witnesses (2 witnesses required)

1. I am a competent adult who is not named above. I witnessed the patient's signature on this form.

_____ Signature of witness number 1

2. I am a competent adult who is not named above. I am not related to the patient by blood, marriage, or adoption and I would not be entitled to any portion of the patient's estate upon his or her death under any existing will or codicil or by operation of law. I witnessed the patient's signature on this form.

_____ Signature of witness number 2

Block B Notarization

STATE OF ARKANSAS
COUNTY OF _____

I am a Notary Public in and for the State and County named above. The person who signed this instrument is personally known to me (or proved to me on the basis of satisfactory evidence) to be the person whose name is shown above as the "patient." The patient personally appeared before me and signed above or acknowledged the signature above as his or her own. I declare under penalty of perjury that the patient appears to be of sound mind and under no duress, fraud, or undue influence.

My commission expires: _____

_____ Signature of Notary Public

APPOINTMENT OF SURROGATE
(ARKANSAS)

I, _____ made the decision to appoint
Designated Physician

_____ as surrogate for
Name of Surrogate

_____.
Name of Patient

Surrogate Contact Information: Home: _____
Work: _____
Cell Phone: _____

Reasons for Appointment (check all that apply):
___ Knows patient's wishes
___ Demonstrates care and concern
___ Knows patient's best interest
___ Had regular contact with patient
___ Available and willing to serve
___ Visits patient regularly during illness
___ Engages in face-to-face contact with caregiver
___ Participates in decision making process

_____ _____
Physician Signature Date/Time

If designated physician is to act as surrogate, one of the following signatures must be obtained:

_____ _____
Ethics Committee Representative Date

or

_____ _____
Concurring Second Physician Date

Any individuals in disagreement? Yes __ No __

If yes, please explain
_____

_____

_____

_____

ACCEPTANCE OF SURROGATE SELECTION

I accept the appointment as surrogate for _____
Patient

and understand I have the authority to make all medical decisions.

_____ _____

Signature of Surrogate Date/Time

"

The Amendment was read _____
By: Representative Branscum
MAG/KFW - 04-01-2013 17:20:23 _____
MAG017 **Chief Clerk**