MICHIGAN
Advance Directive
Planning for Important Health Care Decisions

Caring Connections
1731 King St., Suite 100, Alexandria, VA 22314
www.caringinfo.org
800/658-8898

Caring Connections, a program of the National Hospice and Palliative Care Organization (NHPCO), is a national consumer engagement initiative to improve care at the end of life.

It's About How You LIVE

It's About How You LIVE is a national community engagement campaign encouraging individuals to make informed decisions about end-of-life care and services. The campaign encourages people to:

Learn about options for end-of-life services and care
Implement plans to ensure wishes are honored
Voice decisions to family, friends and healthcare providers
Engage in personal or community efforts to improve end-of-life care

Note: The following is not a substitute for legal advice. While Caring Connections updates the following information and form to keep them up-to-date, changes in the underlying law can affect how the form will operate in the event you lose the ability to make decisions for yourself. If you have any questions about how the form will help ensure your wishes are carried out, or if your wishes do not seem to fit with the form, you may wish to talk to your health care provider or an attorney with experience in drafting advance directives.

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Using these Materials

BEFORE YOU BEGIN

1. Check to be sure that you have the materials for each state in which you may receive healthcare.

2. These materials include:
   - Instructions for preparing your advance directive., please read all the instructions.
   - Your state-specific advance directive forms, which are the pages with the gray instruction bar on the left side.

ACTION STEPS

1. You may want to photocopy or print a second set of these forms before you start so you will have a clean copy if you need to start over.

2. When you begin to fill out the forms, refer to the gray instruction bars — they will guide you through the process.

3. Talk with your family, friends, and physicians about your advance directive. Be sure the person you appoint to make decisions on your behalf understands your wishes.

4. Once the form is completed and signed, photocopy the form and give it to the person you have appointed to make decisions on your behalf, your family, friends, health care providers and/or faith leaders so that the form is available in the event of an emergency.

5. You may also want to save a copy of your form in an online personal health records application, program, or service that allows you to share your medical documents with your physicians, family, and others who you want to take an active role in your advance care planning.

Introduction to Your Michigan Advance Directive

This packet contains a document that protects your right to refuse medical treatment you do not want or to request treatment you do want in the event you lose the ability to make decisions yourself.

The **Michigan Patient Advocate Designation** lets you name someone to make decisions about your medical care — including decisions about life support, mental health treatment and anatomical gifts — if you can no longer speak for yourself. The patient advocate designation is especially useful because it appoints someone to speak for you any time you are unable to make your own health care treatment decisions, not only at the end of life.

Your patient advocate's powers go into effect when your doctor determines that you are no longer able to make or communicate your health care decisions.

Note: Michigan does not currently recognize a separate "living will" document. You may, however, state your end-of-life choices in your patient advocate designation.

This form also allows you to state your desires regarding your health care and other advance planning decisions to help guide your patient advocate and others who may make decisions for you when are no longer able to do so.

This form does not expressly address mental illness. If you would like to make advance care plans regarding mental illness, you should talk to your physician and an attorney about a durable power of attorney tailored to your needs.

Following the patient advocate designation form is an **organ donation form**.

Note: These documents will be legally binding only if the person completing it is a competent adult (at least 18 years old).

Completing Your Michigan Patient Advocate Designation

How do I make my Michigan Patient Advocate Designation legal?

The law requires that you sign your designation in the presence of two witnesses. These 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, or
- an employee of a home for the aged, if you are a patient in that facility.

Your patient advocate designation form will be valid after you and your witnesses sign it. However, your patient advocate and alternate (if any) must receive a copy of your document and date and sign an acceptance of his or her responsibilities before making any decisions on your behalf. An acceptance form is included as pages 5 and 6 of the Michigan Advance Directive, in the event you want to obtain your advocate's acceptance now.

Whom should I appoint as my patient advocate?

Your patient advocate is the person you appoint to make decisions about your health care if you become unable to make those decisions yourself. Your patient advocate may be a family member or a close friend whom you trust to make serious decisions. The person you name as your patient advocate should clearly understand your wishes and be willing to accept the responsibility of making health care decisions for you.

You can appoint a second person as your alternate patient advocate. The alternate will step in if the first person you name as a patient advocate is unable, unwilling, or unavailable to act for you.

Should I add personal instructions to my patient advocate designation?

One of the strongest reasons for naming a patient advocate is to have someone who can respond flexibly as your health care situation changes and deal with situations that you did not foresee. If you add instructions to this document it may help your patient advocate carry out your wishes, but be careful that you do not unintentionally restrict your patient advocate's power to act in your best interest. In any event, be sure to talk with your patient advocate about your future medical care and describe what you consider to be an acceptable "quality of life."

What if I change my mind?

You may revoke your designation at any time and in any manner, regardless of your ability to make medical and/or mental health treatment decisions, so long as you are able to communicate your intent to revoke the designation.

You should be sure that your physician and patient advocate(s) receive notice of your revocation to be sure it is effective.

Your designation will be automatically revoked if:

- You designate your spouse as your patient advocate and there is an entry by a judge of an order for alimony, divorce, or annulment of your marriage. Your patient advocate's designation will be suspended during any legal proceedings that could result in such an order. The designation of an alternate patient advocate, if you have named one, will not be affected by the end of your marriage;
- Your patient advocate resigns his or her responsibilities; or
- You die, unless you have given your patient advocate authority to donate your organs on page 3 of the form.

What other important facts should I know?

Due to restrictions in the state law, your patient advocate does not have the authority to withhold or withdraw treatment from you while you are pregnant if that would result in your death.

How do I make my Michigan Organ Donation Form legal?

The law requires that you sign your organ donation form in the presence of two witnesses. Both witnesses must be 18 years of age or older. At least one of the witnesses must be a disinterested party, meaning that the witness has no interest in your estate or any potential anatomical gift.

PRINT YOUR NAME AND ADDRESS

PRINT THE NAME, ADDRESS AND PHONE NUMBERS OF YOUR PATIENT ADVOCATE

PRINT THE NAME, ADDRESS AND PHONE NUMBERS OF YOUR ALTERNATE PATIENT ADVOCATE

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MICHIGAN PATIENT ADVOCATE DESIGNATION – PAGE 1 OF 6

I ____
(name)

____
(address)
am of sound mind, and I voluntarily make this designation.

I designate ____
(name of primary patient advocate)

residing at ____
(address)

____
(home phone number) (work phone number)

as my patient advocate to make care, custody, medical, or mental health treatment decisions for me in the event that I become unable to participate in medical treatment decisions. The determination of when I am unable to participate in medical and/or mental health treatment decisions shall be made by my attending physician and another physician or licensed psychologist.

If my first choice is unable, unwilling, or not reasonably available to serve as my patient advocate, then I designate:

____
(name of alternate patient advocate)

residing at ____
(address)

____
(home phone number) (work phone number)

to serve as my patient advocate.

YOU MAY CROSS OUT AND INITIAL ANY PARTS OF THIS FORM THAT YOU DO NOT AGREE WITH

I authorize my patient advocate to decide to withhold or withdraw medical and mental health treatment, including the provision of artificial nutrition and hydration, which could or would allow me to die. I am fully aware that such a decision could or would lead to my death.

In making decisions for me, my patient advocate shall be guided by my wishes, whether expressed orally, in this designation, or in another document. If my wishes as to a particular situation have not been expressed, my patient advocate shall be guided by his or her best judgment of my probable decision, given the benefits, burdens and consequences of the decision, even if my death, or the chance of my death, is one consequence.

My patient advocate shall have the same authority to make care, custody, and medical and mental health treatment decisions as I would if I had the capacity to make them, including admission to a hospital or nursing care facility and paying for such services with my funds, EXCEPT (*here list the limitations, if any, you wish to place on your patient advocate's authority*):

LIST INSTRUCTIONS HERE ONLY IF YOU WANT TO LIMIT YOUR PATIENT ADVOCATE'S AUTHORITY

____

____

____

____

____

____

____

____

(Attach additional pages, if needed)

This designation of patient advocate shall not be affected by my disability or incapacity. This designation of patient advocate is governed by Michigan law, although I request that it be honored in any state in which I may be found. I reserve the power to revoke this designation at any time by communicating my intent to revoke it in any manner in which I am able to communicate.

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

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CROSS OUT AND INITIAL THIS STATEMENT IF YOU DO NOT AUTHORIZE YOUR PATIENT ADVOCATE TO MAKE AN ANATOMICAL GIFT

INITIAL YOUR CHOICES REGARDING ORGAN DONATION

LIST LIMITATIONS OR SPECIAL WISHES, IF ANY

ADD OTHER INSTRUCTIONS, IF ANY, REGARDING YOUR ADVANCE CARE PLANS

THESE INSTRUCTIONS CAN FURTHER ADDRESS YOUR HEALTH CARE PLANS, SUCH AS YOUR WISHES REGARDING HOSPICE TREATMENT, BUT CAN ALSO ADDRESS OTHER ADVANCE PLANNING ISSUES, SUCH AS YOUR BURIAL WISHES

ATTACH ADDITIONAL PAGES IF NEEDED

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In the hope that I may help others, I authorize my patient advocate to make this anatomical gift if medically acceptable, to take effect upon my death and to resolve any conflict between the terms of this Designation and the administration of means necessary to ensure the medical suitability of my anatomical gift. The words and marks below indicate my desires.

Upon my death, I wish to donate:

______ My body for anatomical study if needed.
______ Any needed organs, tissues, or eyes.
______ Only the following organs, tissues, or eyes:
____

I authorize the use of my organs, tissues, or eyes:
______ For transplantation
______ For therapy
______ For research
______ For medical education
______ For any purpose authorized by law.

This authority granted to my patient advocate to make an anatomical gift is limited as follows (*list any limitations or special wishes here, if any)*:
____

____

I further direct that:

____

____

____

____

____

____

____

____

(Attach additional pages, if needed)

SIGN AND DATE YOUR DOCUMENT AND PRINT YOUR ADDRESS

I voluntarily sign this designation of patient advocate after careful consideration. I accept its meaning and I accept its consequences.

Your signature: ____

Date: ______________________________

____
(your street address)

____
(city, Michigan, zip code)

Statement of Witnesses

YOUR WITNESSES MUST SIGN AND DATE HERE AND PRINT THEIR NAMES AND ADDRESSES

We sign below as witnesses. This designation was signed in our presence. The designator appears to be of sound mind, and to be making this designation voluntarily, and under no duress, fraud, or undue influence.

Witness 1: ____
(signature)

Date: ______________________________

____
(print or type full name)

____
(address)

Witness 2: ____
(signature)

Date: ______________________________

____
(print or type full name)

____
(address)

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NOTE: YOUR PATIENT ADVOCATE MUST SIGN AN ACCEPTANCE FORM BEFORE HAVING AUTHORITY TO MAKE DECISIONS ON YOUR BEHALF

THIS ACCEPTANCE MAY BE OBTAINED NOW TO STREAMLINE THE PROCESS

Acceptance by Patient Advocate and Alternate Patient Advocate (If Any)

1. This patient advocate designation is not 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 on his or her own behalf.

3. This patient advocate designation cannot be used to make a medical treatment decision to withhold or withdraw treatment from a patient who is pregnant if that would result in the pregnant patient's death.

4. A patient advocate may make a decision to withhold or withdraw treatment that 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 patient advocate designation at any time and 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 a 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.

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9. A patient advocate may revoke his or her acceptance of the patient advocate 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, 1978 PA 368, MCL 333.20201.

YOUR PATIENT ADVOCATE MUST SIGN AND DATE YOUR DOCUMENT HERE BEFORE MAKING DECISIONS ON YOUR BEHALF

I understand the above conditions, terms and responsibilities and I accept the designation as patient advocate for

____
(name of primary patient advocate)

Dated ________________ Signed ________________________________

YOUR ALTERNATE PATIENT ADVOCATE MUST SIGN AND DATE YOUR DOCUMENT HERE BEFORE MAKING DECISIONS ON YOUR BEHALF

I understand the above conditions and I accept the designation of successor patient advocate for

____
(name of alternate patient advocate)

Dated ________________ Signed ________________________________

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ORGAN DONATION (OPTIONAL)

INITIAL THE OPTION THAT REFLECTS YOUR WISHES

ADD NAME OR INSTITUTION (IF ANY)

PRINT YOUR NAME, SIGN, AND DATE THE DOCUMENT

YOUR WITNESSES MUST SIGN AND PRINT THEIR ADDRESSES

AT LEAST ONE WITNESS MUST BE A DISINTERESTED PARTY

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MICHIGAN ORGAN DONATION FORM - PAGE 1 OF 1

Initial the line next to the statement below that best reflects your wishes. You do not have to initial any of the statements. If you do not initial any of the statements, your attorney for health care, proxy, or other agent, or your family, may have the authority to make a gift of all or part of your body under Michigan law.

_____ I do not want to make an organ or tissue donation and I do not want my attorney for health care, proxy, or other agent or family to do so.
_____ I have already signed a written agreement or donor card regarding organ and tissue donation with the following individual or institution:

Name of individual/institution:____________________

_____ Pursuant to Michigan law, I hereby give, effective on my death:

_____ Any needed organ or parts.
_____ The following part or organs listed below:

For (initial one):

_____ Any legally authorized purpose.
_____ Transplant or therapeutic purposes only.

Declarant name: ____

Declarant signature: __________________________, Date: ____________

The declarant voluntarily signed or directed another person to sign this writing in my presence.

Witness ________________________________Date__________________

Address ____

____

I am a disinterested party with regard to the declarant and his or her donation and estate. The declarant voluntarily signed or directed another person to sign this writing in my presence.

Witness _________________________________Date_________________

Address ____

____

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You Have Filled Out Your Health Care Directive, Now What?

1. Your designation of patient advocate is an important legal document. Keep the original signed document in a secure but accessible place. Do not put the original document in a safe deposit box or any other security box that would keep others from having access to it.

2. Give photocopies of the signed original to your agent and alternate agent, doctor(s), family, close friends, clergy, and anyone else who might become involved in your healthcare. If you enter a nursing home or hospital, have photocopies of your document placed in your medical records.

3. Be sure to talk to your agent(s), doctor(s), clergy, family, and friends about your wishes concerning medical treatment. Discuss your wishes with them often, particularly if your medical condition changes.

4. You may also want to save a copy of your form in an online personal health records application, program, or service that allows you to share your medical documents with your physicians, family, and others who you want to take an active role in your advance care planning.

5. If you want to make changes to your documents after they have been signed and witnessed, you must complete a new document.

6. Remember, you can always revoke your Michigan document.

7. Be aware that your Michigan document will not be effective in the event of a medical emergency. Ambulance and hospital emergency department personnel are required to provide cardiopulmonary resuscitation (CPR) unless they are given a separate directive that states otherwise. These directives called "prehospital medical care directives" or "do not resuscitate orders" are designed for people whose poor health gives them little chance of benefiting from CPR. These directives instruct ambulance and hospital emergency personnel not to attempt CPR if your heart or breathing should stop.

   Currently not all states have laws authorizing these orders. We suggest you speak to your physician if you are interested in obtaining one. **Caring Connections does not distribute these forms.**