**SUPPLEMENTAL ADVANCE DIRECTIVE FOR DEMENTIA CARE**

This **SUPPLEMENTAL ADVANCE DIRECTIVE FOR DEMENTIA CARE** is made voluntarily by **\_\_\_\_\_\_\_\_\_\_**, born \_\_\_\_\_\_\_\_\_\_, with the last four digits of my Social Security Number being \_\_\_\_.

I make this Supplemental Advance Directive for Dementia Care to inform my Health Care Agent (Health Care Attorney-in-Fact, Surrogate, Proxy), health care providers, heirs and loved ones of my treatment instructions in the event I become not of sound mind and lose the capacity to give instructions myself. I am executing this document on the date below executed, and am on this date of sound mind with full capacity. I have previously executed a separate Advance Directive for a Natural Death dated \_\_\_\_\_\_\_. I ask that my Advance Directive for a Natural Death be maintained in my patient chart and applied according to its terms, and that it be supplemented by this Supplemental Advance Directive for Dementia Care.

I also have executed a Health Care Power of Attorney dated \_\_\_\_\_\_\_, appointing a Health Care Agent (and Alternate) and directing my Health Care Agent (or Alternate as the case may be) to ensure that both my Advance Directive for a Natural Death and that this Supplemental Advance Directive for Dementia Care are both enforced in the circumstances where each applies.

**When My Directive Applies:** This Supplemental Advance Directive for Dementia Care shall be operative when my cognitive condition has so deteriorated such that, in the sole discretion of my Health Care Agent (or Alternate), all of the points described below have been reached:

* I do not recognize the following individuals: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, and
* I cannot remember the names of (or my relationship to) the following individuals:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, and
* I no longer know the current date, cannot identify the President of the United States, or no longer know my current living address, and
* I am unable to remember numbers or objects which have moments earlier been recited to me, and
* I am no longer able without assistance to bathe, go to the toilet, get dressed or undressed or eat, and
* I am no longer able to understand a simple conversation with friends or acquaintances and exhibit signs of constant confusion whenever asked a simple question.

I desire to be allowed to die quickly and peacefully once all of the circumstances indicated above have been reached. The point at which my cognitive condition has deteriorated such that the circumstances I have indicated above have been reached, as solely determined by my Health Care Agent (or Alternate), shall be called “My Chosen End Point.”

**Further Instructions for My Care:** At My Chosen End Point, I wish to receive the best available palliative and hospice care but refuse any medical treatment that would serve only to postpone my death, including, for example, vaccines, antibiotics, or other antimicrobial drugs, antiarrhythmics, cardiopulmonary resuscitation, blood transfusions, or any artificial or mechanical means of life support. Upon My Chosen End Point, I do not wish to extend my life or prolong the dying process.

At My Chosen End Point, I wish to be allowed to die by application of VSED (Voluntary Stopping of Eating and Drinking), a process which I understand can last as long as two weeks during which time, I ask for the cessation of all oral assisted feeding and hydrating. I do not want to be encouraged, persuaded or forced to eat or drink. I do not want food or fluid to be held near my mouth to provoke me to open my mouth reflexively. I ask that the aroma of food not be introduced in my vicinity so as to avoid the temptation to ask for food. Moistening of my lips to keep them comfortable shall not be considered a form of prohibited hydration. I authorize my Health Care Agent (or Alternate), to apply Comfort Care Only once My Chosen End Point has been reached. As such I wish to be kept clean, warm and dry and request only medication to relieve me of pain and suffering.

Today, while I am of sound mind with full mental capacity and knowing the ravages of dementia, I declare my wish that I be allowed to die naturally and peacefully by VSED at My Chosen End Point. I further state that once I have reached my Chosen End Point, I direct my Health Care Proxy (or Alternate) to adhere to the instructions contained herein, no matter the current circumstances and even if I express, or appear to indicate, a different preference at the time a treatment decision needs to be made. I do not want the wishes of my future demented self, who will lack decision-making capacity, to take precedence over the wishes of my current competent self, as expressed herein.

I ask that any health care institution/facility providing treatment for me, maintain my Advance Directive for a Natural Death and this Supplemental Advance Directive for Dementia Care in my chart and document prominently that these Advance Directives are in place, as required by 42 U.S.C. 1395cc and any applicable state law.

I authorize my Health Care Agent (or Alternate) to determine if any health care institution has any policy against the enforcement of the terms of this document and, if so, I authorize my Health Care Agent (or Alternate) to have me transferred to an appropriate health care institution that does not have a policy inconsistent with the enforcement of the terms of this document.

**My Health Care Agent and Providers May Rely on this Directive:** My Health Care Agent (or Alternate) and health care providers shall not be liable to me or to my family, my estate, my heirs, or my personal representative for abiding by the instructions I give in this instrument. Following my directions shall not be considered abetting or assisting a suicide, elder abuse, the cause of my death, or malpractice or unprofessional conduct.

**I Want this Directive to be Effective Anywhere:** I intend that this Advance Directive be followed by any health care provider in any and all places. I authorize my Health Care Agent (or Alternate) to take any legal action necessary in any place to enforce my choice to die from VSED if I have reached My Chosen End Point.

**Photocopies:** I hereby authorize my Health Care Agent to make photocopies of this instrument as frequently and in such quantity as my Health Care Agent shall deem appropriate. All photocopies of this instrument shall have the same force and effect as the original. Any and all third parties may and are hereby authorized to rely upon a copy of this instrument as though it were the original.

This \_\_\_\_ day of \_\_\_\_\_\_, 202\_\_.

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_(SEAL)
 \_\_\_\_\_\_\_\_\_\_\_\_\_

I hereby state that the Declarant, **\_\_\_\_\_\_\_\_\_\_\_,** being of sound mind and capacity, signed the foregoing Supplemental Advance Directive for Dementia Care in my presence, and that I am not related to the Declarant by blood or marriage, and I would not be entitled to any portion of the estate of the Declarant under any existing will or codicil of the Declarant or as an heir under the Intestate Succession Act, if the Declarant died on this date without a will. I also state that I am not the Declarant’s attending physician, nor a licensed health care provider who is (1) an employee of the Declarant’s attending physician, (2) nor an employee of the health facility in which the Declarant is a patient, or (3) an employee of a nursing home or any adult care home where the Declarant resides. I further state that I do not have any claim against the Declarant or the estate of the Declarant.

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SIGNATURE OF WITNESS SIGNATURE OF WITNESS

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WITNESS (PRINT NAME) WITNESS (PRINT NAME)

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ADDRESS ADDRESS

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DATE DATE

**NORTH CAROLINA \_\_\_\_\_\_\_\_\_\_\_\_\_ COUNTY**

**CERTIFICATE**

I, \_\_\_\_\_\_\_\_\_\_, a Notary Public for \_\_\_\_\_\_\_\_\_ County, North Carolina, hereby certify that **\_\_\_\_\_\_\_\_\_\_\_\_**, identified by her government issued picture identification card, the Principal, appeared before me and swore to me and to the witnesses in my presence that this instrument is an Advance Directive for Dementia Care, and that shewillingly and voluntarily made and executed it as herfree act and deed for the purposes expressed in it.

I further certify that \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ and , witnesses, identified by their government issued picture identification card, appeared before me and swore that they witnessed **\_\_\_\_\_\_\_\_\_\_** sign the attached Supplemental Advance Directive for Dementia Care, believing herto be of sound mind and with capacity; and also swore that at the time they witnessed the signing (i) they were not related within the third degree to her, and (ii) they did not know nor have a reasonable expectation that they would be entitled to any portion of herestate upon her death under any will or codicil thereto then existing or under the Intestate Succession Act as it provided at that time, and (iii) they were not a physician attending hernor an employee of an attending physician, nor an employee of a health facility in which she was a patient, nor an employee of a nursing home or any group-care home in which sheresided, and (iv) they did not have a claim against her. I further certify that I am satisfied as to the genuineness and due execution of the instrument.

This \_\_\_\_ day of \_\_\_\_\_\_ 202\_.

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_(SEAL)

 Notary Public: \_\_\_\_\_\_\_\_\_\_\_\_\_

 My commission expires on: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_