Corewell Health™

# Record
# ADVANCE DIRECTIVE: DESIGNATING/ACCEPTING DURABLE POWER OF ATTORNEY FOR HEALTH CARE (DPOAH)



***NOTE:*** **· This document was developed to meet the State of Michigan requirements for designating a Patient Advocate . It is not designed to replace the counsel of your attorney.**

- **"Individual" will mean Person designating DPOAH.**
- **On the fillable form, a signature must be signed by hand.**

## DESIGNATING/ASSIGNING AUTHORITIES TO MY PATIENT ADVOCATE(S):

Individual designating this DPOAH (print) _____

Date of birth _____

### DESIGNATING MY PATIENT ADVOCATE(S):

FIRST CHOICE FOR PATIENT ADVOCATE:

I designate as my Patient Advocate:

Name of first choice Patient Advocate _____

Address _____

Phone (_____) _____

ALTERNATE PATIENT ADVOCATE(S):

**Second choice for Patient Advocate:**

If the first individual is unable, unwilling or unavailable to serve as my Patient Advocate, then I designate as my Patient Advocate:

Name of second choice Patient Advocate _____

Address _____

Phone (_____) _____

**Third choice for Patient Advocate:**

If both the first and second individual is unable, unwilling or unavailable to serve as my Patient Advocate, then I designate as my Patient Advocate:

Name of third choice Patient Advocate _____

Address _____

Phone (_____) _____

### PATIENT ADVOCATE ROLE AS DPOAH:

- This DPOAH is only in effect if I become unable to participate in treatment decisions.
- Medicines/treatment intended to provide comfort or pain relief will not be withheld or withdrawn.
- Exercise power in my name and for my benefit.
- Authority that includes, but is not limited to, making decisions regarding my care, custody or medical treatment.
- To help me achieve my goals of care. This may include beginning, not starting, or stopping treatment(s). I understand that such decisions could or would allow my death.

**COMMUNICATION WITH MY PATIENT ADVOCATE:**

- I have talked to my Patient Advocate(s) and shared my wishes.
- I have instructed my Patient Advocate(s) concerning my wishes and goals in the use of life sustaining treatment such as, but not limited to:
  - Ventilator (breathing machine)
  - Nutritional tube feedings
  - Kidney dialysis
  - Cardiopulmonary resuscitation (CPR)
  - Intravenous hydration
  - Medicines for blood pressure or antibiotics
- These are my preferences/wishes for my care (e.g., including any religious beliefs that prevent an examination by a doctor, licensed psychologist, or other medical professional).
  ***Note:*** *You do not have to complete this area*

_____

_____

_____

_____

☐ **I have shared my wishes with my Patient Advocate(s) and am giving them authority to make decisions that might allow me to die. This includes having the authority to not start or stop life support or CPR.**

**I UNDERSTAND:**

- I do not intend for others (i.e., my family, the medical facility, doctors, nurses, other medical personnel involved in my care) to be liable for implementing the decisions of my Patient Advocate or honoring wishes expressed in this authorization.
- After it is signed and witnessed, photostatic copies of this document will have the same legal force as the original document.
- This document is to be treated as a DPOAH. It will survive my disability or incapacity.
- This Advance Directive includes Patient Advocate Acceptance and may also include Treatment Preferences.

**I AGREE:**

- I intend this authorization to be applied to the fullest extent possible wherever I may be.
- I am providing this designation of my own free will. I have not been told I am required to give a designation in order to receive care or to have care withheld/withdrawn.
- I am at least eighteen (18) years old.
- I am of sound mind.

**SIGNATURE OF INDIVIDUAL DESIGNATING DPOAH:**

DATE _____

Individual designating this DPOAH signature _____

Phone (_____) _____





***CONTINUED ON PAGE 3*** ➔

## WITNESSES TO INDIVIDUAL DESIGNATING DPOAH SIGNATURE:

***Note:*** **There must be two (2) witnesses for this designation to be valid.**

AS A WITNESS, I CERTIFY THAT I AM:

- At least eighteen (18) years of age.
- Not designated as a Patient Advocate for the above Individual.
- Not the above Individual's spouse, parent, child, grandchild, sibling or presumptive heir.
- Not listed to be a beneficiary of, or entitled to, any gift from the above Individual's estate.
- Not directly financially responsible for the above Individual's health care.
- Not a health care provider treating the above Individual.
- Not an employee of a healthcare/insurance provider treating the above Individual.

***Note:*** **There must be two (2) witnesses for this designation to be valid.**

I AM WITNESSING:

- The above Individual designating their Power of Attorney to their Patient Advocate(s).
- The above Individual is signing voluntarily and without duress, fraud, or undue influence.
- The above Individual is at least eighteen (18) years of age.
- I understand the above Individual to be of sound mind.

**Witness One:**

Witness One signature _____

Witness One (print) _____

Address _____

**Witness Two:**

Witness Two signature _____

Witness Two (print) _____

Address _____

**INTERPRETATION SERVICES**

I certify that I have interpreted, to the best of my ability, into and from the participant's stated primary language, _____, all oral presentations made by all of those present during the informed consent discussion.

**TIME** _____ ☐ AM ☐ PM **DATE** _____ Interpreter signature _____

Interpreter name (print) _____



***OVER FOR "RECORD ADVANCE DIRECTIVE: ACCEPTING ROLE OF PATIENT ADVOCATE DESIGNATED IN DURABLE POWER OF ATTORNEY FOR HEALTHCARE (DPOAH)" ➔***

## ACCEPTING ROLE OF DPOAH:

***NOTE:*** • **"Individual" will mean Person designating DPOAH.**
• **On the fillable form, a signature must be signed by hand.**

Individual designating this DPOAH (print) _____
Date of birth _____

### I UNDERSTAND AND AGREE THAT, ACCORDING TO MICHIGAN LAW:

- This DPOAH is only in effect if the Individual becomes unable to participate in medical or mental health treatment decisions.
- I will not exercise powers concerning the Individual's care, custody or medical/mental health treatment that Individual (if he/she were able to participate in the decision) could not have exercised on his/her own behalf.
- If the Individual is pregnant, I cannot make a medical treatment decision to withhold or withdraw treatment if that would result in the Individual's death, even if these were the Individual's wishes.
- I can make a decision to withhold or withdraw treatment which would allow the Individual to die. I can do this only if the Individual has expressed clearly that I am permitted to make such a decision, and if I understand that such a decision could or would allow his or her death.
- I may not receive payment for serving as Patient Advocate, but I can be reimbursed for actual and necessary expenses which I incur in fulfilling my responsibilities.
- A fiduciary acts on behalf of the Individual. They put the Individual's best interests ahead of their own and have a duty to preserve good faith and trust. I will act as the Individual's fiduciary. The Individual may have expressed his/her treatment preferences or shown in past decisions (while he/she was able to participate in medical or mental health treatment decisions). These are presumed to be in the Individual's best interests.
- The Individual may revoke (take back) his/her designation of me as Patient Advocate at any time and in any manner sufficient to communicate an intent to revoke.
- For mental health treatment decisions, the Individual may waive (give up) the right to revoke his/her designation of me as Patient Advocate. If such waiver is made, the Individual's ability to revoke (for mental health treatment decisions) will be delayed for 30 days after he/she communicates his/her intent to revoke.
- I may revoke my acceptance of my role as Patient Advocate any time and in any manner sufficient to communicate an intent to revoke.






***CONTINUED ON PAGE 5 ➔***

# ADVANCE DIRECTIVE: DESIGNATING/ACCEPTING DURABLE POWER OF ATTORNEY FOR HEALTH CARE (DPOAH) *(CONTINUED)*

- If an Individual is admitted to a health facility or agency, he/she has the rights enumerated in Section 20201 of the Michigan Public Health Code, Exercise of Rights by Individual's Representative 1978 PA 368, MCL 333.20201.

## ACCEPTING ROLE OF DPOAH:

***Note:*** Refer to DURABLE POWER OF ATTORNEY FOR HEALTH CARE (DPOAH) for the order Patient Advocate(s) are designated.

### FIRST CHOICE FOR PATIENT ADVOCATE:

- I am at least 18 years of age.
- I accept the role of Patient Advocate designated by the Individual.
- I understand and agree to take reasonable steps to follow the desires and instructions of the Individual as indicated within their Advance Directives. Advance Directives may come in the form of his/her written or spoken instructions.
- If I am unable or unavailable to act after reasonable efforts to contact me, I delegate my Patient Advocate authority to the person designated as the Second Choice Patient Advocate. The following Patient Advocate(s) is/are authorized (in the order listed) to act until I become available to act.

DATE _____ First Choice Patient Advocate signature _____

First Choice Patient Advocate (print) _____

### ALTERNATE PATIENT ADVOCATE(S):

SECOND CHOICE FOR PATIENT ADVOCATE

- I am at least 18 years of age.
- I accept the role of Patient Advocate designated by the Individual.
- I understand and agree to take reasonable steps to follow the desires and instructions of the Individual as indicated within their Advance Directives. Advance Directives may come in the form of his/her written or spoken instructions.
- If I am unable or unavailable to act after reasonable efforts to contact me, I delegate my Patient Advocate authority to the person designated as the Second Choice Patient Advocate. The following Patient Advocate(s) is/are authorized (in the order listed) to act until I become available to act.

DATE _____ Second Choice Patient Advocate signature _____

Second Choice Patient Advocate (print) _____

THIRD CHOICE FOR PATIENT ADVOCATE:

- I am at least 18 years of age.
- I accept the role of Patient Advocate designated by the Individual.
- I understand and agree to take reasonable steps to follow the desires and instructions of the Individual as indicated within their Advance Directives. Advance Directives may come in the form of his/her written or spoken instructions.

DATE _____ Third Choice Patient Advocate signature _____

Third Choice Patient Advocate (print) _____

### INTERPRETATION SERVICES

I certify that I have interpreted, to the best of my ability, into and from the participant's stated primary language, _____, all oral presentations made by all of those present during the informed consent discussion.

**TIME** _____ ☐ AM ☐ PM **DATE** _____ Interpreter signature _____

Interpreter name (print) _____