Honoring Choices®
MASSACHUSETTS

Maagizo na Hati ya Wakala wa Huduma ya Afya ya Massachusetts

(Massachusetts Health Care Proxy – Swahili)

Maagizo: Kila mtu mkuu mwenye uwezo, umri wa miaka 18 na zaidi, ana haki ya kuteua Wakala wa Huduma ya Afya. Kuunda Wakala wako wa Huduma ya Afya, chapisha fomu hii ya ukurasa huu mbili na uweke ukurasa wa maagizo na hati tupu mbele yako. Fuata maagizo ya hatua kwa hatua na utie saini Wakala wa Huduma ya Afya mbele ya mashahidi wawili, ambao wanasaini na kuweka tarehe hati baada yako.

1. Jina lako na Anwani *(Inahitajika)*
Andika jina lako kamili katika nafasi tupu. Andika anwani yako.

2. Wakala wangu wa Huduma ya Afya ni: *(Inahitajika)*
Andika jina, anwani na nambari za simu za Wakala wako wa Huduma ya Afya.

- Chagua mtu unaye mwamini kufanyia maamuzi ya huduma ya afya kulingana na chaguo, maadili na imani yako, ikiwa huwezi kufanya au kuwasiliana na maamuzi mwenyewe;
- Wakala wako wa Huduma ya Afya na Wakala Mbadala hawawezi kuwa mtu ambaye ni mwendeshaji, msimamizi au mfanyakazi katika kituo ambacho wewe ni mgonjwa au mkazi au umeomba ombi, isipokuwa kama wana uhusiano na wewe kwa damu, ndoa au kupitishwa.

3. Wakala Wangu Mbadala wa Huduma ya Afya *(Haihitajiki, lakini inasaidia kuwa na Wakala Mbadala)*
Ikiwezekana, teua mtu unaye mwamini kama Wakala Mbadala, ambaye anaweza kuingilia kati kufanya maamuzi ya huduma ya afya ikiwa Wakala wako wa Huduma ya Afya hayapatikani, hayupo tayari au hana uwezo wa kuhudumu, au hatarajiwi kufanya uamuzi. Andika jina, anwani na nambari za simu.

4. Mamlaka ya Wakala wa Huduma ya Afya *(Inahitajika)*
Hapa ndipo unampa Wakala wako mamlaka pana zaidi ya kufanya maamuzi ya kufanya maamuzi "yoyote na yote" ikiwa ni pamoja na matibabu ya kuendeleza maisha, au kupunguza mamlaka yake:

- Ikiwa unataka kutoa "yoyote na yote" mamlaka ya kufanya maamuzi, acha eneo hili tupu.
- Ikiwa hautaki kutoa "yoyote na yote" mamlaka ya kufanya maamuzi, eleza njia ambayo unataka kupunguza mamlaka ya Wakala wako na uiandike katika nafasi iliyotolewa.

5. Saini na Tarehe *(Inahitajika)*
USI saini mbele. Saini jina lako kamili na tarehe mbele ya mashahidi wawili ambao wanasaini baada yako.

- Unaweza kumfanya mtu asaini jina lako kwa maelekezo yako mbele ya mashahidi wawili.

6. Taarifa ya Shahidi na Saini *(Inahitajika)*
Mtu aliye na uwezo anaweza kuwa shahidi isipokuwa Wakala wako wa Huduma ya Afya.

- Watu wawili lazima wawe mashahidi wakati hati hii imesainiwa. Wanatazama wakati unasaini waraka huo, au kama mtu mwingine anasaini kwa kuelekezwa kwako, na wanasaini baada yako kusema kuwa una umri wa miaka 18, mwenye akili timamu, na hakuna kizuizi au ushawishi usiofaa.
- Kuwa na ishara ya Shahidi mmoja, kisha uchapisha jina lake na tarehe;
- Kisha kuwa na Shahidi wa pili saini na kuchapisha jina lake na tarehe.

7. Taarifa ya Wakala wa Huduma ya Afya *(Si lazima)*
Sehemu hii haihitajiki, lakini inaweza kusaidia madaktari na familia yako kujua Mawakala uliowateua wamekubali nafasi hiyo. Wakala wako husaini na kuchapisha tarehe katika nafasi zilizotolewa.

Muhimu: Weka Wakala wako wa Huduma ya Afya. Tengeneza nakala na mpe Wakala wako wa Huduma ya Afya. Wape nakala madaktari wako na watoa huduma ili wachanganue rekodi yako ya matibabu ili waweze kujua jinsi ya kuwasiliana na Wakala wako ikiwa unaumwa au umeumia na hauwezi kusema mwenyewe.

Wakala wa Huduma ya Afya ya Massachusetts

(Massachusetts Health Care Proxy – Swahili)

1. Mimi, ________________________________ Anwani__________________________________,

teua mtu wafuatayo kuwa Wakala wa Huduma ya Afya na mamlaka ya kufanya maamuzi ya huduma ya afya kwa niaba yangu. Mamlaka haya yanafaa ikiwa daktari wangu anayehudhuria ataamua kwa maandishi kwamba sina uwezo wa kufanya au kuwasiliana mwenyewe maamuzi ya utunzaji wa afya, kulingana na Sura ya 201D ya Sheria Kuu za Massachusetts.

2. Wakala wangu wa Huduma ya Afya ni:

Jina: ________________________________ Anwani: ________________________________

Simu: ________________________; ________________________; ________________________

3. Wakala Wangu Mbadala wa Huduma ya Afya

Ikiwa Wakala wangu hapatikani, huko tayari au huna uwezo, au hatarajiwi kuamua jinsi unaofaa, ninateua:

Jina: ________________________________ Anwani: ________________________________

Simu: ________________________; ________________________; ________________________

4. Mamlaka ya Wakala wa Huduma ya Afya

Ninampa Wakala wangu wa Huduma ya Afya mamlaka sawa ninayo kuamua yoyote ya huduma ya afya pamoja na maamuzi ya matibabu ya kudumu, isipokuwa (orodha ya mipaka kwa mamlaka au toa maagizo, ikiwa ipo):

____

____

Ninaidhinisha Wakala wangu wa Huduma ya Afya kufanya maamuzi ya huduma ya afya kulingana na tathmini yake ya chaguo, maadili na imani yangu ikiwa inajulikana, na kwa masilahi yangu ikiwa haijulikani. Ninampa Wakala wangu wa Huduma ya Afya haki sawa nilizonazo kwa matumizi na kufunua habari yangu ya kiafya na rekodi za matibabu kama inavyosimamiwa na Sheria ya Uwajibikaji wa Bima ya Afya na Uwajibikaji wa 1996 (HIPAA), 42 USC 1320d. Nakala za Wakala wa Huduma ya Afya zina nguvu sawa na athari kama ile ya asili.

5. Saini na Tarehe. Nasaini jina langu na tarehe hii Wakala wa Huduma ya Afya mbele ya mashahidi wawili.

IMESAINIWA ____ **TAREHE** ____________

6. Taarifa ya Shahidi na Saini

Sisi, waliosainiwa chini, tumeshuhudia kusainiwa kwa waraka huu na au kwa maagizo ya mtia saini hapo juu na kusema anayesaini anaonekana kuwa na umri wa miaka 18, mwenye akili timamu na hana kizuizi chochote au ushawishi usiofaa. Wala sisi sio wakala wa huduma ya afya au wakala mbadala.

Shahidi wa Kwanza

Imesainiwa: ________________________

Andika Jina: ________________________

Tarehe: ________________________

Shahidi wa Pili

Imesainiwa: ________________________

Andika Jina:________________________

Tarehe: ________________________

7. Taarifa ya Wakala wa Huduma ya Afya (Si lazima):

Tumesoma hati hii kwa uangalifu na tunakubali miadi hiyo.

Wakala wa Huduma ya Afya ________________________________ Tarehe____________________

Wakala Mbadala wa Huduma ya Afya ________________________ Tarehe____________________

Wakala huyu wa Huduma ya Afya ya Massachusetts ilitayarishwa na Honoring Choices Massachusetts, Inc.

Honoring Choices® MASSACHUSETTS

Massachusetts Health Care Proxy Instructions and Document

Instructions: Every competent adult, 18 years old and older, has the right to appoint a Health Care Agent in a Health Care Proxy. To create your Health Care Proxy, print this two page form and place the instructions page and the blank document in front of you. Follow the step-by-step instructions and sign and date the Health Care Proxy in front of two witnesses, who sign and date the document after you.

1. Your Name and Address *(Required)*

Print your full name in the blank space. Print your address.

2. My Health Care Agent is*:* *(Required)*

Print the name, address and phone numbers of your Health Care Agent.

- Choose a person you trust to make health care decisions for you based on your choices, values and beliefs, if you cannot make or communicate decisions yourself;
- Your Health Care Agent and Alternate Agent cannot be a person who is an operator, administrator or employee in the facility where you are a patient or resident or have applied for admission, unless they are related to you by blood, marriage or adoption.

3. My Alternate Health Care Agent *(Not required, but helpful to have an Alternate Agent)*

If possible, appoint a person you trust as a back-up or Alternate Agent, who can step-in to make health care decisions if your Health Care Agent is not available, not willing or not competent to serve, or is not expected to make a timely decision. Print the name, address and phone numbers.

4. My Health Care Agent's Authority *(Required)*

Here's where you give your Agent either the broadest possible decision-making authority to make "any and all" decisions including life sustaining treatments, or limit his/her authority:

- If you want to give "any and all" decision-making authority, just leave this area blank.
- If you do not want to give "any and all" decision-making authority, describe the way in which you want to limit your Agent's authority and write it down in the space provided.

5. Signature and Date *(Required)*

Do NOT sign ahead. Sign your full name & date in front of two adult witnesses who sign after you.

- You can have someone sign your name at your direction in front of two witnesses.

6. Witness Statement and Signature *(Required)*

Any competent adult can be a witness except your Health Care Agent and Alternate Agent.

- Two adults must be present as witnesses when this document is signed. They watch as you sign the document, or as another person signs at your direction, and sign after you to state that you are at least 18 years old, of sound mind, and under no constraint or undue influence.
- Have Witness One sign, then print his or her name and the date;
- Then have Witness Two sign and print his or her name and the date.

7. Health Care Agent Statement *(Optional)*

This section is not required, but it can help your doctors and family know the Agents you appointed have accepted the position. Your Agent(s) signs and prints the date in the spaces provided.

Important: Keep your original Health Care Proxy. Make a copy and give it to your Health Care Agent. Give a copy to your doctors and care providers to scan in your medical record so they know how to contact your Agent if you are ill or injured and unable to speak for yourself.

Massachusetts Health Care Proxy

1. I, ____ Address: _________________________________,

appoint the following person to be my Health Care Agent with the authority to make health care decisions on my behalf. This authority becomes effective if my attending physician determines in writing that I lack the capacity to make or communicate health care decisions myself, according to Chapter 201D of the General Laws of Massachusetts.

2. My Health Care Agent is:

Name: _________________________________ Address: __________________________________

Phone(s): _______________________; ________________________; _______________________

3. My Alternate Health Care Agent

If my Agent is not available, willing or competent, or not expected to make a timely decision, I appoint:

Name: _________________________________ Address: _________________________________

Phone(s): _______________________; ________________________; ________________________

4. My Health Care Agent's Authority

I give my Health Care Agent the same authority I have to make any and all health care decisions including life-sustaining treatment decisions, except (list limits to authority or give instructions, if any):

____

____.

I authorize my Health Care Agent to make health care decisions based on his or her assessment of my choices, values and beliefs if known, and in my best interest if not known. I give my Health Care Agent the same rights I have to the use and disclosure of my health information and medical records as governed by the Health Insurance Portability and Accountability Act of 1996 (HIPAA), 42 U.S.C. 1320d. Photocopies of this Health Care Proxy have the same force and effect as the original.

5. Signature and Date. I sign my name and date this Health Care Proxy in the presence of two witnesses.

SIGNED ____ **DATE** ____________

6. Witness Statement and Signature

We, the undersigned, have witnessed the signing of this document by or at the direction of the signatory above and state the signatory appears to be at least 18 years old, of sound mind and under no constraint or undue influence. Neither of us is the health care agent or alternate agent.

Witness One		***Witness Two***	
Signed:	___________________________	Signed:	___________________________
Print Name:	___________________________	Print Name:	___________________________
Date:	___________________________	Date:	___________________________

7. Health Care Agent Statement (Optional):

We have read this document carefully and accept the appointment.

Health Care Agent ____ Date ____________

Alternate Health Care Agent ____________________________________ Date ____________