Advance Directive

Durable Power of Attorney for Health Care

Patient Advocate Designation

INTRODUCTION

This document includes the required content to be legally recognized, in the state of Michigan, as a Durable Power of Attorney for Health Care, also known 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 medical and mental health care decisions if you become unable to make these decisions for yourself. The person you appoint is called your **Patient Advocate**. Your Patient Advocate only has authority to make your decisions *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.

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

Please note: This document is considered a guide. Your wishes must be shared with your provider at time of treatment. Your providers may decline to follow your written instructions, or your Patient Advocate's instructions, if (1) they are not medically indicated or medically achievable, (2) any requested treatment is not available, (3) complying would be inconsistent with the law or court-ordered treatment, (4) there is an emergency situation endangering your life.

For more information or assistance in completing this Advance Directive, contact a member of the Advance Care Planning Team:

989.583.6292 **Tel** • CovenantACP@chs-mi.com **Email**

Courtesy of Covenant HealthCare, Saginaw, MI • DPOA-HC

PF00180 (R 5/23)

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: _____

APPOINTMENT OF PATIENT ADVOCATE

If I am no longer able to make my own healthcare decisions, this document names the person(s) I choose to make these choices for me. This person will be my Patient Advocate. I understand my Patient Advocate(s) must be at least eighteen years old and of sound mind and that it is important to discuss my health status and wishes for medical and mental health treatments with them.

I appoint the following person as my Primary Patient Advocate:

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(s) **if my Primary Patient Advocate named above does not accept my apointment, is incapacitated, resigns or is removed.** My Successor Patient Advocate(s) are to have the same powers and rights as my Primary Patient Advocate.

First Successor Patient Advocate:

Name: _____ Relationship to Patient: _____

Address/City/State/Zip: _____

Contact #: Home:_____ Cell: _____

Second Successor Patient Advocate:

Name: _____ Relationship to Patient: _____

Address/City/State/Zip: _____

Contact #: Home:_____ Cell: _____

Third Successor Patient Advocate:

Name: _____ Relationship to Patient: _____

Address/City/State/Zip: _____

Contact #: Home:_____ Cell: _____

MY CHOICES: INSTRUCTIONS FOR CARE

Section 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, mental health and other personal information.

b. Employ and discharge physicians, nurses, therapists and any other healthcare 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. I understand this treatment may include, but is not limited to: **Ventilator (breathing machine), cardiopulmonary resuscitation (CPR), tube feedings, intravenous hydration, kidney dialysis and blood pressure or antibiotic medications**. I also understand that these decisions could or would allow me to die.

Sections 2-6 are *optional*. If you do not want to complete a section, initial the last choice in that section.

Section 2. Cardiopulmonary Resuscitation (CPR) *(Optional)*

CPR is emergency care that may be provided if your heart and breathing have stopped. This care may include: Chest compressions, defibrillation (electrical shock), specific cardiac arrest medications and intubation/mechanical ventilation (being placed on a breathing machine).

If my heart and breathing were to suddenly stop:

initials **I WANT** to be resuscitated.

initials **I WANT** to be resuscitated, unless any of the following medical conditions exist:

- An illness or injury that cannot be cured and I am dying.
- No reasonable chance of survival.
- The quality of life I have expressed to my Patient Advocate(s) as being important to me is unlikely to be achievable.

initials **I DO NOT WANT** to be resuscitated but instead would like to allow natural death.

Please note: If you choose not to be resuscitated, this wish will need to be shared verbally on each admission to a medical facility and will require an Out of Hospital DNR order to be honored by first responders (ambulance, fire department, etc.)

initials I choose not to complete this section.

Section 3. Life-Sustaining Treatment *(Optional)*

Examples of life-sustaining treatments include, but are not limited to: Tube-feeding, dialysis and artificial hydration.

If following a sudden medical event, my physicians believe that with my medical condition it is unlikely I would recover to know who I am or who I am with:

initials **I WANT** life-sustaining treatments initiated and continued.

initials **I DO NOT WANT** life-sustaining treatments initiated and continued.

initials I choose not to complete this section.

Section 4. Mental Health *(Optional)*

A person with a diagnosed Serious Mental Illness (SMI) should consider completing this section. SMI is defined as someone who has (or has had within the past year) a diagnosable mental, behavioral or emotional disorder that causes serious functional impairment that limits one's life activities. Some examples of when a person may lack functional ability include acute psychosis, mania, catatonia or delirium. You might want to write down medications, therapies or treatments that have worked for you or not worked for you, or mental health facilities or hospitals that you like or do not like. If you have a separate Psychiatric Advance Directive (PAD) in place you may want to list here where that document can be found.

_____

_____

_____

_____

_____

_____

initials I authorize my Patient Advocate to make decisions regarding mental health treatments.

initials I choose not to complete this section.

Section 5: Personal Preferences *(Optional)*

For suggestions, refer to the "Optional Personal Preferences to Consider" section at the end of this document.

_____

_____

_____

_____

_____

_____

initials I authorize my Patient Advocate to make decisions as stated above.

initials I choose not to complete this section.

Section 6. Persons I Want My Advocate to Include in the Decision Process *(Optional)*

This person is desired to have input on decisions but will not have decision-making authority.

If feasible, I would like my Patient Advocate to include the following person(s) in my healthcare decisions:

_____

_____

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.
- I am at least eighteen years old and of sound mind. 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.

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

I know this person to be the individual identified as the "Patient" 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: life or health insurance provider for the Patient, health facility that is treating the Patient, home for the aged where the Patient resides, or community mental health services program or hospital that is providing medical or mental health services to the Patient.
- Not a healthcare provider currently involved in the treatment of the Patient.

Witness Signatures:

1. Sign Name: _____ Print Name: _____

   Address: _____ Date: _____

2. Sign Name: _____ Print Name: _____

   Address: _____ Date: _____

Notary: ONLY required for residents of Missouri, North Carolina, South Carolina and West Virginia

STATE OF:_____

COUNTY OF:_____

On this _____ day of _____, 20_____,

the said: _____,

foregoing instrument and witnesses, respectively, personally appeared before me, a Notary Public, within and for the State and County a foresaid, and acknowledged that they freely and voluntarily executed the same for the purposes stated therein.

My commission expires on (date): _____

Notary Public Signature: _____

ACCEPTANCE OF PATIENT ADVOCATE(S)

The Patient Advocate and Successor(s) 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 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 decisions 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.

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 sufficient to communicate an intent to revoke.

PATIENT ADVOCATE SIGNATURES

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

1. **Carefully read this completed form.**
2. **Discuss, in detail, the person's values and wishes, so that you can gain the information that will allow you to make the decision(s) he or she would desire.**

Primary Patient Advocate: Date: _____

Sign Name: _____ Print Name: _____

First Successor Patient Advocate: Date: _____

Sign Name: _____ Print Name: _____

Second Successor Patient Advocate: Date: _____

Sign Name: _____ Print Name: _____

Third Successor Patient Advocate: Date: _____

Sign Name: _____ Print Name: _____

MAKING CHANGES

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.

Contact information for your Advocate(s) may be revised by drawing one line through the old information and adding new without replacing the entire document. For additional changes, a new document will need to be completed. If you decide to create a new document, please be sure to provide copies to all parties who have a copy of the old document.

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

- **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.

If when you review this document it still reflects your wishes, sign and date below to show the content is still correct.

REAFFIRMED *(signatures below do not need to be witnessed)*

Date:_____ Signature: _____

Date:_____ Signature: _____

Date:_____ Signature: _____

Date:_____ Signature: _____

WHO SHOULD HAVE A COPY OF THIS DOCUMENT?

It is important to have your Advance Directive available when needed in an emergency. For this reason, the following people and places are recommended to have a copy of your Advance Directive.

- **Your physician**
- **Hospital(s) most likely to provide care**
- **Each Patient Advocate**
- **Family member(s) close to you**
- **Your lawyer**
- **Keep a copy in the glove compartment of your vehicle.**
- **Keep a copy in your home where it can be easily found if you need to go to the hospital or call 911.**

I plan to provide copies of this document to *(check box once copy is provided)*:

_____ ☐ _____ ☐

_____ ☐ _____ ☐

_____ ☐ _____ ☐

_____ ☐ _____ ☐

OPTIONAL PERSONAL PREFERENCES TO CONSIDER

This section provides additional topics you may want to consider discussing with your Patient Advocate(s) so they understand your wishes. You may also want to add information to the Personal Preferences *(page 3, section 5)* in this document. Please note: Each section below contains examples of statements which were created as suggestions, not recommendations. If you have any questions, please contact a member of the Advance Care Planning Team at 989.583.6292.

Anatomical Gift or Organ Donation

- *I am registered on the Michigan Donor Registration and/or on my Michigan Driver's License* (Michigan law requires your Patient Advocate and your family to honor donation instructions).
- *I am not registered, but authorize my Patient Advocate to donate any parts of my body.*
- *I am not registered, but authorize my Patient Advocate to donate any parts of my body, with the EXCEPTION of this/these body part(s)* _____ (share which body parts you don't want to donate with your Patient Advocate).
- *I do not wish to donate my organs/tissue/or body.*
- *I have arranged, or plan to arrange, donating my body to an institution of medical science for research or training purposes* (must be arranged in advance).

Autopsy Preference

- *I accept having an autopsy if it can help my blood relatives understand the cause of my death or assist with their future healthcare decisions.*
- *I accept having an autopsy if it can help the advancement of medicine or medical education.*
- *If optional, I do not want an autopsy.*

Burial/Cremation Preference

- *I wish to have a burial.* • *I wish to be cremated.* • *I wish for an alternative funeral services.*
- *I have no preferences – either a burial or cremation. I leave this at the discretion of my next of kin.*
- *I have appointed a Funeral Representative** (requires a separate document – check with funeral home to obtain).

**Note: If you do not have a next of kin or wish for someone else to oversee your funeral arrangements, completing a Funeral Representative designation may be beneficial.*

Guardianship

There may come a time when you need someone to make more than medical decisions on your behalf. If you have not already made other arrangements, guardianship may be necessary to assist with decisions such as, but not limited to, living arrangements, obtaining income, handling finances and property. **Guardianship requires court appointment**. The statement below may be helpful to present to the court if guardianship is needed.

- *If I am in need of a guardian, I nominate the person I have named as my Primary Patient Advocate (followed by his or her successors) to be appointed as my legal guardian.*
- *If I am unable to make my own decisions, I want* _____ *to have guardianship over decisions other than healthcare.*

Long-Term Care or Housing

- *It is important to me to remain in my home if possible. I have prepared for this and ask that this request be honored.*
- *Though it is important to me to remain in my home, I understand that my care may become burdensome, and I would not want this. If in-home help is not an option, please select a living situation that respects my personal values.*

Tube Feeding – Artificial Nutrition/Hydration

- *If I cannot enjoy eating by mouth, please do not tube feed me. I view this as unnatural.*
- *I believe that if I am unable to take food by mouth, or if I have lost interest in eating, this is a natural process and should be respected. Please do not feed or hydrate me via tube or IV.*
- *If I cannot eat by mouth, please provide tube feedings if possible.*

What Makes You Comfortable or Relaxed

Share with your Patient Advocates what would make you comfortable:

- Music
- TV
- Lighting
- Visitors
- Readings or prayer
- Fan to circulate air
- Windows open
- Clergy visit
- Pet

Palliative Care and Hospice

Additional services may be necessary for you. Below is a comparison of palliative care and hospice services that you may want your family to consider. While both palliative care and hospice focus on improving a person's quality of life, there are differences. See below.

PALLIATIVE CARE	HOSPICE
Offered at onset of a serious or chronic illness or life-changing injury	Offered when a person's health condition is considered "terminal" and curative treatment is no longer offered
Manages symptoms at any time	Manages symptoms near end of life
May include aggressive, curative treatment	Care is focused on comfort, without aggressive, curative treatment
Does not take over care – patient continues to see all other providers	Usually manages overall care
May be provided in home, hospital, assisted and skilled living facilities	May be provided in home, hospital, assisted and skilled living facilities

WALLET CARD

The card below may be filled out and carried in your wallet to alert health care teams that you have completed an Advance Directive. This card is not a legal document. The complete Advance Directive is needed to be honored.

Cut here

NOTICE TO ALL MEDICAL PERSONNEL

I have an Advance Directive

Patient's Name:_____

A copy of my Advance Directive can be found at:

_____

One of the persons listed on the reverse of this card who has a copy of my Durable Power of Attorney for Health Care (DPOA-HC) should be contacted immediately, in the order listed (see reverse).

Primary Patient Advocate:_____

Cell #: _____ Alternate #: _____

First Successor Advocate: _____

Cell #: _____ Alternate #: _____

Other:_____

Cell #: _____ Alternate #: _____

Courtesy of Covenant HealthCare, Saginaw, MI

Fold here

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