AMERICAN SAMOA MEDICAID STATE AGENCY
AMERICAN SAMOA GOVERNMENT
PO BOX 998383
PAGO PAGO AMERICAN SAMOA 96799
PH: 699-4777 | FAX: 699-4780
EMAIL: omr@medicaid.as.gov

Advance Directive Form

Important Information about Advance Directive / Living Will

An advance directive is a statement signed by a person setting out in advance the treatment wanted or not wanted in the event of becoming unwell in the future. An advance directive can be a good way to gain more control over the treatment and care you are given if you experience an episode of physical or mental illness that leaves you unable to decide or communicate your preferences at the time.

For your convenience, the Medicaid Office has created this advance directive form which is a combined durable power of attorney for health care and a living will. With this form, you can name someone to make medical decisions on your behalf if you're unable to make those decisions yourself. You can also say what medical treatments you want and what medical treatments you don't want in the future if you're unable to make your wishes known.

Instructions for this form are as follows.

Read each section carefully. Before you fill out the form talk to the person you want to name, to make sure that he/she understands your wishes and is willing to take the responsibility. The person should be at least 18 years of age. Write your initials in the blank spaces before the choices you want to make. Write your initials only beside the choices you want under Parts 1, 2 and 3 of this form. Your advance directive should apply to any part(s) you fill in, as long as it is properly signed.

Add any special instructions in the blank spaces provided. You can write additional comments on a separate sheet of paper, but you should write on this form that there are additional pages to your advance directive. Sign the form and have it witnessed. **Give copies to your doctor, your nurse, the person you name to make your medical decisions for you, people in your family and anyone else who might be involved in your care.** Discuss your advance directive with them.

Understand that you may change or revoke this document at any time. This advance directive is governed by the laws of American Samoa.

If you have questions about this document, please speak to an attorney.

Complete this portion of advance directive form.

I, _____, write this document as a directive regarding my medical care. I intend for this document to be construed in accordance with the law of American Samoa.

Part 1: My Durable Power of Attorney for Health Care (ASCA 13.0801)

_____ I appoint the following person to make decisions about my medical care if there ever comes a time when I cannot make those decisions myself. I want the person I have appointed, my doctors, my family and others to be guided by the decisions I have made in the parts of the form that follow. I want this person to be able to exercise all powers of a health care representative provided for by the law of American Samoa.

Name: _____
Home Telephone: _____ Work Telephone: _____
Address: _____
If the person above cannot or will not make decisions for me, I appoint this person:
Name: _____
Home Telephone: _____ Work Telephone: _____
Address: _____

_____ I have not appointed anyone to make health care decisions for me in this or any other document.

Part 2: My Living Will

These are my wishes for my future medical care if there ever comes a time when I can't make these decisions for myself due to a terminal condition, an end-stage condition, or if I am in a persistent vegetative state. (ASCA 13.0804)

A. These are my wishes if I have a terminal condition.

Life-sustaining treatments

_____ I do not want life-sustaining treatment (including CPR) started. If life-sustaining treatments are started, I want them stopped.
_____ I want the life-sustaining treatments that my doctors think are best for me.
_____ Other wishes
_____
_____

Artificial nutrition and hydration

_____ I do not want artificial nutrition and hydration started if they would be the main treatments keeping me alive. If artificial nutrition and hydration are started, I want them stopped.
_____ I want artificial nutrition and hydration even if they are the main treatments keeping me alive.
_____ Other wishes
_____
_____

Comfort care

_____ I want to be kept as comfortable and free of pain as possible, even if such care prolongs my dying or shortens my life.
_____ Other wishes
_____
_____

Part 3: Other Wishes

A. Organ Donation

_____ I do not wish to donate any of my organs or tissues.
_____ I want to donate all my organs and tissues.
_____ I only want to donate these organs and tissues.
_____
_____ Other wishes
_____

B. Autopsy

_____ I do not want an autopsy.
_____ I agree to an autopsy if my doctors wish it.
_____ Other wishes
_____

C. Other statements about your medical care

If you wish to say more about any of the choices you have made or if you have any other statements to make about your medical care, you may do so on a separate piece of paper. If you do so, put here the number of pages you are adding: _____

Part 4: Signatures: You and two witnesses must sign this document before it will be legal.

A. Your Signature

By my signature below, I show that I understand the purpose and the effect of this document.

Signature: _____
Date: _____
Address: _____

B. Your witness' signatures

I believe the person who has signed this advance directive to be of sound mind, that he/she signed or acknowledged this advance directive in my presence and that he/she appears not to be acting under pressure, duress, fraud or undue influence. **I am not related to the person making this advance directive by blood, marriage or adoption nor, to the best of my knowledge, am I named in his/her will or would otherwise inherit from him/her.** I am at least 18 years of age. I am not the person appointed as the health care representative. I am not a health care provider or an employee of a health care provider who is now, or has been in the past, responsible for the care of the person making this advance directive.

Witness #1
Signature: _____
Date: _____
Address: _____

Witness #2
Signature: _____
Date: _____
Address: _____