Instruction Sheet for Completing a Michigan Health Care Power of Attorney/Living Will

(Please discard instruction sheet after completion of document)

Overview

The attached Power of Attorney for Health Care form is a legal document, developed to meet the legal requirements for *Michigan. This document provides a way for a person to create a Power of Attorney for Health Care that will meet the basic requirements for this state.

This Power of Attorney for Health Care form allows you to appoint another person and alternate persons to make your own health care decisions if you become unable to make these decisions for yourself. The person you appoint is called your **Patient Advocate** in Michigan. This document gives your patient advocate authority to make your decisions only when you have been determined incapable by your physicians to make your own health care decisions. It does not give your patient advocate 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.

***For Michigan Residents Only: The name of a health care agent in Michigan is termed Patient Advocate. Michigan law requires all Patient Advocates to sign an Acceptance by Patient Advocate form found at the back of this document.**

Before completing this Power of Attorney for Health Care form, take time to read it carefully. **It is also 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.

If you want to document your views about future health care, but do not want to, or cannot use, this Power of Attorney for Health Care form, ask your health organization or attorney for advice about alternatives.

How to Complete This Document

This Power of Attorney for Health Care form is divided into four parts.

Part I – Appointing a Patient Advocate
Part II – Authority of the Patient Advocate
Part III – Statement of Desires, Special Provisions, or Limitations
Part IV – Making the Document Legal

Steps to Follow:

In each of the four parts of the attached document you will find instructions. Read and follow these instructions carefully. The basic things you must do are:

1. Provide the information on page 1.
2. Appoint at least one or more patient advocates on pages 2 and 3.
3. Indicate choices for sections 1, 2, and 3 on page 4.
4. Indicate any written instructions you want in Part III.
5. Sign and date the document on page 9.
6. Have the document witnessed. Both witnesses must be present when you sign this document.
7. Michigan residents complete Acceptance by Patient Advocate forms.

If you wish to donate your body after death to medical science, you should contact the closest medical school in your state and make arrangements through that medical school. Here is one Wisconsin option:

University of Wisconsin-Madison Medical School (608) 262-2888

After Completing This Document

After you complete the document, make copies to be given out as follows:

- One copy for yourself.
- One copy for the patient advocate and alternates appointed in the document.
- One copy to share and discuss with your physician.
- One copy for your record at the hospital where you would go in an emergency.
- Extra copies to share with others if you wish (loved ones, your clergy, and your attorney).

A photo or fax copy is as legally valid as an original.

Please mail completed, signed, and witnessed copy of documents, and signed copies of Patient Advocate Acceptance Form to:

To Your Bellin Clinic or Bellin Health Medical Records
744 South Webster Avenue
Green Bay, Wisconsin 54301

Need Assistance?

If you need assistance in completing this document you may contact Bellin Health Chaplaincy at (920) 433-3482 or (920) 433-3770.

Power of Attorney for Health Care Document

Name: _____

Date of Birth: _____

Address: _____

Telephone: _____

Copies of this document are being or have been given to the following health organizations and people (hospital, physician, and patient advocates), and copies might also be given to close family, friends and clergy, as listed below:

1._____ **2.**_____

3._____ **4.**_____

5._____ **6.**_____

7._____ **8.**_____

Notice to the Person Making This Document:

You have the right to make decisions about your health care. No health care may be given to you over your objection, and necessary health care may not be stopped or withheld if you object.

Because your health care providers in some cases may not have had the opportunity to establish a long-term relationship with you, they are often unfamiliar with your beliefs and values, and the details of your family relationships. This poses a problem if you become physically or mentally unable to make decisions about your health care.

In order to avoid this problem, you may sign this legal document to specify a person who you would want to make health care decisions for you if you become unable to make those decisions personally. That person is known as your patient advocate. You should take some time to discuss your thoughts and beliefs about medical treatment with the person or persons you might specify. You may state in this document any types of health care that you do or do not desire, and you may limit the authority of your patient advocate. If your patient advocate is unaware of your desires with respect to a particular health care decision, he or she is required to determine what would be in your best interests in making the decision.

This is an important legal document. It gives your advocate broad powers to make health care decisions for you. It revokes any prior Power of Attorney for Health Care that you

may have made. If you wish to change your Power of Attorney for Health Care, you may revoke this document at any time by destroying it, by directing another person to destroy it in your presence, by signing a written and dated statement, or by stating that it is revoked in the presence of two witnesses.

If you revoke, you should notify your advocate, your health care providers, and any other person to whom you have given a copy. If your advocate is your spouse and your marriage is annulled or you are divorced after signing this document, the designation of your spouse as patient advocate shall no longer be valid.

You may also use this document to make or refuse to make any anatomical gift upon your death. If you use this document to make or refuse to make an anatomical gift, this document revokes any prior record of gift you may have made. You may revoke or change any anatomical gift that you make in this document by crossing out the anatomical gifts provision in this document.

Do not sign this document unless you clearly understand it. It is suggested that you keep the original of this document on file with your physician

Part I – Appointing a Person to Make My Health Care Decisions When I Can't Make My Own Health Care Decisions

If I am no longer able to make my own health care decisions, this document names the person I choose to make these choices for me. This person will be my patient advocate. This person will make my health care decisions when I am determined to be incapable to make health care decisions as provided under state law.

Instructions for Completing This Part:

When selecting someone to be your patient advocate, pick someone who knows you well, who you trust, who is willing to respect your views and values, and who is able to make difficult decisions in stressful circumstances. Often family members are good choices, but not always. Make sure that you pick someone who will closely follow what you want and will be a good advocate for you. Whatever you do, take time to discuss this document and your views with the person(s) you pick to be your advocate(s).

Your patient advocate should be at least 18 years or older and should not be one of your health care providers or an employee of your health care provider unless they are a close relative. Space has been provided for a second and third alternate patient advocate.

The person I choose as my Patient Advocate is:

Name: _____

Day phone: _____ Evening phone: _____

Cell phone: _____

Address: _____

City: _____ State: _____ Zip Code: _____

If this patient advocate is unable or unwilling to make these choices for me, or if my spouse is designated as my patient advocate and our marriage is annulled or we are divorced or legally separated, **then my next choice for a patient advocate is**:

Second choice (1st Alternate Patient Advocate):

Name: _____

Day phone: _____ Evening phone: _____

Cell phone: _____

Address: _____

City: _____ State: _____ Zip Code: _____

If this alternate patient advocate is unable or unwilling to make these choices for me, or if my spouse is designated as my patient advocate and our marriage is annulled or we are divorced or legally separated, **then my next choice for a patient advocate is**:

Third choice (2nd Alternate Patient Advocate):

Name: _____

Day phone: _____ Evening phone: _____

Cell phone: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Part II – General Authority of the Patient Advocate

I want my patient advocate to be able to do the following (please cross out anything you do not want your patient advocate to do that is listed below):

- To make choices for me about my medical care or services, like tests, medicine, and surgery.
- If treatment has already been started, my patient advocate can keep it going or have it stopped depending upon my stated instructions or my best interests.
- To interpret any instruction I have given in this form or given in other discussions according to my patient advocate's understanding of my wishes and values.
- To review and release my medical records and personal files as needed for my medical care.
- To arrange for my medical care and treatment in Wisconsin, Michigan, Minnesota, and Iowa or any other state, as my patient advocate thinks appropriate.
- To determine which health professionals and organizations provide my medical treatment.
- To make decisions about organ/tissue or body donation decisions (anatomical gifts) after my death according to my known wishes or values.

Instructions for Completing These Sections:

Put your initial on the line (e.g., __DJ__) to indicate you have selected a "yes," "no," or "not applicable" in the next three sections. Draw a line through entire statements you do not select (e.g., ~~No, my health care…~~).

1. **Advocate authority to admit me to a nursing home or community-based residential facility for the purpose of long-term care:**

   _____ **Yes**, my patient advocate has authority, if necessary, to admit me to a nursing home or community-based residential facility for a long-term stay, subject to any limits I have set forth in this document.

   _____ **No**, my patient advocate does not have authority to admit me to a nursing home or a community-based residential facility for a long-term stay. If I initialed "no," or leave this section blank, I cannot be admitted to a long-term care facility without a court order.

2. **Advocate authority to order the withholding or withdrawal of feeding tube and IV hydration:**

   _____ **Yes**, my patient advocate has authority to have a feeding tube or IV hydration withheld or withdrawn from me subject to any limits I have set forth in this document.

   _____ **No**, my patient advocate does not have authority to have a feeding tube or IV hydration withheld or withdrawn from me. *If I initialed "no," or leave this section blank, feeding tubes or IV hydration cannot be withheld or withdrawn from me without a court order*.

3. **Advocate authority to make decisions if I am pregnant:**

   _____ **Yes**, my patient advocate has authority to make decisions for me if I am pregnant, subject to any limits I have later set forth in this document.

   _____ **No**, my patient advocate does not have authority to make decisions for me if I am pregnant. *If I initialed "no," or leave this section blank, health care decisions cannot be made for me during my pregnancy without a court order.*

   _____ **Not applicable**, because I am either a male or no longer capable of becoming pregnant.

Part III – Statement of Desires, Special Provisions, or Limitations

My patient advocate shall make decisions consistent with my stated desires and values and is subject to any special instructions or limitations that I may list here. The following are some specific instructions for my patient advocate and/or physician providing my medical care. If there are conflicts among my known values and goals, I want my advocate to make the decision that would best represent my values and preferences. If I require treatment in a state that does not recognize this Power of Attorney for Health Care, or my patient advocate cannot be contacted, I want the instructions below to be followed based on my common law and constitutional right to direct my own health care.

Instructions for Completing This Part:

You are **not required** to provide any written instructions or make any selections in Part III. If you choose **not** to provide any instructions, your patient advocate will make decisions based on your oral instructions or what is considered your best interest. If you choose **not** to provide any instructions, it is recommended that you draw a line and write "no instructions" across the page.

Stopping Attempts of Life-Prolonging Treatments:

[Either put your initial (e.g., __DJ__) *on the line next to each statement if you agree or draw a line through the statement if you do not agree.]*

_____ If I reach a point where it is reasonably certain that I will not recover my ability to interact meaningfully with myself, my family, friends, and environment, I want to stop or withhold all treatments that might be used to prolong my existence. Treatments I would not want if I were to reach this point include but are not limited to tube feedings, IV hydration, respirator/ventilator, CPR, and antibiotics.

Pain and Symptom Control:

_____ If I reach a point where efforts to prolong my life are stopped, I want medical treatments and nursing care that will make me comfortable. The following are important to me for comfort: _____
(If you don't write specific wishes, your physician and nurses will provide the best standard of care possible.)

Cardiopulmonary Resuscitation (CPR):

My CPR choice listed below may be reconsidered by my patient advocate in light of my other instructions or new medical information, if I become incapable of making my own decisions. If I do not want CPR attempted, my physician should be made aware of this choice. If I indicate below that I do not want CPR attempted, this choice, in itself, will not stop emergency personnel from attempting CPR in an emergency. Other documents may be needed to control the actions of emergency personnel.

(Initial one of the following statements and draw a line through the statements that you do not want.)

_____ I want CPR attempted unless my physician determines any one of the following:

- I have an incurable illness or injury and am dying; OR
- I have no reasonable chance of survival if I am resuscitated; OR
- I have little chance of long-term survival if my heart stops and the process of resuscitation would cause significant suffering.

_____ I want CPR attempted if my heart stops.

_____ I do not want CPR attempted if my heart stops, but rather, want to permit a natural death.

Other Instructions or Limitations I Want My Patient Advocate to Follow:

If it is possible, when I am nearing My Death and Cannot Speak, I Want My Friends and Family to Know I have the Following Thoughts and Feelings:

If I am nearing My Death, I Want the Following: (List the type of care, ceremonies, etc. that would make dying more meaningful for you.)

Persons I Want My Advocate to Include in the Decision Process:

I ask that my patient advocate make reasonable attempts to include the following persons in my health care decisions if there is time: _____

_____

Religion:

I am of the _____ faith, and am a member of the _____ congregation, synagogue, or worship group. Phone number of congregation, synagogue, or worship group (if known): _____. Please attempt to notify them.

Upon My Death:

After my death, the following are my instructions. If my patient advocate does not have authority to make these decisions, I ask that my next of kin and physician follow these requests if possible.

Autopsy:

(Initial both the first and second choice, or just one choice, and draw a line through the statements that you do not want.)

_____ I would accept an autopsy if it can help my blood relatives understand the cause of my death or assist them with their future health care decisions.

_____ I would accept an autopsy if it can help the advancement of medicine or medical education.

_____ I do not want an autopsy performed on me.

Donation of My Organs or Tissue (examples of organs are kidney, liver, heart, lung, and examples of tissue are eye, skin, bone, heart valve):

(Initial one and draw a line through the statements that you do not want.)

_____ *****I consent to donate any organs or tissue if I am a candidate. My consent implies First Person Authorization regarding my donation

_____ I consent to donate only the following organs or parts if possible (name the specific organs or tissue): _____

_____ I do not want to donate any organ or tissue.

***Please register your donation in your state at: GiftofLifeMichigan.org**

Part IV – Making the Document Legal

Instructions for Completing This Part:

*Michigan residents must have this document signed and dated in the presence of two witnesses.

I am thinking clearly; I agree with everything that is written in this document and I have made this document willingly.

_____ _____

My signature (or my signature signed by the person named below) Date

If I cannot sign my name, I can ask someone to sign this document for me.

_____ _____

Signature of the person who I asked to sign this document for me Date

_____

Print the name of the person who I asked to sign this document for me

***Statement of Witnesses**

I know this person to be the individual identified in the document. I believe him or her to be of sound mind and at least 18 years of age. I personally witnessed him or her sign this document, and I believe that he or she did so voluntarily. By signing this document as a witness, I certify that I am:

- **At least 18 years of age.**
- **Not related to the person signing this document** by blood, marriage or adoption.
- **Not a Health Care Agent or Patient Advocate** appointed by the person signing document.
- Not directly financially responsible for that's person's health care.
- **Not a health care provider** directly serving the person at this time.
- **Not an employee, volunteer, social worker, or chaplain of a health care provider** directly serving the person at this time.
- Not aware that I am entitled to or have a claim against the person's estate.

Witness number 1

_____ _____

Signature Date

_____

Print Name

_____

Address

Witness number 2

_____ _____

Signature Date

_____

Print Name

_____

Address

STATE OF MICHIGAN

PATIENT ADVOCATE FORM

(1) This designation shall not become effective unless the patient is unable to participate in decisions regarding the patient's medical or mental health, as applicable. If this patient advocate designation includes the authority to make an anatomical gift as described in section 5506, the authority remains exercisable after the patient's death.
(2) A patient advocate shall not exercise powers concerning the patient's care, custody, and medical or mental health treatment that the patient, if the patient were able to participate in the decision, could not have exercised in his or her own behalf.
(3) 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.
(4) 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.
(5) 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.
(6) A patient advocate shall 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.
(7) A patient may revoke his or her designation at any time or in any manner sufficient to communicate an intent to revoke.
(8) A patient may waive his or her right to revoke the patient advocate designation as to the power to make mental health treatment decisions, and if such waiver is made, his or her ability to revoke as to certain treatment will be delayed for 30 days after the patient communicates his or her intent to revoke.
(9) A patient advocate may revoke his or her acceptance to the designation at any time and in any manner sufficient to communicate an intent to revoke.
(10) A patient admitted to a health facility or agency has the rights
enumerated in Section 20201 of the Public Health Code, Act No. 368 of the Public Acts of 1978, Being Section 333.20201 of the Michigan Compiled Laws.

I, **(Print name of Patient Advocate):** _____
understand the above conditions and I accept the designation as Patient Advocate or Successor Patient Advocate for the below named: **(the following information must match the Name, Date of Birth, Address and Phone # on the top of Page 1 of document)**

NAME: _____

DATE OF BIRTH: _____

ADDRESS: _____

TELEPHONE: _____

who signed a power of attorney for health care on: _____
(signed date must match date signed on Page 9 of document)

Signed: _____ **Date:** _____
(Signature of Patient Advocate or Successor Patient Advocate) (Date you signed)

Please mail Immediately to:
To Your Bellin Clinic
or
Bellin Health Medical Records
744 South Webster Avenue
Green Bay, Wisconsin 54301

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