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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www.lifecaredirectives.com
Toll Free: (877) 559-0527

~ Lifecare Directives ~

Advance Health Care Directive

For

Michigan Residents

Statutory Compliant
Advance Directive for
Health Care Choices

~ Lifecare Directives ~

Advance Health Care Directive

For

Michigan Residents

Statutory Compliant Advance Directive for Health Care Choices

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.

Advance Health Care Directive
For Michigan 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 ~~

This advance directive combines a living will (or health care "instruction") and a power of attorney for health care (or "proxy" appointment) with a minimum of legally required content. It should be noted that Michigan has no 'living will' legislation, but has provided for the designation of a "patient advocate" within durable power of attorney statutes.

There is an introduction that summarizes the scope and purpose of the document, as well as providing directions for its completion. Read it carefully to ensure that your advance directive is fully and properly filled out.

By completing your directive, you can know that some of your wishes are recorded and can be followed. It is also a meaningful gift of support and guidance to those you love. Your completed directive will help ensure that your loved ones will have to make fewer difficult choices for you without having an understanding of what you would want done.

***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 required witnesses what you want to have excluded, limited, or added to this directive. They should make the changes you have requested, secure a third person to sign in your behalf and at your direction, and then 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.

Finally, some questions in this directive may be difficult to answer. However, the answers to these challenging questions may well be decided by someone else if they are not decided by you, now.

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.

If there is anything in this Directive you do not understand, you should read the Guidebook, ask your physician or a health care professional, or call an attorney for help.

SECTION I:
Patient Advocate Directives and
LIVING WILL STATEMENT

(MCL, Act 386, Chapter 700:§700.5501-§700.5513)

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1. INTRODUCTION: *The state of Michigan has no statutes providing for the use of Living Wills. However, Michigan statutes specifically state that "A patient advocate designation may include a statement of the patient's desires on care, custody, and medical treatment..." (§700.5507.1). Further, the Michigan Supreme Court has ruled that "clear and convincing evidence" is required for many treatment choices, and has suggested that, ideally, such evidence should be put in writing "in a living will, patient advocate designation, or durable power of attorney" (see In re Martin (538 N.W. 2d 399 (Mich. 1995)). To this end, Lifecare staff have produced this Living Will Statement, through which you may put your wishes in writing. It becomes effective only when you are unable to make and communicate medical treatment decisions for yourself.*

Intent to Complete a Living Will Statement:

2. I have chosen *not* to complete a Living Will Statement at this time, but I *do* want to designate a Patient Advocate to represent me (*skip to page 6*):

Signature: ___________________________ Date: _______________________

OR:

3. I, ____, being of sound mind, and acting willingly and without duress, fraud or undue influence, herein direct that the instructions provided in Section I of this Directive document are to be recognized as a formal statement of "desires on care, custody, and medical treatment," and evidence of my health care wishes. It is my intent that these instructions be used to guide to any agent, attorney-in-fact, proxy, representative, surrogate, court-appointed guardian or conservator, medical professional, or family member, as well as any other person or entity providing or overseeing my care, or making medical decisions in my behalf. These instructions shall be binding upon all involved to the fullest extent allowed by law.

4. *Specific Health Care Directives*: I have specific wishes regarding the delivery of medical care in certain health care conditions. Therefore, in the following conditions, I wish to direct my medical treatment as follows:

_____ If I am ever diagnosed with a **terminal** illness, disease, or injury, and generally given six months or less to live:

- I do [_____], or I do not [_____] want life-sustaining medical treatment used in any attempt to try and prolong my life.

_____ If I am ever diagnosed as being **permanently unconscious** (in a coma, or a persistent vegetative condition):

- I do [_____], or I do not [_____] want life-sustaining medical treatment used in any attempt to try and prolong my life.

_____ If I am ever diagnosed as being in a "**minimally conscious**" condition, where I will remain permanently unable to make decisions or express my wishes:

- I do [_____], or I do not [_____] want life-sustaining medical treatment used in any attempt to try and prolong my life.

_____ If I am ever diagnosed as being in "**untreatable and severe pain**," where no medical, surgical or other relief can be obtained:

- I do [_____], or I do not [_____] want life-sustaining medical treatment used in any attempt to try and prolong my life.

5. *Clarifying "life-sustaining medical treatment*." In the situations described above, I wish to leave the following directions about the treatments and procedures which may be used, withdrawn, or withheld:

- I do [_____], or I do not [_____] want **cardiac resuscitation (CPR)** used in any attempt to try and prolong my life.

- I do [_____], or I do not [_____] want **breathing machines** used to replace or support my natural breathing (i.e., “respirators, “ventilators” or other such devices) in any attempt to try and prolong my life.

- I do [_____], or I do not [_____] want food and water to be given me through **tubes, IV lines, or other medical devices** in any attempt to try and prolong my life.

- I do [_____], or I do not [_____] want **antibiotics** used in any attempt to try and prolong my life.

6. *Comfort Care and Pain Relief*. In the specific medical situations I have outlined, I provide the following directions about comfort care and pain relief:

- I do [_____], or I do not [_____] want maximum pain relief, if it may ***unintentionally*** **hasten my death**.

- I do [_____], or I do not [_____] want maximum pain relief, if it may result in ***temporary*** **addiction**, if I survived an extended hospital stay.

7. *Other Directions*. I wish to provide the following additional directions: ________________

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8. ***Signature of Principal and Witnesses***:

These directions express my legal right to include a statement of "desires on care, custody, and medical treatment," and to accept or refuse treatment under the laws of Michigan. I intend the instructions in this Statement to be carried out, unless I have rescinded them in a new writing or by clearly indicating that I have changed my mind.

By signing below, I indicate that I am fully aware of the contents of this Document, and understand its full purpose, effect, and 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.

9. Signed: ____

Date: ____

Address: ____

Statement of Witnesses

10. I am at least 18 years of age. I know the Principal personally or have been provided convincing evidence of identity, and believe him or her to be of sound mind, under no duress, fraud, or undue influence. The Principal has affixed his/her signature or mark in my presence. I have not signed the Principal's signature (above) for or at the direction of the Principal. I declare under penalty of perjury that I am not related to the Principal by blood, marriage, or adoption, nor am I directly responsible for his or her medical care or costs. Further, I am not the attending physician, nor an employee of the physician or other health care provider or current care facility, nor a party to any parent organization thereof. I am also not the employee of a life or health insurance provider for the Principal, nor am I involved in directly physically caring for the individual. To the best of my knowledge I have no claim against the Principal's estate, nor am I entitled to any part of the individual's estate upon his or her death under a will now existing nor by any other operation of law.

11. Witness: ____

Printed Name: ____

Address: ____

12. Witness: ____

Printed Name: ____

Address: ____

SECTION II:

Power of Attorney for Health Care

DESIGNATION OF PATIENT ADVOCATE

(*MCL, Act 386, Chapter 700:§700.5501-§700.5513*)

13. INTRODUCTION. *This section allows you to name a person to act as your patient advocate (and as attorney-in-fact) to make health care and related decisions for you if you cannot make them for yourself. The individual named 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.*

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

Full Legal Name: ____

Date of Birth: ____

Street Address: ____

City: ______________________________ County: __________________________

State: ______________________________ Zip Code: ________________________

~~ Intend by this document to designate and appoint a Patient Advocate by applicable power of attorney statutes. This designation shall not be affected by my later disability, incompetency, or incapacity (as the "principal" herein). I am of sound mind, and state that execution of this document is voluntary and without duress or undue influence. The individual designated as my Patient Advocate to act in my place to make care, custody, and medical treatment decisions for me if I become unable to make them for myself . It also grants my Patient Advocate the authority to make other legal and personal care decisions as outlined in this document. This designation is effective when, in the opinion of my attending physician and at least one additional physician (or licensed psychologist) who has personally examined me, I am no longer able make medical treatment decisions. By creating this document I revoke any prior Patient Advocate designation.

15. I understand that I am not required to designate a Patient Advocate, but that I am advised to do so to ensure that my wishes are fully represented and followed. Therefore:

(*initial only one*)

_____ I do not want to designate a Patient Advocate at this time (*or I have no one appropriate to the task*). I instruct that Section I of this document be recognized (by statutory law, common law, case law, and/or federal law) as a Statement of my wishes, as allowed in §700.5507.1. (*Proceed now to sign on page 10*);

OR,

_____ I do wish to appoint a patient advocate. I recognize that this person should *not* be my health care provider nor an employer of my health care provider, unless related to me by blood, marriage or adoption. The person I have chosen to act as my advocate is:

16. **Name of Advocate**: ____
Address: ____
Telephone: Home:_____________________ Work:______________________
Cell Phone or Pager: ___________________ E-mail: ____________________

17. 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, I herein name and authorize the following individuals *to act alone and successively, in order of priority as listed* to serve as alternate proxies (with the second alternate named by delegation, if necessary, pursuant to §700.5509.1.g):

18. **Name of Alternate #1:**____
Address: ____
Telephone: Home:_____________________ Work:______________________
Cell Phone or Pager: ___________________ E-mail: ____________________

19. **Name of Alternate #2:** ____
Address: ____
Telephone: Home:_____________________ Work:______________________
Cell Phone or Pager: ___________________ E-mail: ____________________

20. 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. In making decisions in my behalf *if my wishes are not clear*, I direct my advocate 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 advocate shall not be terminated *unless* 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.

21. **Nomination of Guardian/Conservator**: I also nominate my Advocate(s), in priority of the order presented, to be appointed as my guardian and/or conservator should such legal appointment ever become necessary, *unless* I have nominated someone else, or revised the order of priority, here:

22. Name:____
Address: ____
Telephone: Home:_____________________ Work:______________________
Cell Phone or Pager: ___________________ E-mail: ____________________

Patient Advocate's Acceptance of Appointment:

23. Michigan laws require a designated Patient Advocate to sign a statement "that must include substantially" all nine points enumerated below:

1. "This designation is not effective unless the patient is unable to participate in medical treatment decisions."
2. "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." (Translation: you can't exercise legal powers that don't exist for the patient, when competent).
3. "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."
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 treatment decisions are presumed to be in the patient's best interests."
7. "A patient may revoke his or her designation at any time and in any manner sufficient to communicate an intent to revoke."
8. "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." In addition, "a patient advocate...shall not delegate his or her powers to another individual without prior authorization by the patient"(§700.5509).
9. "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."

The Designated Patient Advocate further Acknowledges:

"I have received a copy of this Designation, and have read the entire document. I have also read the above statements. I accept this appointment and agree to serve to the best of my ability. I understand that I have a duty to act consistently with the desires of the principal (the person you are being asked to represent). I understand that it is also my duty to follow any wishes expressed in this document.

I understand that this appointment becomes effective only when the principal is incapable of making his/her own decisions (whether it be temporary or permanent). I

understand that I must act in good faith in exercising my authority under this power of attorney. I further understand that the principal may revoke this designation at any time, and that I should assist and facilitate its revocation if necessary.

If I choose to withdraw as advocate during the time the principal is competent, I understand that I must notify the principal of my decision. If I choose to withdraw when the principal is incapable of making his/her health care decisions, I understand that I must promptly notify the principal's immediate care physician and any alternate advocate both verbally and in writing.

24. ______________________________ ______________________
Advocate's Signature Date

____
Advocate's Printed Name

25. ***Alternates' Acceptance of Appointment***: *The statutes require your advocate alternate(s) sign and date an acceptance of this appointment. A statement is provided here*:

"I understand that I have been chosen as an alternate patient advocate, or attorney-in-fact. Should the previously appointed person be unable or unwilling to act in their primary decision-making capacity, I have then been appointed to serve in their stead. I recognize that I must act in every way in accordance with the appointment statement signed by the primary advocate. I also understand that due diligence should always be exercised to locate and secure representative decisions from the primary advocate previously appointed. However, if an emergency, extended unavailability, or other unforeseen circumstances preclude the prior advocate from fulfilling his or her representative role, I recognize that I should then assume these necessary duties. If or when the primary advocate again becomes available, I will defer to his or her representative role. If, however, the primary advocate has formally resigned his or her role *in writing*, and I am given a copy of this resignation, I understand that I will then become the primary advocate for as long as I am willing and able to serve."

26. ______________________________ ______________________
First Alternate's Signature Date

____
Printed Name

27. ______________________________ ______________________
Second Alternate's Signature Date

____
Printed Name

Statement and Signature of Principal/grantor:

28. This document is governed by Michigan 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 full purpose, effect, consequences, and 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.

(*Must be signed in the presence of two adult qualified witnesses; see below*)

29. Signed:_________________________________ Date: ______________________

At: (City) _____________________________ (State) _____________________

QUALIFIED WITNESSES

30. This Advance Directive for Health Care may not be upheld unless it is: (1) signed by two adult witnesses who are *personally present when you sign*. Notarization is not required, but Lifecare staff recommend this, as witnesses may become unavailable in the future. Your witnesses must qualify to sign the following statement:

Statement of Witnesses:

31. I am at least 18 years of age. I know the principal personally or I have been provided convincing evidence of identity, and believe him or her to be of sound mind, and under no duress, fraud, or undue influence. The principal has had opportunity to read this document, and has signed or acknowledged his/her signature or mark in my presence. I have not signed the principal's signature (above) for or at the direction of the principal. I declare under penalty of perjury that I am not related to the principal by blood, marriage, or adoption, nor am I directly responsible for his or her medical care or costs. Further, I am not the attending physician, nor an employee of the physician or other health care provider or current care facility, nor a party to any parent organization thereof. I am also not the employee of a life or health insurance provider for he principal, nor am I involved in directly physically caring for the individual. I have no claim against the principal's estate, and to the best of my knowledge I am not entitled to any part of the individual's estate upon his or her death under a will now existing nor by any other operation of law.

32. 1st Witness: ____
(Signature)

_________________________________ ______________________
(Name Printed) (Date)

____
(Residence Address)

33. 2nd Witness: ____
(Signature)

____________________________ ________________
(Name Printed) (Date)

____
(Residence Address)

CERTIFICATE OF ACKNOWLEDGMENT OF NOTARY PUBLIC: *(Notarization is not required if the document is properly witnessed, but it is still recommended to ensure full evidence of your intent and wishes*).

34. State of Michigan,

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 is 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 advocate (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.

35. __________________________________ **Notary Seal:**
Signature of Notary Public

____
Date Commission Expires

PHOTOCOPIES AND FACSIMILES:

36. A photocopy (photostatic copy) or electronic facsimile (“fax”) of this document shall be deemed as valid as the original. I understand I should keep the original copy, and give copies of the original to 1) my advocate and alternate advocates, 2) my physician(s), 3) members of my family and others who might be called in the event of a medical emergency, and 4) any hospital or other health care facility where I receive treatment. My advocate(s) any my family or friends should be directed to give a copy of this directive to my health care provider(s) or physician(s) upon request.

37. INDIVIDUALS AND INSTITUTIONS WHO HAVE BEEN GIVEN COPIES OF THIS ADVANCE DIRECTIVE

Name: ______________________________
Address ______________________________
____
Phone (_____) ______ - ________________
Fax: (_____) ______ - ________________
E-mail: ______________________________

Name: ______________________________
Address: ______________________________
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Phone (_____) ______ - ________________
Fax: (_____) ______ - ________________
E-mail: ______________________________

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

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www.lifecaredirectives.com