MICHIGAN PATIENT ADVOCATE DESIGNATION

Before you complete this form, here are a few things to keep in mind:

You have the right to decide your health care as long as you are able to do so. Completing this form does not change that.

Your Patient Advocate will only be able to make decisions for you when a doctor and another provider determine that you cannot participate in your care anymore.

There are optional sections of this form. If any part of this form is left blank the remainder of the form is still in effect.

There are requirements for this form to be completed.

1. Your Patient Advocate must sign an acceptance as part of this form. If you select a Successor Patient Advocate, they must also accept by signing this form.
2. You must have two witnesses with you to sign this form. There are restrictions on who can become a witness in the section entitled "WITNESSES".

Your Name: _____ Address: _____

City: _____ State: _____

Date of Birth (MM/DD/YYYY): _____

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

The person I choose as my Patient Advocate is:

Name: _____ Address: _____

City: _____ State: _____

Phone: _____ Alt. Phone: _____

Email: _____

If my first choice cannot serve, I have chosen another person as my second choice, or my "Successor Patient Advocate". The person I choose as my Successor Patient Advocate is:

Name: _____ Address: _____

City: _____ State: _____

Phone: _____

I understand under Michigan law, 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.

GENERAL POWERS

My Patient Advocate or Successor Patient Advocate shall have power to make care, custody and medical treatment decisions for me only if my attending physician and another physician determine I am unable to participate in medical treatment decisions. For mental health decisions, the second health care professional may be a licensed psychologist.

In making decisions, my Patient Advocate:

- Shall try to follow my previously expressed wishes, whether those wishes were spoken, written down in another document, or are in this designation,
- Has authority to consent to or refuse treatment on my behalf, arrange medical and personal services for me, and pay for such services with my funds, and
- Shall have access to any of my medical records to which I have a right, as well as my birth certificate and other legal documents needed to apply for Medicare, Medicaid or other government programs.

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

It is my intent that 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.

Hard copies and electronic copies of this document can be relied upon as though they were originals.

TREATMENT (optional)

I authorize ☐ Do not authorize ☐ the administration of **medications to relieve pain** even though they may be addictive or may shorten my life.

I authorize ☐ do not authorize ☐ the **use of CPR** (Cardiopulmonary Resuscitation): making the heart beat again and restore breathing after it has stopped. This may involve the use of an electronic device, chest compression and breathing assistance.

I authorize ☐ do not authorize ☐ the **use of artificial life support**: continuous use of a ventilator, IV fluids, medications and other equipment that helps the organs to continue to work.

I authorize ☐ do not authorize ☐ the **treatment of new conditions**: surgery, blood transfusions, or antibiotics that will address a new condition but will not help the main illness.

I authorize ☐ do not authorize ☐ the use of a **tube feeding or IV fluids** to deliver food and water.

I authorize ☐ do not authorize ☐ the use of **treatments that have not been approved by the FDA** (Food and Drug Administration) for my condition, yet have shown promise in a clinical trial.

Special treatment instructions: _____

_____

MENTAL HEALTH TREATMENT (optional)

I have the choice to authorize my Patient Advocate to make decisions concerning my mental health. By marking the box below, I may block or authorize to my Patient Advocate for acting on my behalf. (Mark one of the two options below.)

☐ I do not authorize my Patient Advocate to make decisions concerning my mental health.

OR

☐ I authorize my Patient Advocate to make decisions concerning my mental health if a physician and a mental health professional determine I cannot give informed consent for mental health care.

If you have authorized your Patient Advocate to make mental health choices on your behalf, initial one or more of the following boxes 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 voluntary patient.

I have specific wishes about mental health treatment, such as a preferred health professional, hospital or medication. My wishes are as follows: _____

_____

_____

Organ Donation (optional)

Upon my death I do not wish to make an anatomical donation. ☐

Upon my death I wish to make an anatomical donation as designated below. (Mark one)

☐ Any organ/tissue for transplant

☐ Only the following organs/tissues for transplant: _____

☐ My entire body for research

☐ Only the following organs/tissues for research: _____

Organ donation is voluntary.

If you do not state your wishes or instructions about organ and/or tissue donation on this form, it will not be taken to mean that you do not wish to make a donation or prevent a person who is otherwise authorized by law, to consent to a donation on your behalf.

Autopsy (optional)

My Patient Advocate will have the power to authorize an autopsy of my body unless I have limited my Patient Advocate's power by marking below

☐ My Patient Advocate will not have the power to authorize an autopsy of my body (unless an autopsy is required by law).

Funeral (optional)

I am entitled to veteran's benefits ☐ I am entitled to military honors ☐

I have pre-paid for a funeral plan ☐

I would like my funeral services held at:

Funeral Home ☐ Cemetery ☐ House of Worship ☐

Funeral home preference: _____

I would like my remains to be:

Buried ☐ Entombed ☐ Cremated ☐

My preferred place of burial is: _____

What do you want to be done with your ashes? _____

_____

I would like my funeral services to be held according to the tenets of my faith: ☐

My faith is: _____.

Special requests for service: _____

_____

SIGNATURE

I sign this document voluntarily, and understand its purpose.

_____ _____
Signature Date

_____ _____ _____
Address City State

_____
Phone

WITNESSES

I have chosen two adult witnesses, 18 years of age or older, who are not my spouse, parent child, grandchild, brother, sister, or presumptive heir, who are not my physician or my Patient Advocate, who are not an employee of my life or health insurance company, who are not an employee of a home for the aged where I reside, who are not an employee of a community mental health program providing me services, and who are not an employee of the health care facility where I am now.

_____ _____	_____ _____
Witness Signature Date	Witness Signature Date
_____	_____
Print Name	Print Name
_____	_____
Address	Address
_____ _____	_____ _____
City State	City State
_____	_____
Phone	Phone

ACCEPTANCE BY PATIENT ADVOCATE

According to Michigan Compile Laws:

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 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.
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.

I, _____(Patient Advocate), understand the above conditions and accept the designation as Patient Advocate for _____(Name of Patient), who signed a Patient Advocate designation for health care on the following date: _____.

_____ _____

Signature of Patient Advocate Date

I, _____(Successor Patient Advocate), understand the above conditions and accept the designation as Successor Patient Advocate for _____(Name of Patient), who signed a Patient Advocate designation for health care on the following date: _____.

_____ _____

Signature of Successor Patient Advocate Date