Advance Directive

Durable Power of Attorney for Health Care

Patient Advocate Designation

COVENANT HealthCare

Extraordinary care for every generation.

Covenant HealthCare
1447 North Harrison
Saginaw, MI 48602

Advance Directive

Durable Power of Attorney for Health Care

Patient Advocate Designation

This is an Advance Directive for:

Name: _____ Date of Birth: _____

Address: _____

City/State/Zip: _____

Contact #: Home:_____ Cell: _____

Introduction

This document includes the required content to be legally recognized, in the state of Michigan, as an Advance Directive which includes the appointment of a Patient Advocate.

This **Advance Directive** allows you to appoint a person (and alternates) to make your health care decisions if you become unable to make these decisions for yourself. The person you appoint is called your **Patient Advocate**. This document gives your Patient Advocate authority to make your decisions *only when you have been determined unable to make your own decisions by two physicians, or a physician and a licensed psychologist.*

This form is referred to as the *"Durable Power of Attorney **for Health Care**"* (DPOA-HC) and should not be confused with a *"Durable Power of Attorney"* (DPOA) which relates to decisions about your financial matters.

Your Patient Advocate named in this DPOA-HC does not have the authority to make your financial or other business decisions. In addition, it *does not* give your Patient Advocate authority to make *certain* decisions about your mental health treatment.

Before completing this document, take time to read it carefully. **It also is very important that you discuss your views, values and this document with your Patient Advocate.**

If you do not closely involve your Patient Advocate, and you do not make a clear plan together, your views and values may not be fully respected because they will not be understood.

Appointment of Patient Advocate

If I am no longer able to make my own health care decisions, this document names the person(s) I choose to make these choices for me. This person will be my Patient Advocate and will make my health care decisions **only** when I am determined to be unable of making health care decisions under Michigan law. I understand that it is important to discuss my health and wishes for health care treatment with my Patient Advocate.

I hereby give my Patient Advocate permission to share a copy of this document with doctors, hospitals and health care providers that provide my medical care.

NOTE: If your wishes change, you may revoke your Patient Advocate Designation at any time and in any manner sufficient to communicate an intent to revoke. **It is recommended that you complete a new Advance Directive and give it to everyone who has a previous copy.**

I appoint the following person as my Patient Advocate:

I understand my Patient Advocate(s) must be at least eighteen years old and of sound mind.

Name: _____ Relationship to Patient: _____

Address: _____

City/State/Zip: _____

Contact #: Home:_____ Cell: _____

Appointment of Successor Patient Advocate(s)

I appoint the following person(s), in the order listed, to be my Successor Patient Advocate if my Patient Advocate named above is unable, unwilling or unavailable to serve as my Patient Advocate. My Successor Patient Advocate is to have the same powers and rights as my Patient Advocate.

First Alternative Patient Advocate:

Name: _____ Relationship to Patient: _____

Address: _____

City/State/Zip: _____

Contact #: Home:_____ Cell: _____

Second Alternative Patient Advocate:

Name: _____ Relationship to Patient: _____

Address: _____

City/State/Zip: _____

Contact #: Home:_____ Cell: _____

Bus. Dev. (AQ/RF) 10/15

My Choices: Instructions for Care

This section gives instructions for your care. You may list personalized instructions for treatment you do or do not want. Otherwise, your general instructions will stand as your wishes.

Current law does not permit your Patient Advocate to make decisions to withhold or withdraw treatment if you are pregnant, if such a decision would result in your death; to engage in homicide or euthanasia; or to force medical treatment you do not want because of your religious beliefs.

1. General Instructions

My Patient Advocate shall have the authority to make all decisions and to take all actions regarding my care, custody and medical treatment including but not limited to the following:

a. Have access to, obtain copies of and authorize release of my medical and other personal information.

b. Employ and discharge physicians, nurses, therapists and any other health care providers (Please note: the Patient Advocate is not responsible for payment of services).

c. Consent to, refuse or withdraw, for me, any medical care; diagnostic, surgical or therapeutic procedure; or other treatment of any type or nature, **including life-sustaining treatments**. I understand that life-sustaining treatment may include, but is not limited to, **ventilator (breathing machine), cardiopulmonary resuscitation (CPR), nutritional tube feedings, intravenous hydration, kidney dialysis, blood pressure or antibiotic medications**. I also understand that these decisions could or would allow me to die.

2. Personalized Instructions *(optional)*

My Patient Advocate is to be guided in making medical decisions for me by what I have told him/her about my personal preferences regarding my care. Some of my preferences are recorded below and/or on the following page.

a. Specific instructions regarding care I DO want:

_____

_____

_____

_____

b. Specific instructions regarding care I DO NOT want:

_____

_____

_____

_____

c. _____ *(Initials) I choose not to complete this section.*

Bus. Dev. (AQ/RF) 10/15

3. Specific Instructions Regarding Life-Sustaining Treatment *(optional)*

You do NOT have to choose one of the specific instructions about life-sustaining treatments in this section. If you choose not to provide any instructions, your Patient Advocate will make decisions based on the information you have shared with them verbally or what is considered in your best interest. But if you do select an option below, SIGN ONLY ONE INSTRUCTION. You are encouraged to discuss these choices with your doctor.

I understand that I **do not** have to choose one of the instructions regarding life-sustaining treatment listed below. If I choose one, I will sign below my choice.

If I sign one of the choices listed below, I direct reasonable measures be taken to keep me comfortable and relieve pain.

Choice One:

I do not want my life to be prolonged by providing or continuing life-sustaining treatment if **any** of the following medical conditions exist:

- I am in an irreversible coma or persistent vegetative state.
- I am terminally ill and life-sustaining procedures would only serve to artificially delay my death.
- The burdens of treatment outweigh the expected benefits. In weighing the burdens and benefits of treatment, I want my Patient Advocate to consider the relief of suffering and the quality of my life; as well as the extent of possibly prolonging my life.

I understand that this decision could allow me to die.

If this statement reflects your desires, sign here:_____

Choice Two:

I want my life to be prolonged by life-sustaining treatment **unless** I am in a coma or vegetative state which my doctor reasonably believes to be irreversible. Once my doctor has reasonably concluded that I will remain unconscious for the rest of my life, I do not want life-sustaining treatment to be provided or continued.

I understand this decision could allow me to die.

If this statement reflects your desires, sign here:_____

Choice Three:

I want my life to be prolonged to the greatest extent possible consistent with sound medical practice without regard to my condition, the chances I have for recovery, or the cost of my care; and I direct life-sustaining treatment be provided in order to prolong my life.

I understand that this decision may prolong life without a return to my previous quality of life.

If this statement reflects your desires, sign here:_____

_____ ***(Initials) I choose not to complete this section.***

Signature

- If I am unable to participate in making decisions for my care and there is no Patient Advocate or Successor Patient Advocate able to act for me, I request that the instructions I have given in this document be followed and that this document be treated as conclusive evidence of my wishes.
- This document is signed in the State of Michigan. It is my intent that the laws of the State of Michigan govern all questions concerning its validity, the interpretations of its provisions and its enforceability. I also intend that it can be applied to the fullest extent possible wherever I may be.
- Photocopies of this document can be relied on as if they were originals.
- I am providing these instructions of my free will. I have not been required to give them in order to receive or have care withheld or withdrawn. I am at least eighteen years old and of sound mind.

Sign and date below in the presence of at least two witnesses who meet the requirements in the witness statement below.

Signature:

Sign Name: _____ Date: _____

Print Name: _____

Witness Statement and Signatures

If you do not personally know the person signing this document, ask for identification, such as a driver's license or patient arm band. Only two witnesses are required. Using three will protect the validity of the Designation if one witness is later found ineligible to be a witness.

I know this person to be the individual identified as the "Person" signing this form. I believe him or her to be of sound mind and at least eighteen years old. I personally saw him or her sign this document, and I believe he or she did so under no duress, fraud or undue influence. In signing this document as a witness, I declare that I am:

- At least 18 years of age.
- Not the Patient Advocate, or a Successor Patient Advocate appointed in this document.
- Not the patient's spouse, parent, child, grandchild or presumptive heir.
- Not a known beneficiary of his/her will at the time of witnessing.
- Not an employee of a health or life insurance provider for the person who signed.
- Not an employee of a health care facility that is treating the patient at this time.
- Not a health care provider currently involved in the treatment of the patient.

Signatures: Two required

Sign Name: _____ Print Name:_____

Address: _____ Date:_____

Sign Name: _____ Print Name:_____

Address: _____ Date:_____

Third *(optional)*

Sign Name: _____ Print Name:_____

Address: _____ Date:_____

Bus. Dev. (AQ/RF) 10/15

Acceptance of Patient Advocate and Successor Patient Advocate(s)

The Patient Advocate and any successor Patient Advocate must sign this Acceptance before he/she may act as Patient Advocate.

I agree to be the Patient Advocate for _____ (called "patient" in the rest of this document). I accept the patient's designation of me as Patient Advocate. I understand and agree to take reasonable steps to follow the desires and instructions of the patient as indicated in the Designation of Patient Advocate, in other written instructions of the patient and as we have discussed verbally. If I am unavailable to act after reasonable effort to contact me, I delegate my authority to the persons the patient has designated as Successor Patient Advocate, in the order designated on the following page. The Successor Patient Advocate is authorized to act until I become available to act.

I also understand and agree that:

a. This designation shall not become effective unless the patient is unable to participate in medical treatment decisions.

b. A Patient Advocate shall not exercise powers concerning the patient's care, custody and medical treatment the patient would not have chosen on his or her behalf.

c. This designation cannot be used to make a medical treatment decision to withhold or withdraw treatment from a patient who is pregnant that would result in the pregnant patient's death, even if these were the patient's wishes.

d. A Patient Advocate may make a decision to withhold or withdraw treatment which would allow a patient to die only if the patient has expressed in a clear and convincing manner that the Patient Advocate is authorized to make such a decision, and that the patient acknowledges that such a decision could or would allow the patient's death.

e. A Patient Advocate shall not receive compensation for the performance of his or her authority, rights and responsibilities, but a Patient Advocate may be reimbursed for actual and necessary expenses incurred in the performance of his or her authority, rights and responsibilities.

f. A Patient Advocate shall act to further the patient's best interests. The known desires of the patient expressed or evidenced while the patient is able to participate in medical treatment decisions are presumed to be in the patient's best interests.

g. A patient may revoke his or her designation at any time and in any manner sufficient to communicate his or her intent to revoke.

h. A Patient Advocate may revoke his or her acceptance of the designation at any time and in any manner to communicate an intent to revoke.

Bus. Dev. (AQ/RF) 10/15

Acceptance: Patient Advocate Signatures

Before agreeing to accept the Patient Advocate responsibility, you should:

1. Read the Introduction.
2. Carefully read this completed form.
3. Discuss, in detail, the person's values and wishes, so that you can gain the information to allow you to make the decision he or she would desire.
4. Confirm your contact information listed on page two is correct.
5. If you are willing to accept the role of Patient Advocate, read, sign and date the following statement.

Primary Patient Advocate:

Sign Name: _____ Date: _____

Print Name: _____

First Successor Patient Advocate:

Sign Name: _____ Date: _____

Print Name: _____

Second Successor Patient Advocate:

Sign Name: _____ Date: _____

Print Name: _____

Making Changes

If only the contact information for your advocate(s) changes, it may be revised on the original and on the photocopies without replacing the entire form.

It is recommended that you review this document with your annual physical exam and whenever one of the events below occur:

- ***Decade*** *– when you start each new decade of your life (30, 40, 50, 60, 70, 80…years of age).*
- ***Death*** *– whenever you experience the death of someone close to you.*
- ***Divorce*** *– if you experience a divorce or other major family change.*
- ***Diagnosis*** *– if you are diagnosed with a serious health condition or experience a life threatening injury.*
- ***Decline*** *– if you have decline of an existing health condition, especially if you live alone.*

Who should have a copy of this document?

It is recommended to provide a copy of this document to the following people:

- **Your Physician**
- **Hospital Most Likely to Provide Care**
- **Each Patient Advocate**
- **Family Members Close to You**
- **Your Lawyer**

Bus. Dev. (AQ/RF) 10/15