

APA-1
4/18

TRANSMITTAL SHEET FOR NOTICE OF INTENDED ACTION

Control 420 Alabama Department of Public Health

Rule Number 420-5-19, Appendix I

Rule Title Appendix I, Certification of Health Care Decision Surrogate

New Amend Repeal Adopt by Reference

Would the absence of the proposed rule significantly harm or endanger the public health, welfare or safety? No

Is there a reasonable relationship between the state's police power and the protection of the public health, safety or welfare? Yes

Is there another, less restrictive method of regulation available that could adequately protect the public? No

Does the proposed rule have the effect of directly or indirectly increasing the costs of any goods or services involved and, if so, to what degree? No

Is the increase in cost, if any, more harmful to the public than the harm that might result from the absence of the proposed rule? No

Are all facts of the rulemaking process designed solely for the purpose of and so they have as their primary effect, the protection of the public? Yes

Does the proposed action relate to or affect in any manner any litigation which the agency is a party to concerning the subject matter of the proposed rule? No

Does the proposed rule have an economic impact? No

If the proposed rule has an economic impact, the proposed rule is required to be accompanied by a fiscal note prepared in accordance with subsection (f) of §41-22-23, Code of Alabama, 1975.

Certification of Authorized Official

I certify that the attached proposed rule has been proposed in full compliance with the requirements of Chapter 22, Title 41, Code of Alabama, 1975, and that it conforms to all applicable filing requirements of the Administrative Procedure Division of the Legislative Services Agency.

Signature of Certifying Officer

Date

6/16/2022

REC'D & FILED

JUN 17 2022

LEGISLATIVE SVC AGENCY

**FORM APA2
10/17**

**STATE BOARD OF HEALTH
NOTICE OF INTENDED ACTION**

AGENCY NAME: Alabama Department of Public Health

RULE NUMBER AND TITLE: 420-5-19, Appendix I, Certification of Health Care Decision Surrogate

INTENDED ACTION: To amend the current rule.

SUBSTANCE OF PROPOSED ACTION: To remove the requirement that a health care decision surrogate's certification be notarized.

TIME, PLACE, AND MANNER OF PRESENTING VIEWS: A public hearing will be held on July 14, 2022 at 10:00 a.m., at the RSA Tower, Suite 982, 201 Monroe Street, Montgomery, AL 36104.

FINAL DATE FOR COMMENTS AND COMPLETION OF NOTICE: Written or oral comments will be received until the close of the record at 5:00 p.m. on August 4, 2022. All comments and requests for copies of the proposed amendments should be addressed to the contact person listed below.

CONTACT PERSON AT AGENCY: Jacqueline D. Milledge, Bureau of Health Provider Standards, Department of Public Health, P.O. Box 303017, Montgomery, Alabama 36130-3017, Telephone number: (334) 206-5366.



P. Brian Hale, Agency Secretary

STATE BOARD OF HEALTH
ADMINISTRATIVE CODE

APPENDIX I

CERTIFICATION OF HEALTH CARE DECISION SURROGATE

PATIENT'S NAME: _____

SURROGATE'S NAME: _____

I certify that:

(a) I am at least nineteen 19 years old.

(b) The patient whose name is given above either has not, to my knowledge, made an advance directive for health care (living will or durable power of attorney), or the patient has executed an advance directive for health care, but the document fails to address his or her present circumstances.

(c) I have consulted with the physician who is now overseeing the patient's care.

(d) I am qualified to act as a surrogate health care decision maker for this patient because:

I. My relationship to the patient is the one indicated by checkmark below.

II. I have spoken to or attempted to speak to all other adults, if there are any, who fit into my category, and to all those who fit into a higher category (on the list below, a higher category is one listed before my category). Each such person that I spoke to has either agreed that I may act as surrogate, or has expressed no objection to my acting as surrogate.

III. If I have not spoken to any such person, it is because the person is in an unknown location, or because he or she is in a location so remote that he or she cannot, as a practical matter, be contacted in a timely fashion, or because he or she has been adjudged incompetent and remains incompetent today.

____ 1. I am the judicially-appointed guardian of the patient. My guardianship appointment specifically gives me the authority to make health care decisions for the patient, and to make decisions regarding the providing, withholding, or withdrawal of life-sustaining treatment or artificially provided nutrition and hydration in instances involving terminal illness or injury and permanent unconsciousness.

____ 2. I am the husband or wife of the patient and am neither legally separated from the patient nor a party to a divorce proceeding with the patient.

____ 3. I am a child of the patient.

____ 4. I am a parent of the patient.

____ 5. I am a brother or sister of the patient.

____ 6. I am another person related to the patient by blood. To my knowledge, the patient has no other living relatives, or the patient's closer living relatives either cannot or will not serve as surrogates. I am the patient's _____.

____ 7. The patient has not known relatives who are able and willing to act as surrogate. I am a representative of the ethics committee at the facility where the patient is being treated or I am a representative of some other committee duly appointed to make health care decisions for this patient.

(e) Under penalty of perjury, I affirm that I am exercising my best independent judgment and agreeing to do what I believe the patient desires. I understand that under the laws of Alabama, certification on this form of any information known by me to be false is a eClass C felony, which has a penalty of up to ten 10 years imprisonment, and a fine of up to \$5,000.

Signature Of Health Care Decision Surrogate

~~Sworn to (or affirmed) and subscribed before me this~~ ____ day of _____, _____

Notary Public

Witnesses to the Signature of the Health Care Decision Surrogate (need two witnesses to sign):

By signing this document, I hereby certify that I am at least 19 years of age; that I have witnessed the signature of the individual signing as the surrogate; and that I am not the patient's health care provider or a nonrelative employee of the patient's health care provider.

Name of first witness: _____

Signature: _____

Date: _____

Name of second witness: _____

Signature: _____

Date: _____