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# **Durable Power of Attorney for Health Care**

**If you need help in completing this form or  
have any questions about this form, please contact:**

Social Work at  
McLaren Flint

**(810) 342 2375**

8:00 a.m. to 4:30 p.m.  
Monday thru Friday



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An Advance Directive is a written statement describing a person's health care preferences and/or naming an individual to make health decisions on their behalf. There are two types of Advance Directives: the Durable Power of Attorney for Healthcare and the Living Will. What follows is a description of each as well as other related information.

**1. What is a Durable Power of Attorney for Health Care?**

A Durable Power of Attorney for Health Care is a document in which you appoint someone known as your "Advocate" to make health care, custody and medical treatment decisions if you become unable to do so.

**2. How does it work?**

Appoint someone you trust to be your Advocate. You may also appoint one successor for the first person you chose, if that person becomes unwilling or unable to act as your Advocate. Fill out the form and sign it in the presence of two witnesses, and have the witnesses sign it. Your Advocate and successor must also sign the form to show that they accept the responsibility.

Your Advocate can make a health care, custody or medical treatment decisions on your behalf only if you are not able to do so yourself, as determined by your physician and another physician or a licensed psychologist, or by a court.

**3. Can I appoint a person to manage my financial affairs in a Durable Power of Attorney for health care?**

No. A person appointed in a Durable Power of Attorney for Health Care is allowed only to make health care decisions, arrangements for medical services, and related decisions. If you want to appoint a person to handle your financial or legal affairs, you should consult an attorney.

**4. What decisions will my advocate be able to make?**

Your Advocate will normally make decisions about your routine care, custody and treatment. Examples of this are: Signing for medical treatment, or admitting you to or from a hospital. You may authorize your Advocate to decide to withhold or withdraw treatment (including withholding artificially administered food and water), allowing you to die. If you wish your Advocate to have this option, you must authorize it in writing, stating that you understand such a decision would allow you to die.

You may also authorize your Advocate to exhaust every medical alternative, including experimental medical procedures, which would prevent or slow down the dying process. Your Advocate will not be permitted to make decisions, which are against sound medical advice, even if your Advocate is authorized by you to make such decisions.

**5. If my Advocate makes a decision to withhold or withdraw treatment, and I die, can my Advocate be charged with assisting a suicide?**

Refusing life-sustaining treatment is not considered suicide in Michigan. Withholding or withdrawing treatment, allowing you to die is not considered assisting a suicide under Michigan law. Therefore, your Patient Advocate cannot be charged with assisting a suicide. To protect you and your Advocate, you must state whether you would want treatment withheld or withdrawn which would allow you to die.

**6. Must I have a Durable Power of Attorney for Health Care?**

No. Establishing a Durable Power of Attorney for Health Care is completely voluntary. Neither a health care provider nor an insurance company can require you to have a Durable Power of Attorney as a condition of treatment or coverage. However, without a Durable Power of Attorney, a hospital, nursing home or physician may not be willing to accept direction from your friends or family members about your care.

**7. Do I need an attorney to fill out the form?**

No. Anyone over eighteen years of age can give someone Durable Power of Attorney for Health Care without an attorney.

**8. Must I use the attached form?**

No. This form is a Durable Power of Attorney form which meets the requirements of Michigan law; however, you may use a different form if you choose to do so.

**9. What witnesses do I need?**

Two witnesses must confirm that you are signing the Durable Power of Attorney voluntarily, and under no duress, fraud or undue influence. The witnesses may not be a spouse, parent, child, grandchild, brother or sister, heir or devisee, a physician, the Patient Advocate, an employee of your life or health insurance provider, an employee of a health facility that is treating you, or an employee of a nursing home where you reside.

**10. What should I do with my Durable Power of Attorney after it is signed and witnessed?**

Make it a part of your medical record by giving it to your doctor. Then give signed copies to your Patient Advocate; to your Successor Advocate, if you appoint one; to your attorney if you have one, and give a copy to anyone who may be affected by your decision to appoint a health care advocate. This may be your spouse, significant other, or other family members. If you enter a hospital or nursing home, make sure the facility has copy of your Durable Power of Attorney for Health Care.

**11. How does this law affect physically disabled persons?**

The law affects disabled individuals the same way it affects those who are not physically disabled. Under no circumstances is a physically disabled person obligated under this law to establish a Durable Power of Attorney. If a disabled person desires to establish one, then he or she should execute a Durable Power of Attorney to ensure that if he or she loses decision-making abilities, a trusted person would make health care, custody and medical treatment decisions on behalf of him or her.

**12. How does this law affect minors and mentally ill patients?**

This law has no effect on minors or mentally ill patients. Minors are unable, under Michigan law, to enter into contracts of any kind, including a Durable Power of Attorney for Health Care.

Mentally ill patients cannot establish a Durable Power of Attorney for Health Care; because a person can establish a Durable Power of Attorney only if the person is of sound mind. If there is any disagreement as to whether the patient was of sound mind at the time of the designation, then an interested third party may bring the issue to the probate court for a decision.

**13. Can I change my Durable Power of Attorney?**

Yes. You can change or entirely revoke your Durable Power of Attorney at any time and in any manner in which you are able to communicate your wish. This means that you may revoke the designation of your Advocate with a written statement or just by saying it. You may revoke your Durable Power of Attorney, even if you are otherwise unable to participate in decisions about your medical treatment. If you choose to appoint a different Advocate, or make any other changes, then you may execute a new Durable Power of Attorney indicating your wishes. Your previous Durable Power of Attorney becomes ineffective on the date a new Durable Power of Attorney is signed.

**14. Can I change my instructions about treatment?**

You can revoke or change instructions to withhold or withdraw treatment at any time and in any manner you are able to communicate such an intent. You may therefore change instructions to withhold or withdraw treatment without a written statement, and even if you are otherwise unable to participate in decisions about your medical treatment.

**15. Is there a procedure to ensure that my Advocate is acting according to my expressed wishes?**

Yes. An interested individual who believes that your Advocate is not acting according to your wishes may file a petition with the probate court in the county in which you reside. The court will determine whether or not the Advocate is acting in your best interest or following your wishes.

**16. Is there anyone who may not be appointed as my Advocate?**

You may not appoint anyone who is younger than 18 years old. There are no other restrictions on who may be an Advocate.

**17. Must my Patient Advocate accept being designated as Patient Advocate?**

Your Patient Advocate must acknowledge acceptance of his or her rights and responsibilities as your Patient Advocate before he or she can make decisions for you. If your Advocate chooses not to sign the acceptance, then your Durable Power of Attorney designating this individual may not be honored. You should make this advocate acceptance form a part of your medical record with your Durable Power of Attorney.

**18. When does my Advocate act on my behalf?**

Your Advocate starts to make decisions when you lose decision-making abilities. That time is determined by your physician and a second physician or a licensed psychologist, or by a court. Your Advocate immediately loses the power to make decisions on your behalf when you regain decision-making ability.

**19. What is the difference between a Durable Power of Attorney and a Living Will?**

With a Durable Power of Attorney, you appoint someone you trust to make decisions on your behalf. With a Living Will, you state what type(s) of treatment you want or don't want if you become unable to express your wishes. With a Living Will, however, you do not appoint someone to make those decisions for you. The Living Will is not written into Michigan law; the Durable Power of Attorney is in Michigan law.

**20. If I indicate in my Durable Power of Attorney which medical treatments I want or don't want, why should I establish a Living Will?**

If you don't have anyone to appoint as your Patient Advocate, then creating a Living Will is a good decision. Even if you do have someone to serve as your Patient Advocate, a Living Will may serve as another guide for your Advocate and for your physician to determine which types of treatment you want or don't want. You should, however, discuss with your Advocate and physician what types of treatments you would want if you become unable to communicate your wishes

**21. Can I make a donation of parts of my body to take effect after my death?**

Yes, you can yourself donate all or physical parts of your body, and your donation will take effect after your death. You should specify that you want all or physical parts of your body to be donated by saying so in your will, on an identification card issued by the State of Michigan, on your driver's license, or in a written form such as a Donor Card.

**22. Can my Advocate make a decision to donate parts of my body after my death?**

You may specify that your Advocate may decide to donate all or to donate only one or more physical parts of your body after your death. It is very important that you discuss this option with your Advocate so that they know your preferences and wishes.

**23. Who can revoke my donation or the donation by my Patient Advocate of all or parts of my body?**

If you make the donation yourself, no one, not even the Patient Advocate, can revoke or change the donation that you make. If your Patient Advocate makes the donation after your death, no one can revoke or change the donation.

## **THE MEANING OF TERMS USED IN THESE FORMS**

These are some common terms, which apply to life sustaining decisions. It may be helpful to discuss these with your physician.

1. **RESUSCITATION OF THE HEART:** Pressing on the chest, or the use of electric shock, or medications to restart the heart.
2. **ARTIFICIALLY-ADMINISTERED FOOD AND FLUIDS (TUBE FEEDING):** Food or liquids that are given through a tube inserted into the body through the nose or abdomen.
3. **MECHANICAL RESPIRATION (VENTILATOR OR RESPIRATOR):** Connecting the individual to a machine that breathes for them, or helps them to breath.
4. **KIDNEY DIALYSIS:** Connecting the individual to a machine that removes waste from the blood when the kidneys are not able to do so.
5. **DRUGS TO MAINTAIN BLOOD PRESSURE OR HEART FUNCTION:** Various drugs are used to either increase or decrease blood pressure or heart action.
6. **RADIATION:** The use of radioactive substances or equipment to destroy cancer or other diseases.
7. **CHEMOTHERAPY:** The use of drugs or chemicals to destroy cancer or other diseases.
8. **ANATOMICAL DONATION:** All or any physical part of a person's body to be donated for purposes of organ transplantation or research, upon the person's death.
9. **PHYSICAL PART:** Organs, tissues, eyes, bones, arteries, blood, other fluids, and any other portion of a human body.

## **PATIENT DESIGNATION OF ADVOCATE FOR HEALTH CARE DECISIONS**

I, \_\_\_\_\_, am of sound mind, 18 years of age or older and I voluntarily make this designation.

I designate as my Patient Advocate \_\_\_\_\_  
(Type or print name)

who resides at: \_\_\_\_\_

Telephone #: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

with the following power to be exercised in my name and for my benefit: to make decisions regarding my care, custody and medical treatment. I understand that this power may be exercised only if I am unable to participate in treatment decisions about my medical care; and that determination of when I am unable to participate in care, custody and medical treatment decisions will be made by my attending physician and another physician or licensed psychologist.

(Optional) If the first individual does not accept, is incapacitated, resigns, or is removed as my Patient Advocate, then I designate as my successor Patient Advocate -  
who resides at \_\_\_\_\_

Telephone #: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_.

With respect to my care, custody and medical treatment, my Patient Advocate and my successor Patient Advocate shall have the power to make each and every judgment necessary for the proper and adequate care and custody of my person that I could have exercised on my own behalf, if able, including, but not limited to:

- (a) to have access to and control over my medical and personal information.
- (b) to employ and discharge physicians, nurses, therapists and any other care providers; and, without liability to my patient advocate, to arrange to pay them reasonable compensation with my funds.
- (c) to give an informed consent or an informed refusal on my behalf with respect to any medical care; diagnostic, surgical or therapeutic procedure; or other treatment of any type or nature.
- (d) to execute waivers, medical authorizations and such other approval as may be required to permit or authorize care, which I may need, or to discontinue care that I am receiving.

- (e) to make an anatomical gift of all or of parts of my body upon my death in accordance with Michigan Public Acts 62 and 63 and Section 10102 of the Michigan Public Health Code, 1978 PA 368, MCL 333.10102.

Many individuals prefer to state their wishes in writing and so this page is included for your use. However, it is not required and is optional. It may be completed or left blank.

My Advocate shall be guided in making such decisions by what I have told my Advocate about my personal preferences regarding my medical care. I have the following special requests concerning my care (Describe, for example, any religious limitations upon care; if prolonging life by any or by certain means is desired; whether your condition should affect decisions of your Patient Advocate regarding your treatment.):

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**My General Instructions Regarding Life-Sustaining Treatment:**

I understand that I do not have to choose one of the instructions regarding life sustaining treatment listed below. I understand that I may make changes to the instructions below or create my own form of instructions. If I choose one, I will sign below my choice.

If I sign one of the choices listed below, I direct that reasonable measures be taken to keep me comfortable and relieve pain.

**Choice 1:** I do not want my life to be prolonged by providing or continuing life-sustaining treatment if any of the following medical conditions exist;  
I am in an irreversible coma or persistent vegetative state.  
I am terminally ill and life-sustaining procedures would serve only to artificially delay my death. Under any circumstances where my medical condition is such that the burdens of the treatment outweigh the expected benefits. In weighing the burdens and benefits of treatment, I want my Patient Advocate to consider the relief of suffering and the quality of my life as well as the extent of possibly prolonging my life.

**If this statement reflects your desires, sign here:** \_\_\_\_\_

**Choice 2:** I want my life to be prolonged by life-sustaining treatment unless I am in a coma or vegetative state which my doctor reasonably believes to be irreversible. Once my doctor has reasonably concluded that I will remain unconscious for the rest of my life, I do not want life-sustaining treatment to be provided or continued. I understand that this decision could or would allow me to die.

**If this statement reflects your desires, sign here:** \_\_\_\_\_

**Choice 3:** I want my life to be prolonged to the greatest extent possible consistent with sound medical practice. I direct life-sustaining treatment be provided in order to prolong my life.  
**If this statement reflects your desires, sign here:** \_\_\_\_\_

**Choice 4:** I have provided my Advocate with other instructions  
**If this statement reflects your desires, sign here:** \_\_\_\_\_

**OPTIONAL:** I authorize my Patient Advocate to make a decision to withhold or withdraw treatment which could or would allow me to die. Such treatment may include artificial food and water or artificially administered food and water. I acknowledge that such a decision could or would allow me to die.

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***You must sign this statement, if you wish to give this authority to your Advocate.***

This Designation of Patient Advocate shall not be affected by my disability or incapacity. This Designation of Patient Advocate is governed by Michigan law. I may revoke this designation at any time and by communicating in any manner that this designation does not reflect my wishes.

It is my intent that my family, the medical facility, and any doctors, nurses and other medical personnel involved in my care, not be liable for implementing the decisions of my Patient Advocate or honoring wishes expressed in this designation.

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

I voluntarily sign this Designation of Patient Advocate after careful consideration. I accept its meaning and I accept its consequences.

YOUR SIGNATURE: \_\_\_\_\_

YOUR STREET ADDRESS: \_\_\_\_\_

DATE: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

**NOTICE REGARDING WITNESSES**

You must have two adult witnesses who should be disinterested individuals and must not be your spouse, parent, child, grandchild, sibling, presumptive heir, known devisee at the time of the witnessing, physician, Patient Advocate, an employee of your life or health insurance provider, an employee of a health facility that is treating you, or an employee of a home for the aged.

**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, and under no duress, fraud, or undue influence.

**Witness 1 Signature:** \_\_\_\_\_

Print or Type Full Name: \_\_\_\_\_

Address: \_\_\_\_\_

**Witness 2 Signature:** \_\_\_\_\_

Print or Type Full Name: \_\_\_\_\_

Address: \_\_\_\_\_

**PATIENT ADVOCATE ACCEPTANCE**

- (a) This designation shall not become effective unless the patient is unable to participate in medical treatment decisions.
- (b) A Patient Advocate shall not exercise powers concerning the patient’s care, custody, and medical treatment that the patient, if the patient were able to participate in the decision, could not have exercised on his or her own behalf.
- (c) 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.
- (d) A Patient Advocate may make a decision to withhold or withdraw treatment which would allow the 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.
- (e) A Patient Advocate shall not receive compensation for performance as an advocate, but a Patient Advocate may be reimbursed for actual and necessary expenses incurred as an advocate in the performance of his or her authority, rights and responsibilities.
- (f) When acting for the patient, a Patient Advocate shall act in accordance with the standards of care applicable to fiduciaries, and shall act consistently with the patient’s best interests. The known desires of the patient expressed or evidenced while the patient is able to participate in medical treatment decisions are presumed in the patient’s best interests.
- (g) A patient may revoke his or her designation at any time and in any manner sufficient to communicate an intent to revoke.
- (h) A Patient Advocate may revoke his or her acceptance of the designation at any time and in any manner sufficient to communicate an intent to revoke.
- (i) 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 have received a copy of the Designation of Patient Advocate for Health Care For Care, Custody and Medical Treatment Decisions and understand it an the above conditions; and I accept the designation under those conditions as Patient Advocate.

Signed: \_\_\_\_\_ (Patient Advocate)

Dated: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Address: \_\_\_\_\_

Signed: \_\_\_\_\_ (Successor Patient Advocate)

Dated: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Address: \_\_\_\_\_







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