Triage Cancer Estate Planning Toolkit: Michigan

Part II: Understanding Estate Planning Documents in Your State

State Laws About Wills

A will is a legal document that provides instructions for what you would like to have happen to your property upon death. A will is also a place where parents can name a guardian for any minor children or adult children with developmental disabilities.

Michigan probate courts accept written, statutory, and holographic wills. To make a valid written will in Michigan:

1. You need to be in the right state of mind to create a will. This means you need to be:
    - At least 18 years old
    - Of "sound mind" (meaning you know what you're doing)
2. You need to sign the will, in front of two witnesses who have watched you sign or authorize someone else to sign the will, and understand what they are signing.
3. You might also want to make your will "self-proving," or accepted in probate court without the court needing to contact your witnesses. To do this, you and your witnesses must sign a statement in front of a notary public.

The Michigan state legislature created a statutory will form to make this process easier and more accessible. With this free form, you can execute your will by filling in the blanks and signing it in front of two witnesses (who meet the same requirements as those for a written will).

The benefits of this statutory will are that it is free to complete, and you can complete it on your own, without hiring an attorney. The downsides of a statutory will are that they cannot be customized. Therefore, statutory wills are best for very simple estates. Part III of this toolkit includes a sample form.

Michigan allows you to execute your will remotely (e.g. sign an affidavit by teleconferencing with a notary). However, before you execute your will remotely, you should check your state's laws to make sure that this is still allowed at the time you are executing your will.

A holographic will is one that is handwritten by you. To make a valid holographic will in Michigan:

1. You need to be in the right state of mind to create a will. This means you need to be:
    - At least 18 years old
    - Of "sound mind" (meaning you know what you're doing)
2. Your will must be written in your handwriting and you must sign and date it.

If you make a holographic will, it does not need to be signed by witnesses. However, most estate planning experts do not recommend relying on holographic wills because it is more difficult to prove that they are valid in probate court.

State Laws About Financial Powers of Attorney

A power of attorney for financial affairs is a legal document where you (the principal) name a trusted adult (the agent) who is authorized to make financial decisions on your behalf.

In Michigan, you can use this document to appoint someone (an "attorney-in-fact") to make all financial decisions (including managing property, bank accounts, and paying bills) for you. You can also appoint a successor, or someone to take over if the first person you choose is not available. This document takes effect when you sign it. As of July 1, 2024, a Michigan power of attorney is presumed durable, unless it expressly states that it will terminate upon the principal's incapacity.

Part III includes a sample form.

State Laws About Advance Health Care Directives

An advance health care directive (AHCD) is a legal document you can use to provide written instructions, or state preferences, about your medical care in case you become unable to communicate. In Michigan, this document is called a Michigan Patient Advocate Designation.

Michigan Patient Advocate Designation: This document allows you to choose someone (your "patient advocate") to make any and all health care decisions for you, including decisions about life-prolonging care, mental health care, and organ donation, if your doctor determines you can no longer make or communicate these decisions yourself. You can indicate your preferences for health care in advance to guide your patient advocate. You can also choose an alternate if the first person you choose is not available.

You can state your end-of-life preferences in this document, but Michigan does not currently recognize separate "living will" documents.

There are limits to this document. If you are pregnant, your patient advocate cannot make a decision to withhold or withdraw treatment if it would result in your death.

To make this document legal, you need to sign it (or direct someone to sign it for you) in front of two adult witnesses. Your witnesses cannot be:

- Your spouse, parent, child, grandchild, or sibling
- A person who stands to inherit from your estate
- Your physician or patient advocate
- An employee of your life or health insurance provider
- An employee of a health care or mental health care facility where you are being treated
- An employee of a home for the aged, if you are a resident

You can revoke this document at any time and in any way, as long as you are able to communicate your intent. Make sure you tell your physician and patient advocate to be sure your revocation is effective.

If you designate your spouse as your proxy and your marriage dissolves, your health care proxy is automatically revoked.

There is a separate organ donation form where you can share that you want to donate all organs, or only specific organs, as well as using your body for study and any other special wishes.

Part III includes a sample form.

State Laws About POLST/MOLST

A physician order for life-sustaining treatment (POLST) is a medical order completed by a seriously ill person and signed by a physician. In Michigan, this form is called Michigan Physician Orders for Scope of Treatment (MI-POST). The MI-POST does not replace an advance directive. You can complete the MI-POST form with your doctor.

This form lets you indicate your preferences for:

- Cardiopulmonary resuscitation orders (also known as a "Do not resuscitate," or DNR order)
- Medical Interventions, ranging from all medical and surgical treatments available to prolong your life, selective treatments to restore your health while avoiding burdensome procedures, or comfort-focused treatments to manage symptoms and allow natural death
- Additional orders or instructions for your care, where you can indicate medically assisted nutrition, or food and hydration offered through surgically-placed tubes

This form will not expire, so it is important for you and your physician to review it regularly to make sure it still reflects your wishes.

Part III includes a sample MI-POST form.

State Laws About Funeral Designation Forms

Funeral designation forms allow you to tell your loved ones what you would like to happen to your remains after you pass away. These forms can be used to choose someone to control what happens to your remains after your death, specify what you would like to have happen, and other wishes depending on your state.

Michigan does not have a dedicated funeral designation form, but Michigan law allows you to appoint a funeral representative, who is a person with the authority to make decisions regarding your final arrangements and resting place after death. You can designate who you want to serve as your funeral representative in your will, in your health care power of attorney document, or in a separate document either witnessed by two other persons or notarized.

State Laws About Death with Dignity

"Death with Dignity" laws, or physician-assisted dying/aid-in-dying laws, allow certain terminally ill people to voluntarily and legally request and receive a prescription medication from their physician to hasten their death in a peaceful, humane, and dignified way. By adding a voluntary option to the continuum of end-of-life care, these laws can give you dignity, control, and peace of mind during your final days with family and loved ones.

Michigan does not have a death with dignity law.

Federal Law About HIPAA

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) is a federal law that protects the privacy of your health information. HIPAA does allow your protected health information to be shared with your personal representative who has authority to make health care decisions for you (i.e., your health care agent or proxy).

To guarantee your agent's access to information, a HIPAA authorization form should be signed and dated by you. Also, it must identify the information to be disclosed, the purpose of the disclosure, the recipients of the information, and an expiration date. This means that any advance health care directives should be clear about the scope of your agent's authority to receive protected health care information.

You can revoke a HIPAA authorization form at any time by notifying your health care provider in writing.

Part III of this toolkit includes a sample HIPAA authorization form. For more information: www.cdc.gov/phlp/publications/topic/hipaa.html.

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Part III: Your State's Estate Planning Forms

- Statutory Will
- Power of Attorney for Financial Affairs
- Michigan Patient Advocate Designation
- Michigan Physician Orders for Scope of Treatment (MI-POST)
- HIPAA Authorization Form

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Part III: Your State's Estate Planning Forms

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Statutory Will

ESTATES AND PROTECTED INDIVIDUALS CODE (EXCERPT)
Act 386 of 1998

700.2519 Statutory will.

Sec. 2519. (1) A will executed in the form prescribed by subsection (2) and otherwise in compliance with the terms of the Michigan statutory will form is a valid will. A person printing and distributing the Michigan statutory will shall print and distribute the form verbatim as it appears in subsection (2). The notice provisions shall be printed in 10-point boldfaced type.

(2) The form of the Michigan statutory will is as follows:

MICHIGAN STATUTORY WILL NOTICE

1. An individual age 18 or older who has sufficient mental capacity may make a will.

2. There are several kinds of wills. If you choose to complete this form, you will have a Michigan statutory will. If this will does not meet your wishes in any way, you should talk with a lawyer before choosing a Michigan statutory will.

3. Warning! It is strongly recommended that you do not add or cross out any words on this form except for filling in the blanks because all or part of this will may not be valid if you do so.

4. This will has no effect on jointly held assets, on retirement plan benefits, or on life insurance on your life if you have named a beneficiary who survives you.

5. This will is not designed to reduce estate taxes.

6. This will treats adopted children and children born outside of wedlock who would inherit if their parent died without a will the same way as children born or conceived during marriage.

7. You should keep this will in your safe deposit box or other safe place. By paying a small fee, you may file this will in your county's probate court for safekeeping. You should tell your family where the will is kept.

8. You may make and sign a new will at any time. If you marry or divorce after you sign this will, you should make and sign a new will.

INSTRUCTIONS:

1. To have a Michigan statutory will, you must complete the blanks on the will form. You may do this yourself, or direct someone to do it for you. You must either sign the will or direct someone else to sign it in your name and in your presence.

2. Read the entire Michigan statutory will carefully before you begin filling in the blanks. If there is anything you do not understand, you should ask a lawyer to explain it to you.

MICHIGAN STATUTORY WILL OF _____
(Print or type your full name)

ARTICLE 1. DECLARATIONS

This is my will and I revoke any prior wills and codicils.
I live in _____ County, Michigan.
My spouse is _____.
(Insert spouse's name or write "none")
My children now living are:
_____ _____
_____ _____
_____ _____
(Insert names or write "none")

ARTICLE 2. DISPOSITION OF MY ASSETS

2.1 CASH GIFTS TO PERSONS OR CHARITIES.
(Optional)

I can leave no more than two (2) cash gifts. I make the following cash gifts to the persons or charities in the amount stated here. Any transfer tax due upon my death shall be paid from the balance of my estate and not from these gifts. Full name and address of person or charity to receive cash gift (name only 1 person or charity here):

_____
(Insert name of person or charity)
_____
(Insert address)
AMOUNT OF GIFT (In figures): $ _____
AMOUNT OF GIFT (In words): _____ Dollars
_____
(Your signature)

Full name and address of person or charity to receive cash gift
(Name only 1 person or charity):

_____
(Insert name of person or charity)

_____
(Insert address)
AMOUNT OF GIFT (In figures): $ _____
AMOUNT OF GIFT (In words): _____ Dollars

_____
(Your signature)

2.2 PERSONAL AND HOUSEHOLD ITEMS.

I may leave a separate list or statement, either in my handwriting or signed by me at the end, regarding gifts of specific books, jewelry, clothing, automobiles, furniture, and other personal and household items.

I give my spouse all my books, jewelry, clothing, automobiles, furniture, and other personal and household items not included on such a separate list or statement. If I am not married at the time I sign this will or if my spouse dies before me, my personal representative shall distribute those items, as equally as possible, among my children who survive me. If no children survive me, these items shall be distributed as set forth in paragraph 2.3.

2.3 ALL OTHER ASSETS.

I give everything else I own to my spouse. If I am not married at the time I sign this will or if my spouse dies before me, I give these assets to my children and the descendants of any deceased child. If no spouse, children, or descendants of children survive me, I choose 1 of the following distribution clauses by signing my name on the line after that clause. If I sign on both lines, if I fail to sign on either line, or if I am not now married, these assets will go under distribution clause (b).

Distribution clause, if no spouse, children, or descendants of children survive me.

(Select only 1)

(a) One-half to be distributed to my heirs as if I did not have a will, and one-half to be distributed to my spouse's heirs as if my spouse had died just after me without a will.

_____
(Your signature)

(b) All to be distributed to my heirs as if I did not have a will.

_____
(Your signature)

ARTICLE 3. NOMINATIONS OF PERSONAL REPRESENTATIVE, GUARDIAN, AND CONSERVATOR

Personal representatives, guardians, and conservators have a great deal of responsibility. The role of a personal representative is to collect your assets, pay debts and taxes from those assets, and distribute the remaining assets as directed in the will. A guardian is a person who will look after the physical well-being of a child. A conservator is a person who will manage a child's assets and make payments from those assets for the child's benefit. Select them carefully. Also, before you select them, ask them whether they are willing and able to serve.

3.1 PERSONAL REPRESENTATIVE.
(Name at least 1)

I nominate _____
(Insert name of person or eligible financial institution)
of _____to serve as personal representative.
(Insert address)
If my first choice does not serve, I nominate _____

_____
(Insert name of person or eligible financial institution)
of_____ to serve as personal representative.
(Insert address)

3.2 GUARDIAN AND CONSERVATOR.

Your spouse may die before you. Therefore, if you have a child under age 18, name an individual as guardian of the child, and an individual or eligible financial institution as conservator of the child's assets. The guardian and the conservator may, but need not be, the same person.

If a guardian or conservator is needed for a child of mine, I nominate _____
(Insert name of individual)

of _____ as guardian and
(Insert address)

_____
(Insert name of individual or eligible financial institution)
of _____ to serve as conservator.
(Insert address)

If my first choice cannot serve, I nominate

_____
(Insert name of individual)
of _____ as guardian and
(Insert address)

_____
(Insert name of individual or eligible financial institution)
of _____ to serve as conservator.
(Insert address)

3.3 BOND.

A bond is a form of insurance in case your personal representative or a conservator performs improperly and jeopardizes your assets. A bond is not required. You may choose whether you wish to require your personal representative and any conservator to serve with or without bond. Bond premiums would be paid out of your assets. (Select only 1)

(a) My personal representative and any conservator I have named shall serve with bond.

_____
(Your signature)

(b) My personal representative and any conservator I have named shall serve without bond.

_____
(Your signature)

3.4 DEFINITIONS AND ADDITIONAL CLAUSES.

Definitions and additional clauses found at the end of this form are part of this will.

I sign my name to this Michigan statutory will on _____ , 20_____.

_____
(Your signature)

NOTICE REGARDING WITNESSES

You must use 2 adults as witnesses. It is preferable to have 3 adult witnesses. All the witnesses must observe you sign the will, have you tell them you signed the will, or have you tell them the will was signed at your direction in your presence.

STATEMENT OF WITNESSES

We sign below as witnesses, declaring that the individual who is making this will appears to have sufficient mental capacity to make this will and appears to be making this will freely, without duress, fraud, or undue influence, and that the individual making this will acknowledges that he or she has read the will, or has had it read to him or her, and understands the contents of this will.

_____
(Print Name)

_____
(Signature of witness)

_____
(Address)

_____ _____ _____
(City) (State) (Zip)

_____
(Print name)

_____
(Signature of witness)

_____
(Address)

_____ _____ _____
(City) (State) (Zip)

_____
(Print name)

_____
(Signature of witness)

_____
(Address)
_____ _____ _____
(City) (State) (Zip)

DEFINITIONS

The following definitions and rules of construction apply to this Michigan statutory will:

(a) "Assets" means all types of property you can own, such as real estate, stocks and bonds, bank accounts, business interests, furniture, and automobiles.

(b) "Descendants" means your children, grandchildren, and their descendants.

(c) "Descendants" or "children" includes individuals born or conceived during marriage, individuals legally adopted, and individuals born out of wedlock who would inherit if their parent died without a will.

(d) "Jointly held assets" means those assets to which ownership is transferred automatically upon the death of 1 of the owners to the remaining owner or owners.

(e) "Spouse" means your husband or wife at the time you sign this will.

(f) Whenever a distribution under a Michigan statutory will is to be made to an individual's descendants, the assets are to be divided into as many equal shares as there are then living descendants of the nearest degree of living descendants and deceased descendants of that same degree who leave living descendants. Each living descendant of the nearest degree shall receive 1 share. The remaining shares, if any, are combined and then divided in the same manner among the surviving descendants of the deceased descendants as if the surviving descendants who were allocated a share and their surviving descendants had predeceased the descendant. In this manner, all descendants who are in the same generation will take an equal share.

(g) "Heirs" means those persons who would have received your assets if you had died without a will, domiciled in Michigan, under the laws that are then in effect.

(h) "Person" includes individuals and institutions.

(i) Plural and singular words include each other, where appropriate.

(j) If a Michigan statutory will states that a person shall perform an act, the person is required to perform that act. If a Michigan statutory will states that a person may do an act, the person's decision to do or not to do the act shall be made in good faith exercise of the person's powers.

ADDITIONAL CLAUSES

Powers of personal representative

1. A personal representative has all powers of administration given by Michigan law to personal representatives and, to the extent funds are not needed to meet debts and expenses currently payable and are not immediately distributable, the power to invest and reinvest the estate from time to time in accordance with the Michigan prudent investor rule. In dividing and distributing the estate, the personal representative may distribute partially or totally in kind, may determine the value of distributions in kind without reference to income tax bases, and may make non-pro rata distributions.

2. The personal representative may distribute estate assets otherwise distributable to a minor beneficiary to the minor's conservator or, in amounts not exceeding $5,000.00 per year, either to the minor, if married; to a parent or another adult with whom the minor resides and who has the care, custody, or control of the minor; or to the guardian. The personal representative is free of liability and is discharged from further accountability for distributing assets in compliance with the provisions of this paragraph.

POWERS OF GUARDIAN AND CONSERVATOR

A guardian named in this will has the same authority with respect to the child as a parent having legal custody would have. A conservator named in this will has all of the powers conferred by law.

History: 1998, Act 386, Eff. Apr. 1, 2000;—2000, Act 54, Eff. Apr. 1, 2000;—Am. 2005, Act 204, Imd. Eff. Nov. 10, 2005;—Am. 2009, Act 46, Eff. Apr. 1, 2010;—Am. 2010, Act 325, Eff. Apr. 1, 2010.

Compiler's note: As to actions taken with respect to a clerical error detected in Enrolled Senate Bill No. 1045 filed with the Secretary of State on March 30, 2000, see the following correspondence:

"September 14, 2000

"Secretary of State Candice Miller

"Department of State

"Treasury Building

"430 W. Allegan

"Lansing, MI 48918-9900

"Dear Secretary Miller:

"The purpose of this letter is to document the action I am taking in order to correct a clerical error recently detected in Enrolled Senate Bill 1045. I signed this bill on March 29, 2000. It was filed with the Secretary of State on March 30, 2000, and assigned Public Act Number 54 of 2000. This legislation made various, largely technical amendments to the Estates and Protected Individuals Code that, having been given immediate effect, took effect on April 1, 2000.

"The Secretary of the Senate and the Clerk of the House re-presented a corrected version of Enrolled Senate Bill 1045 to me on September 11, 2000, along with the accompanying letter. Apparently, a clerical error was made during the enrollment process.

Specifically, Section 2519, which updated the year '19 __' to '20__' on the Michigan statutory will form was inadvertently omitted from the bill. During the 6 months this error remained undetected, an unknown and unknowable number of persons may have relied on its provisions, all but one of which are unaffected by this correction which, in effect, makes a century date change.

"The Secretary of the Senate and the Clerk of the House have recommended that I now re-sign a corrected version to be assigned the same date and public act number of the originally signed bill. Michigan case law supports this recommended procedure due to the fact that the omission was a 'clerical mistake' that dealt with a non-substantive provision of the bill.

"As the court held in Board of Control v Auditor General, 149 Mich 386, 388 (1907), '(an) omission in the enrolled bill of words not essential to its substance or effect will not render the act invalid.' Similar decisions can be found in more recent court opinions. Beacon Club v Kalamazoo Sheriff, 332 Mich 412 (1952).

"Therefore, I have affixed the revised enrolled bill with the same date as the date of my original signature. In addition, it is my expectation that the corrected enrolled bill will receive Public Act Number 54 of 2000.

"Sincerely,

"John Engler

"Governor

"cc: Michigan State Senate

"Michigan House of Representatives"

"September 10, 2000

"The Honorable John Engler

"Capitol Building

"Lansing, Michigan 48913

"Subject: PA 54 of 2000

"Dear Governor Engler:

"A clerical error has been detected in Enrolled Senate Bill 1045, which was filed with the Secretary of State on March 30, 2000, and assigned Public Act No. 54 of 2000. The bill presented to you on March 29, 2000, did not accurately reflect what was agreed to by both houses of the Legislature. Specifically, Section 2519, which updated the year from '19 __' to '20__' on the Michigan statutory will form was inadvertently omitted from the bill.

"Therefore, we are presenting a correct Enrolled Senate Bill for your signature and filing with the Secretary of State. Upon filing, the defective Enrolled Senate Bill 1045 will be replaced with the correct Enrolled Senate Bill 1045 and assigned the same public act number. The inaccurate enrolled bill was signed by you on March 29, 2000, and filed with the Secretary of State on March 30, 2000. The effective date of Public Act No. 54 of 2000 will remain April 1, 2000.

"This procedure ensures that the bill as passed by both houses of the Legislature is accurately filed and effective, while this document will provide notification to the public. We apologize for any inconvenience this may have caused you and the citizens of the state of Michigan. If you have any questions, please feel free to contact us.

"Sincerely,

"Carol Morey Viventi

"Secretary of the Senate

"Gary L. Randall

"Clerk of the House of Representatives

"cc: Candice S. Miller, Secretary of State"

Enacting section 1 of Act 325 of 2010 provides:

"Enacting section 1. (1) Except as provided in subsection (2), this amendatory act takes effect April 1, 2010.

"(2) Section 3207 of the estates and protected individuals code, 1998 PA 386, MCL 700.3207, as amended by this amendatory act, takes effect on the date this amendatory act is enacted into law."

Popular name: Statutory Will

Popular name: EPIC

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Power of Attorney for Financial Affairs

MICHIGAN
GENERAL POWER OF ATTORNEY FORM

I. NOTICE - This legal document grants you (Hereinafter referred to as the "Principal") the right to transfer unlimited financial powers to someone else (Hereinafter referred to as the "Attorney-in-Fact"), unlimited financial powers are described as: **all financial decision making power legal under law**. The Principal's transfer of financial powers to the Attorney-in-Fact are granted upon authorization of this agreement, and DO NOT stay in effect in the event of incapacitation by the Principal (incapacitation is described in Paragraph II). This agreement does not authorize the Attorney-in-Fact to make medical decisions for the Principal. The Principal continues to retain every right to all their financial decision making power and may revoke this General Power of Attorney Form at anytime. The Principal may include restrictions or requests pertaining to the financial decision making power of the Attorney-in-Fact. It is the intent of the Attorney-in-Fact to act in the Principal's wishes put forth, or, to make financial decisions that fit the Principal's best interest. All parties authorizing this agreement must be at least 18 years of age and acting under no false pressures or outside influences. Upon authorization of this General Power of Attorney Form, it will revoke any previously valid General Power of Attorney Form.

II. INCAPACITATION – The powers granted to the Attorney-in-Fact by the Principal in this General Power of Attorney Form DO NOT stay in effect upon incapacitation by the Principal, incapacitation is describes as: **A medical physician stating verbally or in writing that the Principal can no longer make decisions for them self.**

III. REVOCATION - The Principal has the right to revoke this General Power of Attorney Form at anytime. Any revocation will be effective if the Principal either:

A. Authorizes a new General Power of Attorney Form.
B. Authorizes a Power of Attorney Revocation Form.

IV. WITNESS & NOTARY - This document is not valid as a General Power of Attorney unless it is acknowledged before a notary public or is signed by at least two adult witnesses who are present when the Principal signs or acknowledges the Principal's signature**. It is recommended to have this General Power of Attorney Form notarized.**

V. PRINCIPAL - I, _____, residing at
Name of Principal

_____
Street Address of Principal

City of _____, State of _____, appoint
City of Principal *State of Principal*
the following as my Attorney-in-Fact, whom I trust with any and all my financial decision making power immediately upon the authorization of this form:

VI. ATTORNEY-IN-FACT - _____, residing at
Name of Attorney-in-Fact

_____
Street Address of Attorney-in-Fact

City of _____, State of _____ grant
City of Attorney-in-Fact *State of Attorney-in-Fact*
the Attorney-in-Fact the legal authority to act on my behalf for any power legal under law in regard to my financial decisions under the State of

_____.
State

VII. SUCCESSOR ATTORNEY-IN-FACT (*Optional*) - If the Attorney-in-Fact named above cannot or is unwilling to serve, then I appoint _____,
Name of Successor Attorney-in-Fact
residing at

_____
Street Address of Successor Attorney-in-Fact

City of _____, State of _____ grant
City of Successor Attorney-in-Fact *State of Successor Attorney-in-Fact*

the Attorney-in-Fact the legal authority to act on my behalf for any power legal under law in regard to my financial decisions under the State of

_____.
State

VIII. TERMS & CONDITIONS – Upon authorization by all parties, the Attorney-in-Fact accepts their designation to act in the Principal's best interests for all financial decisions legal under law.

IX. THIRD PARTIES – I, the Principal, agree that any third party receiving a copy via: physical copy, email, or fax that I, the Principal, will indemnify and hold harmless any and all claims that may be put forth in reference to this Durable Power of Attorney Form.

X. COMPENSATION – The Attorney-in-Fact agrees not to be compensated for acting in the presence of the Principal. The Attorney-in-Fact may be, but not entitled to, reimbursement for all: food, travel, and lodging expenses for acting in the presence of the Principal.

XI. DISCLOSURE - I intend for my attorney-in-fact under this Power of Attorney to be treated, as I would be with respect to my rights regarding the use and disclosure of my individually identifiable health information or other medical records. This release authority applies to any information governed by the Health Insurance Portability and Accountability Act of 1996 (aka HIPAA), 42 USC 1320d and 45 CFR 160-164

XII. PRINCIPAL'S SIGNATURE - I, _____, the Principal,
Printed Name of Principal

sign my name to this power of attorney this _____ day of
Day
_____ and, being first duly sworn, do declare to the
Month
undersigned authority that I sign and execute this instrument as my power of attorney and that I sign it willingly, or willingly direct another to sign for me, that I execute it as my free and voluntary act for the purposes expressed in the power of attorney and that I am eighteen years of age or older, of sound mind and under no constraint or undue influence.

_____
Signature of Principal

XIII. ATTORNEY-IN-FACT'S SIGNATURE - I, _____
Name of Attorney-in-Fact
have read the attached power of attorney and am the person identified as the attorney-in-fact for the principal. I hereby acknowledge and accept my appointment as Attorney-in-Fact and that when I act as agent I shall exercise the powers for the benefit of the principal; I shall keep the assets of the principal separate from my assets; I shall exercise reasonable caution and prudence; and I shall keep a full and accurate record of all actions, receipts and disbursements on behalf of the principal.

_____ _____
Signature of Attorney-in-Fact *Date*

SUCCESSOR ATTORNEY-IN-FACT'S SIGNATURE (*Optional)* -

I, _____ have read the attached power of
Name of successor Attorney-in-Fact
attorney and am the person identified as the successor attorney-in-fact for the principal. I hereby acknowledge that I accept my appointment as Successor Attorney-in-Fact and that, in the absence of a specific provision to the contrary in the power of attorney, when I act as agent I shall exercise the powers for the benefit of the principal; I shall keep the assets of the principal separate from my assets; I shall exercise reasonable caution and prudence; and I shall keep a full and accurate record of all actions, receipts, and disbursements on behalf of the principal.

_____ _____
Signature of Successor Attorney-in-Fact *Date*

Notary Acknowledgement (*Must be completed by Notary*)

State of _____ County of _____ Subscribed, Sworn and acknowledged before me by _____, the Principal, and subscribed and sworn to before me by _____, witness, this _____ day of _____.

_____
Notary Signature

Notary Public
In and for the County of _____
State of _____
My commission expires: _____ Seal

Acknowledgement and Acceptance of Appointment as Attorney-in-Fact

I, _____ have read the attached power of attorney
Name of Attorney-in-Fact
and am the person identified as the attorney-in-fact for the principal. I hereby acknowledge that accept my appointment as Attorney-in-Fact and that when I act as agent I shall exercise the powers for the benefit of the principal; I shall keep the assets of the principal separate from my assets; I shall exercise reasonable caution and prudence; and I shall keep a full and accurate of all actions, receipts and disbursements on behalf of the principal.

_____ _____
Signature of Attorney-in-Fact *Date*

Acceptance of Appointment as successor Attorney-in-Fact

I, _____ have read the attached power of
Name of successor Attorney-in-Fact
attorney and am the person identified as the successor attorney-in-fact for the principal. I hereby acknowledge that I accept my appointment as Successor Attorney-in-Fact and that, in the absence of a specific provision to the contrary in the power of attorney, when I act as agent I shall exercise the powers for the benefit of the principal; I shall keep the assets of the principal separate from my assets; I shall exercise reasonable caution and prudence; and I shall keep a full and accurate record of all actions, receipts, and disbursements on behalf of the principal.

_____ _____
Signature of Successor Attorney-in-Fact *Date*

Witness Attestation

I, _____, the first witness, and I _____
Printed Name of First Witness *Printed Name of Second Witness*
the second witness, sign my name to the foregoing power of attorney being first duly sworn and do not declare to the undersigned authority that the principal signs and executed this instrument as him or her, and that I, in the presence and hearing of the principal, sign this power of attorney as witness to the principal's signing and that to the best of my knowledge the principal is eighteen years of age or older, of sound mind and under no constraint or undue influence.

_____ _____
Signature of First Witness *Signature of Second Witness*

Triage Cancer Estate Planning Toolkit

⌘

Part III: Your State's Estate Planning Forms

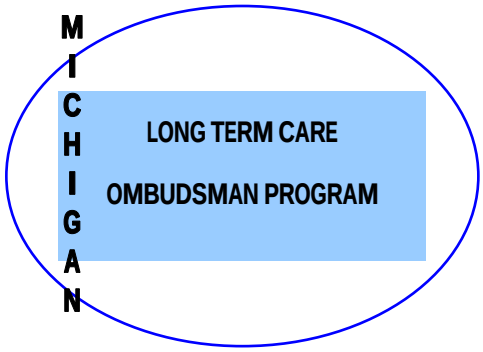
⌘

Advance Health Care Directive

Advance Directives

Planning for Medical Care in the Event of

Loss of Decision-Making Ability



Bradley Geller

Michigan Long Term Care Ombudsman Program

Foreword

We all value the right to make decisions for ourselves. Whether we term this autonomy, liberty or independence, it is central to our concept of dignity.

One important area in which we exercise independence is in choosing the medical treatment we receive. Few would deny a competent adult has the right to consent to or refuse particular medical treatments or medically related services.

Unfortunately, due to illness or injury, we may not remain able to participate in treatment decisions. Such disability may be temporary or permanent.

No one likes to consider the possibility of becoming unable to make decisions. It is easy to put off thinking about that happening, and what treatment we would like in those circumstances.

As difficult as it is to confront these issues, by doing so we can help ensure our wishes are honored in the future.

Once you determine your wishes, the process of planning is relatively simple and inexpensive or free. This pamphlet contains information on advance directives to assist you. The fill-in-the-blanks forms at the end of the pamphlet are but one option should you choose to proceed.

Questions and Answers About Advance Directives

A. Introduction

What is an *advance directive*?

An advance directive is a written document in which you specify what type of medical care you want in the future, or who you want to make decisions for you, should you lose the ability to make decisions for yourself.

Why is there a need for advance directives?

Years ago, most individuals died in their own homes. Today, there is greater chance of dying in a hospital or nursing home.

Expanding technology has increased the treatment choices we face, and improved public health has increased life expectancy. Decisions may have to be made concerning our care at a time we can no longer communicate our wishes.

What are the advantages of having an advance directive?

We each have our own values, wishes and goals. Having an advance directive provides you some assurance your personal wishes concerning medical and mental treatment will be honored at a time when you are not able to express them. Having an advance directive may also prevent the need for a guardianship imposed through the probate court.

Must I have an advance directive?

No. The decision to have an advance directive is purely voluntary. No family member, hospital or insurance company can force you to have one, or dictate what the document should say if you decide to write one.

A hospital or nursing home or hospice organization cannot deny you service because you do or don't have an advance directive.

Are there different types of advance directives?

Yes. Three types are a durable power of attorney for health care, a living will, and a do-not-resuscitate declaration.

There is also a declaration of anatomical gift, to take effect when you die.

Can I have more than one type of advance directive?

Yes. You may choose to have any number of advance directives, or to have none at all.

B. Durable Power of Attorney For Health Care

What is a *durable power of attorney for health care*?

A durable power of attorney for health care, also known as a health care proxy or a patient advocate designation, is a document in which you appoint another individual to make medical treatment and related personal care decisions for you when you can no longer make them for yourself.

You can, in addition, choose to give your patient advocate power to make decisions concerning mental health care you may need.

Finally, you can empower your patient advocate to donate specific organs or your entire body upon your death.

Is a durable power of attorney for health care legally binding?

Yes.

Who is eligible to have a durable power of attorney for health care?

You must be at least 18 years old, and you must understand you are giving another person power to make certain decisions for you should you become unable to make them.

Is there a required form for a durable power of attorney for health care?

No. You may choose to use the sample form in this pamphlet. There are a number of organizations that provide different, free forms.

Make sure in completing any document you type or print clearly.

Must I use a fill-in-the-blanks form?

No. You may write out your own document or have a lawyer draft a document for you. Using the form in this pamphlet is one option you have.

What is the person to whom I give decision-making power called?

That person is known as your *patient advocate*.

When can the patient advocate act in my behalf?

Your patient advocate can make decisions for you only when you become unable to participate in medical treatment decisions yourself. Until that time, you make your own decisions directly.

If you choose to give your patient advocate power to make decisions about mental health treatment, your patient advocate can only act if you cannot give informed consent to mental health treatment.

How might I become unable to participate in medical or mental health decisions?

You might have a temporary loss of ability to make or communicate decisions if, for example, you had a stroke or were knocked unconscious in a car accident. You might suffer permanent loss through a degenerative condition, such as dementia.

You might become unable to make mental health decisions if a condition such as severe depression or schizophrenia affected your mood or thought process.

Who determines I am no longer able to participate in these decisions?

The doctor responsible for your care and one other doctor or psychologist who examines you will make that determination in the case of medical decisions.

After examining you, a doctor and a mental health professional (physician, psychologist, registered nurse or masters-level social worker) must

each make the determination in respect to mental health treatment. You may in the document choose the doctor and mental health professional you wish to make this determination.

What if my religious beliefs prohibit an examination by a doctor?

You should state in your durable power of attorney document your religious beliefs prohibit an examination by a doctor, and how you want it determined you are unable to participate in health care decisions.

What powers can I give a patient advocate?

You can give a patient advocate power to make those personal care decisions you normally make for yourself. For example, you can give your patient advocate power to consent to or refuse medical treatment for you; arrange for mental health treatment, home health care or adult day care; or admit you to a hospital, nursing home or home for the aged.

You can also authorize your patient advocate to make a gift of your organs or body, to be effective upon your death.

Will my patient advocate have power to handle my financial affairs?

You can give your patient advocate power to arrange for medical and personal care services, and to pay for those services using your funds. Your patient advocate will <u>not</u> have general power to handle all your property and finances.

If you wish another person to handle all your property and financial affairs should you become incapacitated, you could seek a lawyer's help to draft a *durable power of attorney for finances* or a *living trust*.

Can I give my patient advocate the right to withhold or withdraw treatment that would allow me to die?

Yes, but you must express in a clear and convincing manner the patient advocate is authorized to make such decisions, and you must acknowledge these decisions could or would allow your death.

Can I authorize my patient advocate to decide to withhold or withdraw food and water administered through tubes?

Yes.

If you want to give you patient advocate this authority, you can describe in the document the specific circumstances in which he or she can act - terminal illness, and permanent unconsciousness, for example.

Can I give my patient advocate authority to sign a Do-Not-Resuscitate Order?

Yes.

Do I have the right in the document to express other wishes?

Yes. You might, for example express your wishes concerning other types of care you want during terminal illness. You could also express a desire not to be placed in a. nursing home and a desire to die at home. Your patient advocate has a duty to try to follow your wishes.

What are my options about mental health care?

First, you have a choice whether or not to give your patient advocate any powers concerning mental health care.

If you choose to give your patient advocate powers concerning mental health care, you should specify clearly which powers he or she can exercise. Some powers to consider are outpatient treatment, hospitalization, administration of psychotropic medication, and electro-convulsive therapy (ECT).

You can also provide greater detail - what hospital you prefer and what medications you want or don't want, for instance.

What are my options concerning organ donation?

You can choose whether or not to give your patient advocate this power.

If you wish your patient advocate to have this power, you can specify which organs you want donated, or whether your whole body is to be donated. You can specify where or to whom you wish your organs donated.

Is there an alternative to using a durable power of attorney for health care to arrange for organ donation?

Yes. You can complete the separate form in this booklet, *Declaration of Anatomical Gift.*

If you state your wishes both in the durable power of attorney and in the declaration of anatomical gift, make sure your wishes are the same in both documents.

Is it important to express my specific wishes in an advance directive?

Your wishes cannot be followed if no one is aware of them. It can also be a burden for your advocate to make a decision for you without guidance. If you have specific desires, make these clear to your patient advocate in talking to him or her. Also consider including these wishes in the document.

What is the duty of my patient advocate?

Your patient advocate has a duty to take reasonable steps to follow your desires and instructions, oral and written, expressed while you were able to participate.

Are there exceptions?

A mental health professional can refuse to honor your wishes concerning a specific mental health treatment, location or professional, if there is a psychiatric emergency endangering your life or the life of another person.

What if I don't ever express any specific wishes concerning medical treatment?

Your patient advocate must act in your best interests.

Will a hospital or nursing home allow my patient advocate to review my records?

Yes. A patient has the right to inspect and copy his or her hospital or nursing home records. Your patient advocate has the same right you have, once you are unable to participate in treatment decisions.

The form in this pamphlet allows a patient advocate to have access to your medical records at any time after you appoint him or her.

Whom can I appoint as patient advocate?

Any person age 18 or older is eligible; you can appoint your spouse, an adult child, a friend or other individual. You should choose someone you trust, who can handle the responsibility, and who is willing to serve.

You should speak with the individual you propose to name as patient advocate before you complete and sign the document, to ensure she or he is willing to serve.

Can I appoint a second person to serve as patient advocate in case the first person is unable to serve?

Yes. It is a good idea to do so.

There is no provision in law providing for more than one person to serve at the same time.

What must I do to have a valid durable power of attorney for health care?

The declaration must be in writing, signed by you, and witnessed by two adults.

There are restrictions on who can be a witness. You need witnesses who are not family members, not your doctor or proposed patient advocate, not an employee of a health facility or program where you are a patient or client.

What does a patient advocate need to do before acting in my behalf?

Before the patient advocate can act, he or she must sign an *acceptance.* This can be done at the time you complete the document or at a later time. The general language of the acceptance is set forth in law.

Once I sign a durable power of attorney, may I change my mind?

Yes. Regardless of your physical or mental condition, you can revoke or cancel the durable power of attorney by indicating in any way the document does not reflect your current wishes.

What if two physicians have determined I can no longer participate in treatment decisions?

You maintain the right to revoke the document even if two doctors have found you are unable to participate in treatment decisions.

Can I change my mind without revoking the document?

Yes. Any spoken wish to have a specific life-extending treatment provided must be honored at the time by a patient advocate, even if the wish contradicts a written directive.

Are there different rules for mental health treatment regarding revocation?

Yes. You can choose in the document to waive your right to immediately revoke the durable power of attorney insofar as mental health treatment.

In the document you can specify any period up to 30 days after you communicate your intent to revoke, during which your patient advocate is still authorized to make decisions for you.

If I revoke my durable power of attorney for health care, can I sign a new one?

Yes, if you are of sound mind.

You may want to name a different patient advocate or alter the expression of your wishes. If you sign a new document, destroy the old one and all copies.

Can my patient advocate refuse to act in my behalf?

Yes. A patient advocate can revoke his or her Acceptance at any time. If so, your named successor would become patient advocate.

What if there is a dispute when my patient advocate is making decisions for me?

If an interested person disputes whether the patient advocate is acting in your best interests, or has the authority to act in your behalf, the interested person may petition the local probate court to resolve the dispute.

What if I regain the ability to participate in medical or mental health decisions?

The powers of your patient advocate are suspended during the time you are able to participate in decisions, and he or she will have no power to make those decisions for you.

Who decides whether I have regained the ability to participate in medical decisions?

The statute is silent on the issue. It is likely the determination of an attending physician or a psychologist is sufficient.

Is there a statewide registry of durable powers of attorney for health care?

Yes. You have the right to voluntarily have your durable power of attorney for health care on a statewide registry. Health care providers will have immediate access to your information.

How do I register my durable power of attorney?

You can submit your durable power of attorney electronically or through regular mail. If through regular mail, the original will be returned to you.

Is there any cost?

No. The registry is free to both you and to health care providers.

Who operates the registry?

The registry is operated by Gift of Life Michigan, under contract from the Michigan Department of Community Health. For more information, visit www.mipeaceofmind.org, or call 1-(800) 482-4881.

If my durable power of attorney is registered, can I still revoke it?

Yes. You maintain the right to revoke the document at any time by notifying the registry.

What if I have no one to appoint as a patient advocate?

You can still choose to complete a living will or a do-not-resuscitate order, or both.

C. Living Will

What is a *living will*?

A living will is a written document in which you inform doctors, family members and others what type of medical care you wish to receive should you become terminally ill or permanently unconscious.

When will a living will take effect?

A living will only takes effect after a doctor diagnoses you as terminally ill or permanently unconscious and determines you are unable to make or communicate decisions about your care.

How is a living will different from a durable power of attorney for health care?

Although there can be overlap, the focus of a durable power is on *who* makes the decision; the focus of a living will is on *what* the decision should be.

A living will is limited to care during terminal illness or permanent unconsciousness, while a patient advocate may also have authority in circumstances of temporary disability.

Are there advantages to each type?

A durable power of attorney for health care may be more flexible because your patient advocate can respond to unexpected circumstances, but a living will might be honored without the presence of a third person making the actual decision.

What might a living will say?

You might express your wishes in general terms - "Do whatever is necessary for my comfort, but nothing further." Or, "I authorize all measures be taken to prolong my life."

You might instead state whether or not you wish specific medical interventions, such as a respirator, cardiopulmonary resuscitation (CPR), surgery, antibiotic medication, and blood transfusions. You could authorize experimental or non-traditional treatment.

Whichever approach you choose, you should express your wishes concerning food and water administered through tubes.

Is a living will legally binding on health care providers?

Although 47 states have statutes giving living wills legal force, Michigan has not passed such a law. However, based on a Michigan court decision, there is an argument living wills are binding in this state. No one, however, can provide absolute assurance your wishes will be honored.

Is it worth having a living will?

Yes, in some circumstances. It is particularly important to have a living will if you don't have a durable power of attorney for health care. Your wishes cannot be honored if they are not known.

Can I have both a durable power of attorney for health care and a living will?

Yes. Your patient advocate can read your living will as an expression of your wishes. The living will might also be valuable if your patient advocate were unavailable when a decision needed to be made.

If you have both documents, make sure your wishes expressed in the documents are consistent.

What are the requirements for a living will?

Since there is no state law, there are no formal requirements. But it is strongly recommended the document be entitled, "Living Will;" be dated; signed by you; and signed by two witnesses who are not family members.

D. Do-Not-Resuscitate Order

What is a *do-not-resuscitate order*?

A do-not-resuscitate order (DNR order) is a written document in which you express your wish that if your breathing and heartbeat cease, you do not want anyone to attempt to resuscitate you.

Must I sign a DNR order?

No.

For whom might such a document be particularly useful?

For example, a hospice patient who is home to die as peacefully as possible or a nursing home resident might wish to consider signing a DNR order.

Must I be terminally ill before signing a DNR order?

No. For example, you may be in good health but still not want to be resuscitated should your heart and lungs fail.

Are such documents legally binding?

Yes. A Michigan law provides these documents are valid in settings *other* than hospitals.

Are there standard forms for a DNR order?

Yes. One form provides spaces for your doctor to sign, for you to sign, and for two witnesses to sign.

There is an alternate form for individuals who have religious beliefs against using doctors. Both forms are included in this booklet.

Can my patient advocate sign the form instead of me?

If your patient advocate has authority, he or she can sign the form instead of you. Your doctor would also sign.

If I have a guardian, can the guardian sign a DNR order for me?

A court can grant a guardian power to sign a DNR order. Upon a petition for guardianship being filed, one responsibility of the guardian *ad litem* is to ask you if you object to a guardian having this power.

Does my guardian have to speak with me before signing a DNR order?

Yes, unless you are unable to communicate your wishes. In any circumstance your doctor would also have to sign the document.

Do I have the right to revoke a DNR order?

Yes. Whether you have signed the DNR order, or your patient advocate has signed it, or your guardian has signed it, you always have the right to revoke it.

How do I revoke a DNR order?

You can communicate your wishes to a health care provider or you can tear up the document if you have signed it.

Is it necessary to have a DNR order if I have a durable power of attorney or living will?

Perhaps. A durable power of attorney for health care and a living will only take effect when you are unable to participate in treatment decisions. If you are competent until the moment your heart and breathing stop, these documents will never take effect.

What else can be done to prevent unwanted resuscitation?

If you are home, ask your relatives in advance not to call 9-1-1 or the police if your breathing should stop. If you are under the care of a registered nurse, she or he has the authority to pronounce death.

What about when I am in a hospital?

These facilities can set their own policies about resuscitation. Upon admission or afterward, you should express your wishes on this issue and ask that these wishes be reflected on your medical chart.

E. General Information

In general, what should I do before completing an advance directive?

Take your time; these are difficult decisions. Think about what treatment you would like under various circumstances in the future. Consider whom you might choose as your patient advocate, and make sure that person is willing to serve.

Discuss the issue with family members. Talk with your minister, rabbi, priest or other spiritual leader if you feel it would be helpful.

Should I also talk with my doctor?

Yes! Bring the subject up with your doctor. Have a discussion about the benefits and burdens of various types of treatment. Express at least your general wishes and make sure the doctor is comfortable with carrying them out.

Are there issues to which I should give particular attention?

Yes. Many people have strong feelings about the administration of food and water. If you become unable to swallow, nutrients can be supplied by a tube down your throat, a tube surgically placed into your stomach, or intravenously. Consider in what circumstances, if any, you wish such procedures withheld or withdrawn.

What should I do with an advance directive after it is signed?

Give the original durable power of attorney for health care to your patient advocate (or at least make sure she or he knows where it is). Give a photostatic copy to your doctor and keep a copy yourself. Let people know whom you have chosen as your patient advocate.

Decide whether you want to register your durable power of attorney with the statewide registry. If so, contact them as explained earlier in this booklet.

What will the doctor do with the copy of my durable power of attorney?

She or he will make the document part of your medical record.

What about a living will?

Keep the original of a living will. Give a copy to family members who are close to you, a friend and your doctor. Keep a list of these people.

What about a do-not-resuscitate order?

Always keep the order with you , in plain sight, while you are at home.. Give a copy to family members who might be with you at your death.

You have the option of wearing a DNR bracelet.

Should I bring a copy of my advance directive(s) with me if I go in the hospital a nursing home?

Yes, definitely.

.

After I sign one or more advance directives, should I continue to discuss the issue of my care?

Yes. Sit down with the person you have chosen as patient advocate. The clearer picture he or she has of your wishes, the better. If some time has passed since you signed the document, discuss the issue again.

It is almost always a good idea for you to make relatives and friends aware of your desires.

When I should review an advance directive?

Since medical technology is constantly changing, and since there may be changes in your outlook, it would be wise to review your advance directives once a year. Upon review, you can decide to keep the document, write a new one, or have no advance directive at all.

If you decide to keep the advance directive, you can put your initials and the date on the bottom.

What should I do if I write a new advance directive?

Whether you choose a different person to be your patient advocate or alter your wishes for care, try to get back copies of the old document and destroy them. Contact the statewide registry if you have registered the document

Distribute copies of the new document.

What are the responsibilities of health care facilities?

Hospitals, nursing homes, hospice organizations and home health agencies receiving federal funds have an obligation to inform incoming patients, clients or

residents of their rights to consent to or refuse treatment, including the right to have advance directives.

A health care facility cannot force you to sign an advance directive, or refuse to care for you if you have signed one.

Will the hospital or nursing home honor my advance directive?

If given an advance directive, the hospital or nursing home must make it part of your medical record.

If the facility has no reason to question the document's authenticity, has evidence you are no longer able to participate in treatment decisions, and believes a patient advocate is acting consistent with your wishes, the facility has a responsibility to comply.

Be aware even though you have an advance directive, there is no absolute assurance your wishes will be honored.

What if I decide not to have an advance directive?

Decisions would still have to be made for you should you become unable to make them. Sometimes, a doctor or hospital will accept a spouse or child as an informal decision-maker. In some situations, a family member has some role by law. At other times a guardianship proceeding will have to be initiated in probate court.

DURABLE POWER OF ATTORNEY FOR HEALTH CARE

I, _____, am of

(Print or type your full name)

sound mind and I voluntarily make this designation.

APPOINTMENT OF PATIENT ADVOCATE

I designate _____, my _____

(Insert name of patient advocate) (Spouse, child, friend …)

living at _____

(Address and telephone number of patient advocate)

as my patient advocate. If my first choice cannot serve, I designate

_____, my _____,

(Name of successor patient advocate) (Spouse, child, friend ...)

living at _____

(Address and telephone number of successor patient advocate)

to serve as my patient advocate.

My patient advocate or successor patient advocate must sign an acceptance before he or she can act. I have discussed this appointment with the individuals I have designated as patient advocate and successor patient advocate.

GENERAL POWERS

My patient advocate or successor patient advocate shall have power to make care, custody and medical treatment decisions for me if my attending physician and another physician or licensed psychologist determine I am unable to participate in medical treatment decisions.

In making decisions, my patient advocate shall try to follow my previously expressed wishes, whether I have stated them orally, in a living will, or in this designation.

My patient advocate has authority to consent to or refuse treatment on my behalf, to arrange medical and personal services for me, including admission to a hospital or nursing care facility, and to pay for such services with my funds.

My patient advocate shall have access to any of my medical records to which I have a right, immediately upon signing an Acceptance. This shall serve as a release under the Health Insurance Portability and Accountability Act.

Immediately upon signing an Acceptance, my patient advocate shall have access to my birth certificate and other legal documents needed to apply for Medicare, Medicaid, and other government programs.

POWER REGARDING LIFE-SUSTAINING TREATMENT

(OPTIONAL)

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. My patient advocate can sign a do-not-resuscitate declaration for me. My patient advocate can refuse food and water administered to me through tubes.

_____

(Sign your name if you wish to give your patient advocate this authority)

POWER REGARDING MENTAL HEALTH TREATMENT

(OPTIONAL)

I expressly authorize my patient advocate to make decisions concerning the following treatments if a physician and a mental health professional determine I cannot give informed consent for mental health care:

(check one or more consistent with your wishes)

❑ outpatient therapy

❑ my admission as a formal voluntary patient to a hospital to receive inpatient mental health services. I have the right to give three days notice of my intent to leave the hospital.

❑ my admission to a hospital to receive inpatient mental health services

❑ psychotropic medication

❑ electro-convulsive therapy (ECT)

❑ I give up my right to have a revocation effective immediately. If I revoke my designation, the revocation is effective 30 days from the date I communicate my intent to revoke. Even if I choose this option, I still have the right to give three days notice of my intent to leave a hospital if I am a formal voluntary patient.

_____

(Sign your name if you wish to give your patient advocate this authority

POWER REGARDING ORGAN DONATION

(OPTIONAL)

I expressly authorize my patient advocate to make a gift of the following

(check any that reflect your wishes)

❑ any needed organs or body parts for the purposes of transplantation, therapy, medical research or education

❑ only the following listed organs or body parts for the purposes of transplantation, therapy, medical research or education: _____

❑ my entire body for anatomical study

❑ (optional) I wish my gift to go to -

_____

(Insert name of doctor, hospital, school, organ bank or individual)

The gift is effective upon my death. Unlike other powers I give to my patient advocate, this power remains after my death.

_____

(Sign your name if you wish to give your patient advocate this authority)

STATEMENT OF WISHES

My patient advocate has authority to make decisions in a wide variety of circumstances. In this document, I can express general wishes regarding conditions such as terminal illness, permanent unconsciousness, or other disability; specify particular types of treatment I do or not want in such circumstances; or I may state no wishes at all. If you have chosen to give your patient advocate power concerning mental health treatment, you can also include specific wishes about mental health treatment such as a preferred mental health professional, hospital or medication. (Choose A or B.)

A. My wishes are as follows (you may attach more sheets of paper):

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

<u>or</u>

B. I choose not to express any wishes in this document. This choice shall not be interpreted as limiting the power of my patient advocate to make any particular decision in any particular circumstance.

I may change my mind at any time by communicating in any manner that this designation does not reflect my wishes or that I do not want my patient advocate to have authority to make decisions for me.

It is my intent no one involved in my care shall be liable for honoring my wishes as expressed in this designation or for following the directions of my patient advocate.

Photocopies of this document can be relied upon as though they were originals.

SIGNATURE

I sign this document voluntarily, and I understand its purpose.

Dated: _____

Signed: _____

(Your signature)

_____

(Your address and telephone number)

STATEMENT REGARDING WITNESSES

I have chosen two adult witnesses who are not named in my will; who are not my spouse, parent, child, grandchild, brother or sister; who are not my physician or my patient advocate; who are not an employee of my life or health insurance company, an employee of a home for the aged where I reside, an employee of community mental health program providing me services or an employee at the health care facility where I am now.

STATEMENT AND SIGNATURE OF WITNESSES

We sign below as witnesses. This declaration was signed in our presence. The declarant appears to be of sound mind, and to be making this designation voluntarily, without duress, fraud or undue influence.

_____ _____

(Print name) (Signature of witness)

_____

(Address)

_____ _____

(Print name) (Signature of witness)

_____

(Address)

ACCEPTANCE BY PATIENT ADVOCATE

(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 heath 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, _____ understand the above

(Name of patient advocate)

conditions and I accept the designation as patient advocate or successor patient advocate for _____, who signed a

(Name of patient)

durable power of attorney for health care on the following date: _____

Dated: _____

Signed: _____

(Signature of patient advocate)

_____

(Signature of successor patient advocate)

Living Will

I, _____ am of sound mind, and I voluntarily make this declaration.

If I become terminally ill or permanently unconscious as determined by my doctor and at least one other doctor, and if I am unable to participate in decisions regarding my medical care, I intend this declaration to be honored as the expression of my legal right to authorize or refuse medical treatment.

My desires concerning medical treatment are -

_____

_____

_____

_____

_____

_____

_____

_____

_____

(attach additional sheets if you wish)

My family, the medical facility, and any doctors, nurses and other medical personnel involved in my care shall have no civil or criminal liability for following my wishes as expressed in this declaration.

I may change my mind at any time by communicating in any manner that this declaration does not reflect my wishes.

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

I sign this document after careful consideration. I understand its meaning and I accept its consequences.

Dated: _____ Signed: _____

(Your signature)

_____

(Your address)

STATEMENT OF WITNESSES

We sign below as witnesses. This declaration was signed in our presence. The declarant appears to be of sound mind, and to be making this designation voluntarily, without duress, fraud or undue influence.

_____ _____

(Print Name) (Signature of Witness)

_____

(Address)

_____ _____

(Print Name) (Signature of Witness)

_____

(Address)

DO-NOT-RESUSCITATE ORDER

This do-not-resuscitate order is issued by _____,
(Type or print physican's name)

attending physician for _____.
(Type or print declarant's or ward's name)

Use the appropriate consent section below, A. or B. or C.

A. DECLARANT CONSENT

I have discussed my health status with my physician named above. I request that in the event my heart and breathing should stop, no person shall attempt to resuscitate me.

This order will remain in effect until it is revoked as provided by law.

Being of sound mind, I voluntarily execute this order, and I understand its full import.

_____ _____
(Declarant's signature) (Date)

_____ _____
(Signature of person who signed for declarant, if applicable) (Date)

_____
(Type or print full name)

B. PATIENT ADVOCATE CONSENT

I authorize that in the event the declarant's heart and breathing should stop, no person shall attempt to resuscitate the declarant. I understand the full import of this order and assume responsibility for its execution.

This order will remain in effect until it is revoked as provided by law.

_____ _____

(Patient advocate's signature) (Date)

_____

(Type or print patient advocate's name)

C. GUARDIAN CONSENT

I authorize that in the event the ward's heart and breathing should stop, no person shall attempt to resuscitate the ward. I understand the full import of this order and assume responsibility for its execution.

This order will remain in effect until it is revoked as provided by law.

_____ _____

(Guardian's signature) (Date)

_____

(Type or print guardian's name)

PHYSICIAN'S SIGNATURE

_____ _____
(Physician's signature) (Date)

_____
(Type or print physician's full name)

ATTESTATION OF WITNESSES

The individual who has executed this order appears to be of sound mind, and under no duress, fraud, or undue influence. Upon executing this order, the individual has (has not) received an identification bracelet.

_____ _____
(Witness signature) (Date)

_____
(Type or print witness's name)

_____ _____
(Witness signature) (Date)

_____
(Type or print witness's name)

THIS FORM WAS PREPARED PURSUANT TO, AND IN COMPLIANCE WITH, THE MICHIGAN DO-NOT-RESUSCITATE PROCEDURE ACT

DO-NOT-RESUSCITATE ORDER

Use the appropriate consent section below, A or B.

A. DECLARANT CONSENT

I request that in the event my heart and breathing should stop, no person shall attempt to resuscitate me.

This order is effective until it is revoked as provided by law.

Being of sound mind, I voluntarily execute this order, and I understand its full import.

_____ _____
(Declarant's signature) (Date)

_____ _____
(Signature of person who signed for declarant, if applicable) (Date)

_____
(Type or print full name)

B. PATIENT ADVOCATE CONSENT

I authorize that in the event the declarant's heart and breathing should stop, no person shall attempt to resuscitate the declarant. I understand the full import of this order and assume responsibility for its execution.

This order will remain in effect until it is revoked as provided by law.

_____ _____

(Patient advocate's signature) (Date)

_____

(Type or print patient advocate's name)

ATTESTATION OF WITNESSES

The individual who has executed this order appears to be of sound mind, and under no duress, fraud, or undue influence. Upon executing this order, the individual has (has not) received an identification bracelet.

_____ _____

(Witness signature) (Date)

_____

(Type or print witness's name)

_____ _____

(Witness signature) (Date)

_____

(Type or print witness's name)

THIS FORM WAS PREPARED PURSUANT TO, AND IN COMPLIANCE WITH, THE MICHIGAN DO-NOT-RESUSCITATE PROCEDURE ACT

Declaration of Anatomical Gift

I, _____, am of sound mind, and I voluntarily make this declaration. In the hope I may help others, I make the following anatomical gift to take effect upon my death: (You may check any one box, or both boxes A and C)

❑ A. Any needed organs or body parts for the purposes of transplantation, therapy, medical research or education.

❑ B. Only the following listed organs or body parts for the purposes of transplantation, therapy, medical research or education: _____, _____, _____.

❑ C. My entire body for anatomical study.

Dated: _____ Signed: _____

(Your Signature)

_____

(Address)

OPTIONAL

I wish my gift to go to _____.

(Insert name of doctor, hospital, school, organ bank or individual)

I wish to have my body at my funeral: ____ yes ____ no

STATEMENT OF WITNESSES

This declaration was signed in our presence by the declarant or at his or her direction. We sign below as witnesses in the presence of the declarant.

_____ _____

(Print Name) (Signature of Witness)

_____

(Address)

_____ _____

(Print Name) (Signature of Witness)

_____

(Address)

Triage Cancer Estate Planning Toolkit

⌘

Part III: Your State's Estate Planning Forms

⌘

Physician Orders for Life Sustaining Treatment (POLST)

MDHHS-5836, MICHIGAN PHYSICIAN ORDERS FOR SCOPE OF TREATMENT (MI-POST)

Michigan Department of Health and Human Services (MDHHS)
(Revised 8-22)

HIPAA permits disclosure of MI-POST to other Health Care Professionals, as necessary. This MI-POST form is void if Part 1 or Section D are blank. Leaving blank any section of the medical orders (Sections A, B, or C) does not void the form and is interpreted as full treatment for that section.

PART 1 – PATIENT INFORMATION

Patient Last Name	Patient First Name	Patient Middle Initial

Date of Birth (mm/dd/yyyy)	Date Form Prepared (mm/dd/yyyy)

Diagnosis supporting use of MI-POST

This form is a Physician Order sheet based on the medical conditions and decisions of the person identified on this form. Paper copies, facsimiles, and digital images are valid and should be followed as if an original copy. This form is for adults with an advanced illness. It is not for healthy adults.

PART 2 – MEDICAL ORDERS

Section A – Cardiopulmonary Resuscitation (CPR)

Person has no pulse and is not breathing. See MDHHS-5837 for further details.

☐ Attempt Resuscitation/CPR (Must choose Full Treatment in Section B).

☐ DO NOT attempt Resuscitation/CPR (No CPR, allow Natural Death).

Section B – Medical Interventions

Person has pulse and/or is breathing. See MDHHS-5837 for further details on medical interventions.

☐ **Comfort-Focused Treatment**
Primary goal of maximizing comfort. May include pain relief through use of medication, positioning, wound care, food and water by mouth, and non-invasive respiratory assistance.

☐ **Selective Treatment**
Primary goal of treating medical conditions while avoiding burdensome measures. May include IV fluids, cardiac monitoring including cardioversion, and non-invasive airway support.

☐ **Full Treatment**
Primary goal of prolonging life by all medically effective means. May include intubation, advanced invasive airway interventions, mechanical ventilation, other advanced interventions.

Section C – Additional Orders (optional)

Medical orders for whether or when to start, withhold, or stop a specific treatment. Treatments may include but are not limited to dialysis, medically assisted provisions of nutrition, long-term life-support, medications, and blood products.

Send form with Patient whenever transferred or discharged.

Section D – Signature of Attending Health Professional
My signature below indicates that these orders are medically appropriate given the patient's current medical condition, reflect to the best of my knowledge the patient's goals for care, and that the patient (or the patient representative) has received the information sheet.

Print Name | Date

Signature | Phone Number

Print Name of Collaborating Physician | Phone Number

Section E – Signature of Patient or Patient Representative
My signature indicates I have discussed, understand, and voluntarily consent to the medical orders on this MI-POST form. I acknowledge that if I am signing as the patient's representative, these decisions are consistent with the patient's wishes to the best of my knowledge.

☐ Patient ☐ Patient Advocate/Durable Power of Attorney for Health Care (DPOAHC)
☐ Court-Appointed Guardian

Print Name of Patient | Print Name of Patient Representative

Signature | Date

Information of Legally Authorized Representative
Complete this section if this MI-POST form was signed by a Patient Advocate/DPOAHC or Court-Appointed Guardian.

Address | City | State | Zip Code

Phone Number | Alternate Phone Number

Section F – Individual Assisting with Completion of MI-POST Form

Print Preparer's Name | Title | Date

Preparer's Signature | Organization | Phone Number

Section G – To Reaffirm or Revoke this Form
This MI-POST form can be reaffirmed or revoked at any time, verbally or in writing. See MDHHS-5837 for further details on reaffirmation or revocation. **If this document is revoked or is not reaffirmed, and a new form is not completed, full treatment and resuscitation will be provided.**

Healthcare Provider Name/Collaborative Physician (if applicable) | Healthcare Provider Signature

Patient/Representative Name | Patient/Representative Signature | Reaffirmation Date

Send form with Patient whenever transferred or discharged.
HIPAA permits disclosure of MI-POST to other Health Care Professionals, as necessary.

The Michigan Department of Health and Human Services will not exclude from participation in, deny benefits of, or discriminate against any individual or group because of race, sex, religion, age, national origin, color, height, weight, marital status, partisan considerations, or a disability or genetic information that is unrelated to the person's eligibility.

Triage Cancer Estate Planning Toolkit

⌘

Part III: Your State's Estate Planning Forms

⌘

HIPAA Authorization Form

Sample HIPAA Right of Access Form for Family Member/Friend

I, _____, direct my health care and medical services providers and payers to disclose and release my protected health information described below to:

Name: *Relationship:*

_____ _____

Contact information: _____

_____

Health Information to be disclosed upon the request of the person named above -- (Check either A or B):

- ☐ A. **Disclose** my complete health record (including but not limited to diagnoses, lab tests, prognosis, treatment, and billing, for all conditions) **OR**
- ☐ B. **Disclose** my health record, as above, **BUT do not disclose** the following (check as appropriate):
  - ☐ Mental health records
  - ☐ Communicable diseases (including HIV and AIDS)
  - ☐ Alcohol/drug abuse treatment
  - ☐ Other (please specify):

    _____
    _____

Form of Disclosure (unless another format is mutually agreed upon between my provider and designee):

- ☐ An electronic record or access through an online portal
- ☐ Hard copy

This authorization shall be effective until (Check one):

- ☐ All past, present, and future periods, OR
- ☐ Date or event:_____

unless I revoke it. (NOTE: You may revoke this authorization in writing at any time by notifying your health care providers, preferably in writing.)

_____ _____
Name of the Individual Giving this Authorization Date of birth

_____ _____
Signature of the Individual Giving this Authorization Date

Note: HIPAA Authority for Right of Access: 45 C.F.R. § 164.524