NEW YORK STATE OF OPPORTUNITY. | Justice Center for the Protection of People with Special Needs

Declaration for End of Life Care

SDMC
401 State Street
Schenectady, NY 12305
Fax: 518-549-0460
Email: SDMC@justicecenter.ny.gov

INSTRUCTIONS:

- All four declaration forms must be completed and submitted with the required supporting documentation
- Please type or print in black ink
- Part 13 – Declarant must sign and date where indicated
- Please send by mail, secure email (sdmc@justicecenter.ny.gov) or by fax: 518-549-0460

Always call SDMC at 518 549-0328 to confirm receipt

For SDMC Use Only:

Part 1. Patient Information

Last Name:		First Name:	
Date of Birth:	Age:	Religion: *optional*	Sex: ☑ MALE ☐ FEMALE
Street Address:			
City:		State:	Zip:
Phone: Include area code	Ext:	Fax: Include area code	Cell: Include area code

COUNTY of Patient's Residence

Type of Residence

☐ Intermediate Care Facility ☐ Family Care ☐ Individualized Residential Alternative (IRA) ☐ Nursing Home

☐ Community Residence ☐ Developmental Center ☐ Assisted Living ☐ Adult Home ☐ Waiver

☐ Other Services: _____

Part 2a. Declarant (Required) *The declarant must also sign the attestation on page 8*

The declarant should be familiar with the patient and be able to speak to the issues of capacity, surrogacy and best interest for this specific case.

Last Name:		First Name:	
Title:		Email Address:	
Agency Name: (Please avoid abbreviations)			
Work Mailing Address:			
City:		State:	Zip:
Phone: Include area code	Ext:	Fax: Include area code	Cell: Include area code

If the patient is hospitalized, please provide the residential contacts (residential nurse, house manager, and care coordinator/care manager) where indicated on this declaration.

Patient Last Name:

For SDMC Use Only:

*The **alternate declarant below** will be contacted if the declarant is not available and should be familiar with the patient and be able to speak to the issues of capacity, surrogacy and best interests for this specific case.*

Part 2b. Alternate Declarant (Required)		THIS CANNOT BE THE SAME PERSON LISTED AS THE DECLARANT IN 2a. [This could be the Agency RN, Residential Manager, Care Coordinator, or other agency staff]	
Last Name:		First Name:	
Title:		Email Address:	
Agency Name: (Please avoid abbreviations)			
Work Mailing Address:			
City:		State:	Zip:
Phone: Include area code	Ext:	Fax: Include area code	Cell: Include area code

Part 3. Service Providers Provide information relating to other service providers that are involved in the care of this patient			
Part 3a. Agency/Residential Nurse or Nursing Home Primary Nurse assigned to patient's care			
Last Name:		First Name:	
Title:		Email Address:	
Agency Name: (Please avoid abbreviations)			
Work Mailing Address:			
City:		State:	Zip:
Phone: Include area code	Ext:	Fax: Include area code	Cell: Include area code

Part 3b. Residential Manager | Family Care Liaison | or Director of Nursing Home			
Last Name:		First Name:	
Title:		Email Address:	
Agency/Residence or Name of Nursing Home:			
Work Mailing Address:			
City:		State:	Zip:
Phone: Include area code	Ext:	Fax: Include area code	Cell: Include area code

Patient Last Name:

For SDMC Use Only:

Part 3c. Care Manager | Care Coordinator | Social Worker | Service Coordinator

Last Name:		First Name:	
Title:		Email Address:	
Agency Name: (Please avoid abbreviations)			
Work Mailing Address:			
City:		State:	Zip:
Phone: Include area code	Ext:	Fax: Include area code	Cell: Include area code

Part 3d. Hospice Contact (*If a hospice admission is anticipated, please include the hospice contact below)* ☐ NA

Last Name:		First Name:	
Title:		Email Address:	
Hospice Name: (Please avoid abbreviations)			
Work Mailing Address:			
Phone: Include area code	Ext:	Fax: Include area code	Cell: Include area code

Part 3e. Hospital | Nursing Home Contact **[Preferably a case manager, social worker, or discharge planner is listed in Part 3e.]**

Provide the following information if the patient is hospitalized, or presently in a rehabilitation center or nursing home ☐ NA

Last Name:		First Name:	
Title:		Business Email Address:	
Hospital | Nursing Home Name:			
Address of Hospital/Nursing Home:			
City:		State:	Zip:
Phone: Include area code	Ext:	Fax: Include area code	Cell: Include area code
Pager: Include area code		Patient's Room Number:	

The Hospital or Nursing Home Contact person listed above in 3e. will be asked to assist in obtaining copies of medical information relevant to the case and also with reserving a room at the hearing location if the patient is in a hospital or nursing home.

Patient Last Name:

For SDMC Use Only:

Part 4. Other Agencies Providing Services for the Patient

(i.e. day program, respite, senior center or care coordination)

- Please list any other agencies providing services for the patient if not previously listed on this declaration:
  (not medical clinics or service providers)

Part 5a. Legally Authorized Surrogates
Provide the following information for known surrogates:

Status of the patient's mother:	☐ Living *(List below in 5b)*	☐ Deceased	☐ Whereabouts Unknown
Status of the patient's father:	☐ Living *(List below in 5b)*	☐ Deceased	☐ Whereabouts Unknown

If the patient has any of these possible decision-makers, please complete 5b.

Actively involved is defined as having significant and ongoing involvement so as to have knowledge of the person's needs.

- Health Care Proxy
- Guardian
- Actively Involved Spouse
- Actively Involved Parent
- Actively Involved Adult Child
- Actively Involved Adult Sibling
- Other Actively Involved family member

5b. Surrogate Information:

Please identify the possible surrogate and provide information to explain why the surrogate does not wish or is not able to make the decision:

(attach an additional page if there is more than one surrogate)

Last Name:	First Name:	Relationship:
Mailing Address:		
City:	State:	Zip:
Email Address:		
Phone:	Ext:	Fax:	Cell:

- **Please indicate if the surrogate has an opinion on the proposed treatment or withdrawal of treatment?**

☐ Unknown opinion ☐ Does not wish to make the decision ☐ Agrees ☐ Disagrees

- **When (*date*) and how (*phone, mail, email, etc.*) was the surrogate last contacted?**

- **If attempts to contact the surrogate were unsuccessful, please describe the attempts made and the approximate dates and method of contact:**

If there are additional surrogates, please include the surrogate information on an additional page

Patient Last Name:

For SDMC Use Only:

Part 6. Correspondent, Community Advocate or Family Care Provider

☐ **N/A** proceed to Part 7

Correspondent means a person who has demonstrated a genuine interest in promoting the best interests of the patient by having a personal relationship with the patient, by participating in the patient's care and treatment, by regularly visiting the patient, or by regularly communicating with the patient [Mental Hygiene Law 80.03(k)].

Last Name:		First Name:	
Email Address:		Relationship:	
Address:			
City:		State:	Zip:
Phone: Include area code	Ext:	Fax: Include area code	Cell: Include area code

Indicate if the correspondent has an opinion on the proposed treatment or withdrawal of treatment.

☐ Agrees ☐ Disagrees ☐ Unknown

How was the correspondent last contacted? ☐ Phone ☐ Mail ☐ Email ☐ In Person

Attempts to contact the correspondent on the following date(s) were unsuccessful *:* ☐ Other: _____

Part 6b. Correspondents, Community Advocates or Family Care Provider(s)

Last Name:		First Name:	
Email Address:		Relationship:	
Address:			
City:		State:	Zip:
Phone: Include area code	Ext:	Fax: Include area code	Cell: Include area code

- Does the correspondent have a known opinion on the proposed treatment or withdrawal of treatment?

☐ Agrees ☐ Disagrees ☐ Unknown

How was the correspondent last contacted? ☐ Phone ☐ Mail ☐ Email ☐ In Person

Attempts to contact the correspondent on the following date(s) were unsuccessful: ☐ Other:

Patient Last Name:

For SDMC Use Only:

Part 7. The SDMC Hearing

If the patient is hospitalized, the SDMC hearing will be held at the hospital.
At least one SDMC panel member will visit the patient to observe and interview the patient prior to the hearing, as required by regulation.

The patient is presently hospitalized and will need to be visited by a panel member prior to the hearing: ☐

The patient is not presently hospitalized and the hearing may be held at the patient's home: ☐

Part 8. Supporting Documentation Review [REQUIRED]

- **As the Declarant, I have read the Certification on Capacity for End of Life Care (SDMC Form 310)** stating that the patient does not have the capacity to provide informed consent for the proposed withholding/withdrawal of life sustaining treatment(s) completed by an Attending Physician and a Consulting Physician or NYS Licensed Psychologist.

☐ **YES** *I have reviewed the Capacity Certification*

- **As the Declarant, I have read the Attending Physician and Concurring Physician Certification for End of Life Care (SDMC Form 320A-B)** describing the patient's medical condition, the risks, benefits and alternative(s) to the proposed withholding/withdrawal of life sustaining treatment(s) completed by an Attending Physician and a Concurring Physician.

☐ **YES** *I have reviewed the Medical Certification*

Part 9a. Proposed Treatment to be Withheld and/or Withdrawn

- The proposed withholding and withdrawal of life sustaining treatment(s) is/are as follows:

See Part 5 of the Attending Physician and the Concurring Physician Certification for End of Life Care (SDMC Form 320A-B)

Part 9b. Artificial Nutrition and/or Hydration:

- Has the physician requested to withhold/withdraw life-sustaining artificially provided nutrition or hydration for the patient? ☐ **YES** ☐ **NO**

Part 10. Hospice

- Is a Hospice admission anticipated? ☐ **Yes** ☐ **No** *If the patient has been evaluated by Hospice already, please attach the evaluation.*

Part 11. Additional Information ***[Required by the Health Care Decisions Act, SCPA Article 17-A, § 1750-b]***

- List the title of the person that explained the proposed treatment decision to the patient:

- Describe the efforts to determine the moral and religious beliefs of the patient and the patient's reaction when the proposed withholding/withdrawal of life-sustaining treatment(s) was/were explained:

Patient Last Name:

For SDMC Use Only:

Part 11. Additional Information, continued

- Based on your personal knowledge of this patient, explain in your own words why the patient cannot give informed consent or refuse the proposed withholding/withdrawal of life sustaining treatment.

- Based on your personal knowledge of this patient, explain in your own words why you believe the proposed treatment decision(s) is/are in the best interest of the patient.

Part 12. Communication Needs

Please check all that apply

Does the patient understand English? ☐ Yes ☐ No

Does the patient speak English as his/her primary language? ☐ Yes ☐ No

If the patient is a non-English speaker, please indicate the language that is spoken or understood:

Does the patient require an interpreter for sign language or for a language other than English? ☐ Yes* ☐ No

***If YES**, please indicate type (foreign language, sign language, other):

☐ Patient is nonverbal or unable to verbally communicate (due to medical condition such as heavy sedation, unconsciousness, or intubation)

☐ Patient is able to point or gesture to make needs known

☐ The patient's expressive skills are limited.

Is the patient able to verbally communicate his/her needs? ☐ Yes ☐ No Comments:

Part 13. Attestation by the Declarant

This request is based on the patient's qualifying medical condition other than intellectual or developmental disability, with recognition that a person with an intellectual or developmental disability is entitled to full and equal rights, equal protection, respect, medical care and dignity afforded to persons without intellectual or developmental disabilities and without any financial considerations that affect the health care provider or any other party.

The information and statements which I have provided are accurate and truthful, to the best of my knowledge.

Signature of Declarant:

Date: 10/23 / 10/23/2018

MM DD YEAR

Declarant is listed on page 1, Part 2a

NOTE:
This form must be dated the same or later than the other forms in this case.

Please submit this declaration together with the following:

- Certification on Capacity for End of Life Care (SDMC Form 310); and
- Attending Physician and Concurring Physician Certification for End of Life Care (SDMC Form 320A-B); and
- Related Medical Information for End of Life Care (SDMC Form 330); and
- Supplemental medical information to support the declaration for an end of life care decision.

REMINDER:

- The OPWDD MOLST Legal Requirements Checklist for Individuals with Developmental Disabilities must be completed after the SDMC End of Life hearing
- Notifications per SCPA § 1750-b are required