Name: Be sure to use your full legal name here, and in the required areas on pages 4 and 5.

Appointment of Patient Advocate

One of the most important decisions to make when completing a DPOA-HC is who you appoint as your Patient Advocate. It is important to think carefully about this decision. When selecting your Patient Advocate(s), thoughtfully consider the following:

Your Patient Advocate should be:

- Someone who knows you well and will be able to make decisions in stressful situations. Sometimes a family member is the best choice as they know you well, but other times they may not be because they are too emotionally involved or for other personal reasons.
- Someone who will follow your wishes (even if he or she may not agree with them).
- Easy to contact. They do not need to be physically present to make decisions. They do, however, need to be easily contacted as the need to make decisions arise.
- Willing to accept the role of a Patient Advocate. Be sure to share your wishes with the person you would like to be your Patient Advocate before you actually appoint them. Without this conversation, your wishes may not be honored as they will not be known. If a crisis happens, this can make the role of a Patient Advocate very difficult.

You may select two Patient Advocate successors. However, only one person will be the decision maker at any given time. If your primary Patient Advocate is not available, your first Successor Patient Advocate will be your decision maker. If your primary Patient Advocate becomes available, he or she will resume their role as the decision maker.

My Choices: Instructions for Care

1. General Instructions

This section specifies the Patient Advocate’s authority to make decisions regarding:

- Access to your medical records
- Selecting your health care team
- Making medical decisions when you are not able to

2. Personalized Instructions

This section is optional, providing an area for you to list your specific personal requests. For example:

a. Specific instructions regarding care

I DO want: 

______________________

to be cremated
Page 2 (continued)

b. Specific instructions regarding care
   I DO NOT want:
   ____________________________________________________________________________
   If you do not wish to add any specifications, simply initial the bottom of the page:

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

Page 3

**My Choices** (continued)

3. Specific Instructions Regarding Life-Sustaining Treatment

   This section is optional, providing three different possible options to select from regarding life-sustaining treatment. If you want to complete this section, sign after the choice that meets your wishes.

   If you do not wish to select one of these options, simply initial the bottom of the page:
   **TMP** (Initials) I choose not to complete this section.

4. Persons I Want My Advocate to Include in the Decision Process

   This section is optional, allowing you to include additional individuals you would like to be involved in making decisions, whenever possible, regarding your care.

Page 4

**Signature**

You must sign your full legal name and date your Advance Directive DPOA-HC form in the presence of two witnesses.

**Witness Statement and Signatures**

This section spells out, in detail, the requirements and restrictions required for someone to qualify as a witness to you signing your DPOA-HC. Two witness signatures are required, but three are recommended in case a witness is found to be ineligible.

Page 5

**Acceptance of Patient Advocate(s)**

Print your full legal name in the space provided at the top of the page.

**Patient Advocate Signatures**

Each of your Patient Advocates must sign and date your DPOA-HC in the spaces provided on the bottom portion of the page.

**Please note:** It is recommended for you and your Patient Advocate(s) to sign on the same day. If this cannot happen, have your Patient Advocate(s) sign your DPOA-HC form as soon after you have signed as possible. In Michigan, Patient Advocate signature(s) are required to make this a legal document. Witnesses are not required for Patient Advocate signature(s).

Page 6

**Making Changes**

This section is provided to help you keep track of periodically reviewing your DPOA-HC.

**Who Should Have a Copy of This Document?**

This section provides recommendations and can help you keep track of who you have given copies of your DPOA-HC to.

**FINAL PAGE**

**Create Your Own Personal Wallet Card**

The last page is **NOT** part of the Advance Directive DPOA-HC legal document. It includes a wallet card that you can fill in and cut out for your convenience. It is recommended that you complete the card, have it laminated and keep it with you at all times.

**For questions or assistance in completing your Advance Directive, please feel free to contact the Covenant HealthCare Advance Care Planning Specialist at 989.583.6292.**