DOWNLOAD COVERSHEET:

This is a standard advance directive for your state, made available to you as a courtesy by Lifecare Directives, LLC. You should be aware that extensive research has demonstrated that there are significant drawbacks to using a very brief state-standard document. As one researcher has noted, "the development of statutory forms occurs in the legislative arena, [so] their content is the result of a political rather than a 'scientific' process." Because of "political compromise, ...many of the forms ultimately passed by the legislatures are not optimal from a consumer perspective" (see: Hoffmann, Diane E; Zimmerman, S; Tompkins, C. The dangers of directives, or the false security of forms. *Journal of Law, Medicine & Ethics*. 1996;24(1) (Spring):5-17).

American Bar Association concurs, noting that "The statutory advance directive is not necessarily the exclusive, or even the best, pathway for individuals to follow," and suggesting that revised and enhanced documents "may be especially helpful as a...replacement for statutory forms where restrictions in a statutory directive prevents the individual from fully expressing his or her wishes" (see: American Bar Association. (1991). *Patient Self Determination Act State Law Guide*. Government printing office, Washington, DC).

Lifecare Directives staff have reviewed more than 6,000 medical, legal, academic, and news media articles on advance directives, as well as reviewing hundreds of document forms. They have also conducted formal research with scores of medical, legal, and academic processionals along with more than 1,000 lay public participants. From this process, more than 30 additional key living will and medical power of attorney enhancements have been identified that should be included in any living will (or "health care instruction" or "declaration") and medical power of attorney (or "proxy") forms that you may use.

Please consider obtaining the *Lifecare Advance Healthcare Directive* to obtain these important additions and benefits. To better understand the important enhancements available through this combined living will and medical power of attorney, you may wish to obtain the booklet, "*Should I Use a Shorter Standard Directive?*" available through Lifecare Directives, LLC.

If you have any other questions about this document or other Lifecare resources, please do not hesitate to contact our staff who will make every effort to fully respond your inquiries and address any questions you may have. We can be reached at the following:

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~ Lifecare Directives ~

Statutory Advance Directive

For Health Care Decisions For Missouri Residents

Statutory Compliant Advance Directive for Health Care Choices

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Statutory Advance Directive

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Important Notice:

An advance directive is not a substitute for medical, legal or other necessary advice or direction. This document should not be construed as offering counseling, medical, legal, financial, or estate planning or advice, nor any other similar guidance or direction. Such counsel should be obtained from qualified, certified, and licensed professionals in your locale who are experienced in the specific areas of concern. Completion of this document constitutes acceptance of its content both in whole and in part, as well as a determination of its utility for the purposes indicated. Lifecare Directives, LLC, and all involved in this document's design, publication, and distribution assume no liability for its use, including that which may arise from omissions, technical inaccuracies, and typographical errors. Diligent efforts notwithstanding, this document is not warrantied to be in compliance with state and local laws. All warranties, including those of merchantability, fitness for a particular purpose, and non-infringement are expressly disclaimed. The utilizer agrees to seek appropriate outside review prior to completion. The utilizer and all heirs, assigns, designees, devisees, representatives, and all others involved, agree to assume all liability for its use and any subsequent outcomes, and to release and hold harmless all involved in its design, publication, advertising and distribution. The utilizer also agrees that any physician, health care provider, agent, proxy, surrogate, representative, mediator, court officer, and all others relying on the document's content are similarly free of all liability, when they act in good faith and with due diligence to follow the recorded wishes and directions.

Statutory Advance Directive For Missouri Residents

_____ _____

Print Full Name *Date of Birth*

Your right *(when age 18 or older): To Document Your Personal Wishes, and to have these wishes followed ~~*

The Missouri state legislature has designed a Living Will for use by the public, and provided statutory instructions for the structure of a durable power of attorney for health care. As these documents were designed/outlined by your state government, each is in full compliance with all applicable statutes and laws.

There is an introduction that summarizes the scope and purpose of each document, as well as providing directions for completion. Read them carefully to ensure that your combined Advance Directive is fully and properly filled out.

***Understanding Your Directive*:**

To make the *best* choices for your medical care, your physician needs to know *your* wishes. In fact, the law requires doctors to seek your permission before giving you *any* treatment. However, if you are ever unable to speak due to severe illness or injury, this may not be possible. Completing this Directive will help your family and physicians know who should speak for you, and understand what you want, if you cannot speak for yourself.

You can **revoke** (cancel) this directive at ***any*** time by: **1**) writing "revoked" across the front of the directive, followed by your signature and date, and the signature of at least one witness aged 18 years or older ; or **2**) by completing a Notice of Revocation; or **3**) by *telling* an adult witness that you want it revoked (who must then sign and date a statement, which becomes effective only when given to your doctor or health care provider); or **4**) *by simply completing a new directive* in which you state that any prior directive is no longer valid (as is already stated in this directive).

You can **limit** your directive and the authority of anyone named in it, but *only at the time of first completion*. Any scope-of-authority changes needed *after* your directive has been witnessed must be made by completing a new directive. First-time changes can be made by lining out anything in the directive and writing "deleted" beside that clause or section (or initialing above any word(s) you have lined out), followed by your signature, and the signature of at least one of the persons serving as a witness to this document, placed in the margin immediately beside the change.

If you are **unable to write**, you may tell your directive witnesses what you want to have excluded, limited, or added to this directive. They must then sign, date, witness and/or notarize

the statement of the limitations and exclusions as you have described them.

Remember, unless you direct otherwise, this directive will **only** be used to guide your family and doctors if you are unable to make and communicate medical treatment decisions for yourself.

Instructions for Completing the Directive:

This directive is written in two parts. While it is best if you fill out the whole document, you may choose to complete only ***Section I***, leaving just a statement of your values and wishes. Or you may complete only ***Section II***, just naming someone to speak for you. However, this may leave your family and others without any evidence to support your wishes in the future, or leave them unsure who is to make decisions and speak for you. Thus, omitting either section may cause your loved ones difficulty if they must eventually make medical choices in your behalf. So, you are strongly encouraged to complete the entire directive.

To complete the document, you should ***initial*** in the underlined spaces provided beside all the questions that are asked, and fill in any blank lines as directed. Feel free to write "No," "None," or "Does Not Apply" in areas that would otherwise be left blank.

SECTION I:

LIVING WILL DECLARATION

and Personal Instructions

(Pursuant to MRS Title 31: Ch.459, §459.010 to §459.055)

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1. INTRODUCTION: *The Missouri living will Declaration statutes provide the following statement regarding the authority and use of a living will*:

   "*The directions of a declarant able to make treatment decisions shall at all times supersede the declaration. The declaration shall be* ***given operative effect only if*** *the declarant's condition is determined to be* ***terminal*** *and the declarant is not able to make treatment decisions. Such determinations shall be recorded in the declarant's medical record. A* ***physician****, health care professional or facility or other person* ***shall not act contrary to the declarant's expressed intent*** *to withhold or withdraw death-prolonging procedures* ***without serious reason*** *therefor consistent with the best interest of the declarant. Such reason shall be recorded in the declarant's medical record. The declaration to withdraw or withhold treatment by a patient diagnosed as pregnant by the attending physician shall have no effect during the course of the declarant's pregnancy*" *(§459.025, emphases added)*.

2. I have chosen *not* to complete a Declaration at this time, but I *do* want to complete a Health Care Power of Attorney (*sign here, and skip to page 4*):

   Signature: _____ Date: _____

   OR,

DECLARATION

3. I have the primary right to make my own decisions concerning treatment that might unduly prolong the dying process. By this declaration I express to my physician, family and friends my intent:

(*initial and complete all that apply*)

4. _____ If I should have a terminal condition it is my desire that my dying not be prolonged by administration of death-prolonging procedures. If my condition is terminal and I am unable to participate in decisions regarding my medical treatment, I direct my attending physician to withhold or withdraw medical procedures that merely prolong the dying process and are not necessary to my comfort or to alleviate pain.
5. _____ It is not my intent to authorize affirmative or deliberate acts or omissions to shorten my life, rather only to permit the natural process of dying.
6. _____ Other wishes: _____
_____
_____
_____(*attach additional pages, if needed*)

7. Signed this_____day of _____, 20_____

8. Signature _____

9. City, County and State of residence: _____

Statement and Signatures of Witnesses

10. The declarant is known to me, is eighteen years of age or older, appears to be of sound mind, and voluntarily signed this document in my presence.

11. Witness: _____
Printed Name:_____
Address: _____

12. Witness: _____
Printed Name:_____
Address: _____

REVOCATION PROVISION

13. I hereby revoke the above declaration.

14. Signed this_____day of _____, 20_____

15. Signature _____

SECTION II:
DURABLE POWER OF ATTORNEY FOR HEALTH CARE

Designation of Health Care Agent

(MRS, Title 26: Ch.404: §404.800 to §404.865)

16. INTRODUCTION: *This section lets you name a person (called an "agent" or "attorney-in-fact") to make health care decisions for you, if you cannot make them for yourself. The person you name must be at least 18 years of age. Unless you indicate otherwise, the powers which you may grant through this document include the authority to make health care decisions – including life-sustaining treatment decisions – as well as other authorities regarding related affairs. If you have questions, you should seek further counsel and advice.*

17. ***Be it known that I***:

Full Legal Name: _____

Date of Birth: _____

Street Address: _____

City: _____ County: _____

State: _____ Zip Code: _____

~~ Intend by this document to create a power of attorney for health care. THIS IS A DURABLE POWER OF ATTORNEY AND THE AUTHORITY OF MY ATTORNEY IN FACT SHALL NOT TERMINATE IF I BECOME DISABLED OR INCAPACITATED OR IN THE EVENT OF LATER UNCERTAINTY AS TO WHETHER I AM DEAD OR ALIVE. I am of sound mind, and state that execution of this document is voluntary and without duress. Creation of this power of attorney is for the purpose of designating someone to act as my health care agent (also known as my attorney-in-fact), to act in my place to make medical decisions for me if I become unable to make them for myself . It also grants my agent the authority to make other legal and personal care decisions as outlined in this document. This designation is effective when, in the opinion of two licensed medical doctors who have personally examined me, I am no longer able make medical treatment decisions for myself and will remain so when treatment decisions are required. I revoke any prior power of attorney for health care.

18. I understand that I am <u>not</u> required to choose an agent, but recognize that by doing so I may more fully ensure that my wishes are represented and carried out. Therefore:

(*initial only <u>one</u>*)

_____ I do <u>not</u> want to choose a health care agent at this time (or I have no one appropriate to the task). However, I instruct that Section I of this document be recognized by statutory law, case law, common law and/or federal law as a declaration of my wishes within this Advance Health Care Directive (*proceed now to sign on page 6*); ***OR***,

_____ I <u>do</u> wish to appoint a health care agent. I recognize that, by Missouri law, this person may *<u>not</u>* be my health care provider nor an employer of my health care

provider, nor an owner, operator or employee of a health care facility in which I reside – unless related to me within at least the second degree (grandparent, parent, sibling, nephew/niece, uncle/aunt), or members of the same religious community, "bound by vows and regularly engaged in religious, charitable, educational, or health care services" *(§404.815)*. The person I have chosen to act as my agent and to whom I give **full** authority to make all medical and health care decisions for me at any time I am unable to make them for myself, is:

19. **Name of Agent**: _____
Address: _____
Telephone: Home:_____ Work:_____
Cell Phone or Pager: _____ E-mail: _____

20. If for any reason I revoke the authority of my agent, or this individual is unavailable, unwilling, or otherwise ineligible to make decisions for me, then the following individuals (who meet the same agent eligibility requirements) are appointed *to act alone and successively, in order of priority as listed* as alternate proxies:

21. **Name of Alternate #1:**_____
Address: _____
Telephone: Home:_____ Work:_____
Cell Phone or Pager: _____ E-mail: _____

22. **Name of Alternate #2:** _____
Address: _____
Telephone: Home:_____ Work:_____
Cell Phone or Pager: _____ E-mail: _____

23. Each alternate successor designated shall be vested with the same power and duties as if originally named as my health care agent. These persons, *in priority of the order presented*, are to have binding authority over any and all other persons to make my personal and health care decisions, including decisions to withhold or withdraw any form of life support. I specifically authorize my agent and successors to make decisions regarding the use, withholding or the withdrawal of nutrition (food) and hydration (water) ***if*** given, or to be given, by artificial medical means (through tubes, IV lines, or by other medical devices or mechanisms). In making decisions in my behalf *if my wishes are not clear*, I direct my agent to act in his/her best understanding of what my wishes would have been. And, where not reasonably sure of what I would have wanted, to act according to his/her belief in my interests as determined from his/her knowledge of my personal and family affairs, and other goals and values in life. The authority of my agent shall not be terminated <u>*unless*</u> it appears that he or she is clearly and obviously not acting in accordance with my known wishes, or is overwhelmingly ignoring my best interests if my wishes are not otherwise known.

STATEMENT AND SIGNATURE OF PRINCIPAL/GRANTOR:

24. This document is governed by Missouri law, although I request that it be honored in any state in which I may be found.

By signing below, I indicate that I am fully aware of the contents of this document, and understand its purpose, effect, consequences, and full import. Further, I am of legal age, and I am emotionally and mentally competent to complete this document. I am acting voluntarily and without fraud, duress or undue influence.

25. Signed:_____ Date: _____

At: (City) _____ (State) _____

Statement of Witnesses

26. I am at least 18 years of age. I know the principal personally, or I have been provided convincing evidence of identity. The principal has had opportunity to read this document, and has signed or acknowledged his/her signature or mark in my presence. This document is being executed voluntarily, and the principal appears to be of sound mind and under no duress, fraud, or undue influence.

27. 1st Witness: _____
(Signature)

_____ _____
(Name Printed) (Date)

_____
(Residence Address)

28. 2nd Witness: _____
(Signature)

_____ _____
(Name Printed) (Date)

_____
(Residence Address)

CERTIFICATE OF ACKNOWLEDGMENT OF NOTARY PUBLIC:

29. State of Missouri,

County of_____ }

Place: _____

On this_____day of _____, in the year_____, before me (insert officer name/title): _____, personally appeared (insert name of Principal on line here):_____, personally known to me (or proved to me on the basis of satisfactory evidence* (describe:_____)) to be the person(s) whose name(s) is/are subscribed to this/these instrument(s) and acknowledged to me that he/she executed the same in his/her authorized capacity, and that by his/her signature on the instrument(s), executed the instrument(s). I declare that he/she appears of sound mind and not under or subject to duress, fraud, or undue influence, that he/she acknowledges the execution of the same to be his/her voluntary act and deed, and that I am not the agent (attorney-in-fact), proxy, surrogate, or a successor of any such, as designated within this document, nor do I hold any interest in his/her estate through a Will or by other operation of law.

WITNESS my hand and official seal.

_____ **Notary Seal:**

Signature of Notary Public

_____

Date Commission Expires

For additional copies of this directive, or other related materials, please contact Lifecare Directives, LLC, at:

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