Durable Power of Attorney for Health Care

SpectrumHealth

One of three pages

I, _____ _____
(Name) (Date of Birth)

hereby appoint _____
(Patient Advocate)

residing at _____ _____
(Patient Advocate Address) (Phone Number)

as my attorney in fact (herein called patient advocate) with the following power to be exercised in my name and for my benefit, including, but not limited to, making decisions regarding my care, custody or medical treatment. This power of attorney has effect only if I become unable to participate in treatment decisions.

If the first individual is unable, unwilling or unavailable to serve as my patient advocate,

then I designate _____ **,**
(Successor Patient Advocate)

residing at _____ _____
(Successor Patient Address) (Phone Number)

to serve as my patient advocate.

I have instructed my Patient Advocate(s) concerning my wishes and goals in the use of life sustaining treatment - such as, but not limited to: ventilator (breathing machine), cardiopulmonary resuscitation (CPR), nutritional tube feedings, intravenous hydration, kidney dialysis, blood pressure or antibiotic medications—and hereby give my Patient Advocate(s) express permission to help me achieve my goals of care. This may include beginning, not starting, or stopping treatment(s). I understand that such decisions could or would allow my death. Medications and treatment intended to provide comfort or pain relief shall not be withheld or withdrawn.

☐ **I expressly authorize my Patient Advocate to make decisions to withhold or withdraw treatment which would allow me to die, and I acknowledge such decisions could or would allow my death.**

With respect to other personal care, my advocate shall have the power to make each and every judgment necessary for the proper and adequate care and custody of my person, including, but not limited to:
(If any of the following do not apply, I may place my initials next to the item.)

A. To have access to and control over my medical and other personal information.

B. To employ and discharge physicians, nurses, therapists and any other care providers, and to pay them reasonable compensation.

C. To execute waivers, medical authorizations and such other approval as may be required to permit or authorize care that I may need or to discontinue care that I am receiving.

D. My advocate shall be guided in making such decisions by what I have told my advocate about personal preferences regarding such care. Some of those preferences may be recorded below:

Recording any of your preferences in the space below is optional.

My wishes concerning care are as follows, including any religious beliefs that prevent an examination by a doctor, licensed psychologist, or other medical professional.

_____

_____

_____

It is my intent that my family, the medical facility, and any doctors, nurses and other medical personnel involved in my care not be liable for implementing the decisions of my patient advocate or honoring wishes expressed in this designation.

Photostatic copies of this document, after it is signed and witnessed, shall have the same legal force as the original document.

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This document is to be treated as a Durable Power of Attorney and shall survive my disability or incapacity.

This Advance Directive includes Patient Advocate acceptance.

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 construction of its provisions and its enforceability. I also intend that it be applied to the fullest extent possible wherever I may be.

I voluntarily sign this Durable Power of Attorney for Healthcare after careful consideration. I understand its meaning and accept its consequences.

_____ _____

(Signature) (Date)

_____

(Contact Phone Number)

WITNESSES:

I know this person to be the individual identified as the "Individual" signing this form. I believe him or her to be of sound mind and at least eighteen (18) years of age. I personally saw him or her sign this form, and I believe that he or she did so voluntarily and without duress, fraud, or undue influence.

By signing this document as a witness, I certify that I am:

- At least 18 years of age.
- Not the Patient Advocate or alternate Patient Advocate appointed by the person signing this document.
- Not the patient's spouse, parent, child, grandchild, sibling or presumptive heir.
- Not listed to be a beneficiary of, or entitled to, any gift from the patient's estate.
- Not directly financially responsible for the patient's health care.
- Not a health care provider directly serving the patient at this time.
- Not an employee of a health care or insurance provider directly serving the patient at this time.

Names and Addresses of Witnesses:

WITNESS ONE

Name: _____

Signature: _____

Address: _____

WITNESS TWO

Name: _____

Signature: _____

Address: _____

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Accepting the Role of Patient Advocate

Person completing
Advance Directive (Print Name): _____

Date of Birth: _____

I accept the person's selection of me as Patient Advocate. I understand and agree to take reasonable steps to follow the desires and instructions of the person as indicated within this "Advance Directive: My Patient Advocate" document or in other written or spoken instructions from the person. I also understand and agree that, according to Michigan law:

A. This appointment shall not become effective unless the patient is unable to participate in medical or mental health treatment decisions, as applicable.

B. I will not exercise powers concerning the patient's care, custody, medical or mental health treatment that the patient—if the patient were able to participate in the decision—could not have exercised on his or her own behalf.

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

D. I can make a decision to withhold or withdraw treatment which would allow the patient to die only if he or she has expressed clearly that I am permitted to make such a decision, and understand that such a decision could or would allow his or her death.

E. I may not receive payment for serving as Patient Advocate, but I can be reimbursed for actual and necessary expenses which I incur in fulfilling my responsibilities.

F. I am required to act in accordance with the standards of care applicable to fiduciaries when acting for the patient and shall act consistent with the patient's best interests. The known desires of the patient expressed or evidenced while the patient is able to participate in medical or mental health treatment decisions are presumed to be in the patient's best interests.

G. The patient may revoke his or her appointment of me as Patient Advocate at any time and in any manner sufficient to communicate an intent to revoke.

H. The patient may waive the right to revoke a designation as to the power to exercise mental health treatment decisions, and if such waiver is made, the patient's ability to revoke as to certain treatment will be delayed for 30 days after the patient communicates his or her intent to revoke.

I. I may revoke my acceptance of my role as Patient Advocate any time and in any manner sufficient to communicate an intent to revoke.

J. A patient admitted to a health facility or agency has the rights enumerated in Section 20201 of the Michigan Public Health Code, (Exercise of Rights by Patient's Representative 1978 PA 368, MCL 333.20201).

Patient Advocate Signature

Signature : _____ Date: _____

Print Name: _____

If I am unable or unavailable to act after reasonable efforts to contact me, I delegate my authority to the person designated as the second choice Patient Advocate. The following Patient Advocates are authorized (in the order listed) to act until I become available to act.

Successor Patient Advocate (Optional)

Signature : _____ Date: _____

Print Name: _____

Patient signature sections must be **signed by hand**, it is not fillable on electronic form.
Date section on the can be **typed** on the fillable form.

Treatment Preferences (Goals of Care)

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One of two pages. This document is a supplement to my Durable Power of Attorney for Healthcare document.

Person completing
Advance Directive (Print Name): _____

Date of Birth: _____

The following are my specific preferences and values concerning my health care. Hopes for health:

TODAY, IN YOUR CURRENT HEALTH

Put an X along this line to show how you feel today, in your current health.

My main goal is to live as long as possible, no matter what.

Equally Important

My main goal of focus is on quality of life and being comfortable.

AT THE END OF LIFE

Put an X along this line to show how you feel if you were so sick that you may die soon.

My main goal is to live as long as possible, no matter what.

Equally Important

My main goal of focus is on quality of life and being comfortable.

Unacceptable situations (outcomes):

- ❑ Not able to wake up or talk to my family and friends
- ❑ Not being able to live without being hooked up to machines
- ❑ Not being able to think for myself, such as dementia
- ❑ Not being able to feed, bathe, or take care of myself
- ❑ Not being able to live on my own
- ❑ Having constant, severe pain or discomfort
- ❑ Something else _____

Values and experiences that are important to me:

- ❑ Communicate with my family and friends
- ❑ Activities with my family and friends
- ❑ Remain independent for as long as possible
- ❑ _____
- ❑ _____
- ❑ _____

Treatment Preferences (Goals of Care)

SpectrumHealth

Two of two pages

Person completing
Advance Directive (Print Name): _____

Date of Birth: _____

Put your initials (or "X") next to the choice you prefer for each situation below.

TREATMENT TO PROLONG LIFE

If a circumstance arises where I am no longer able to recognize my family or friends and not expected to recover that ability:

____ I want all possible efforts to prolong life. Living as long as possible is more important than how I live.

____ I want to receive treatment and care to keep me comfortable.
How I live is more important than how long I live.

____ Undecided at this time.

If my health worsens, and a decision needs to be made about using a ventilator:

____ I want to receive ventilator therapies to help my breathing.

____ I want to try the ventilator to help my breathing, and if I do not improve,
I would like my care to be comfort focused. I understand this may result in my death.

____ I want to receive treatment and care to keep me comfortable.
How I live is more important than how long I live.

Additional considerations: _____

____ Undecided at this time.

If my heart or breathing stops, my preference for Cardiopulmonary Resuscitation (CPR):

____ I want CPR

____ I do not want CPR but instead want to allow natural death.

____ Undecided at this time.

Signature : _____ Date: _____

NOTE: This is not a "Do Not Resuscitate" (DNR) Order, which is a separate legal document.
Talk with your personal healthcare provider if you would like a DNR Order.

Patient signature section must be **signed by hand**, it is not fillable on electronic form.
Date section on the can be **typed** on the fillable form.