

MISSISSIPPI
Advance Directive
Planning for Important Healthcare Decisions

Caring Connections
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CARING CONNECTIONS

Caring Connections, a program of the National Hospice and Palliative Care Organization (NHPCO), is a national consumer engagement initiative to improve care at the end of life, supported by a grant from The Robert Wood Johnson Foundation.

Caring Connections tracks and monitors all state and federal legislation and significant court cases related to end-of-life care to ensure that our advance directives are up to date.

It's About How You LIVE

It's About How You LIVE is a national community engagement campaign encouraging individuals to make informed decisions about end-of-life care and services. The campaign encourages people to:

- L**earn about options for end-of-life services and care
- I**mplement plans to ensure wishes are honored
- V**oice decisions to family, friends and healthcare providers
- E**ngage in personal or community efforts to improve end-of-life care

Visit www.caringinfo.org to learn more about the LIVE campaign, obtain free resources, or join the effort to improve community, state and national end-of-life care.

If you would like to make a contribution to help support our work, please visit www.nationalhospicefoundation.org/donate. Contributions to national hospice programs can also be made through the Combined Health Charities or the Combined Federal Campaign by choosing #11241.

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Using these materials

BEFORE YOU BEGIN

Check to be sure that you have the materials for each state in which you could receive healthcare.

1. These materials include:
 - Instructions for preparing your advance directive.
 - Your state-specific advance directive forms, which are the pages with the gray instruction bar on the left side.

PREPARING TO COMPLETE YOUR ADVANCE DIRECTIVE

2. Read the HIPAA Privacy Rule Summary on page 4.
3. Read all the instructions, on pages 7, as it will give you specific information about the requirements in your state.
4. Refer to the Glossary located in Appendix A if any of the terms are unclear.

ACTION STEPS

5. You may want to photocopy these forms before you start so you will have a clean copy if you need to start over.
6. When you begin to fill out the forms, refer to the gray instruction bars - they will guide you through the process.
7. Talk with your family, friends, and physicians about your advance directive. Be sure the person you appoint to make decisions on your behalf understands your wishes.
8. Once the form is completed and signed, photocopy the form and give it to the person you have appointed to make decisions on your behalf, your family, friends, healthcare providers and/or faith leaders so that the form is available in the event of an emergency.

If you have questions or need guidance in preparing your advance directive or about what you should do with it after you have completed it, please refer to the state-specific contacts for Legal & End-of-Life Care Resources Pertaining to Healthcare Advance Directives, located in Appendix B.

Introduction to Your Mississippi Advance Healthcare Directive

This packet contains a legal document, the **Mississippi Advance Health-Care Directive**, that protects your right to refuse medical treatment you do not want, or to request treatment you do want, in the event you lose the ability to make decisions yourself.

1. Part 1, **Power of Attorney for Healthcare**, lets you name someone to make decisions about your healthcare—including decisions about life support—if you can no longer speak for yourself, or immediately, if you designate this on the document. The Power of Attorney for Healthcare is especially useful because it appoints someone to speak for you any time you can not or do not choose to make your own healthcare decisions, not only at the end of life.

2. Part 2, **Instructions for Healthcare**, functions as your living will. It lets you state your wishes about healthcare in the event that you can no longer speak for yourself and:

- a) you have an incurable or irreversible condition that will result in death within a relatively short time, or
- b) you become unconscious and, to a reasonable degree of medical certainty, will not regain consciousness, or
- c) the likely risks and burdens of treatment would outweigh the expected benefits.

3. Part 3, **Primary Physician**, is an optional section that allows you to designate your primary physician.

4. Part 4, **Organ Donation**, is an optional section that authorizes your agent to make a gift of your organs in accordance with your wishes in the event that you have not done so.

Note: These documents will be legally binding only if the person completing them is a competent adult who is 18 years of age or older or an emancipated minor under the age of 18 who has been married, or who has been declared by court order to be emancipated.

Instructions for Completing Your Mississippi Advance Healthcare Directive

Who should I appoint as my agent?

Your agent is the person you appoint to make decisions about your medical care, mental health treatment, and anatomical gifts if you become unable to make those decisions yourself. Your agent may be a family member or a close friend whom you trust to make serious decisions. The person you name as your agent must be an adult who is of sound mind and clearly understands your wishes and is willing to accept the responsibility of making medical, mental health, and anatomical gift decisions for you. (An agent may also be called an "attorney-in-fact" or "proxy.")

Unless related to you by blood, marriage, or adoption, your agent may not be an owner, operator, or employee of a residential long-term care facility where you are receiving care.

How do I make my Advance Healthcare Directive legal?

In order to make your Advance Healthcare Directive legally binding you have two options:

1. Sign your document in the presence of two witnesses, who must also sign the document to show that they personally know you and believe you to be of sound mind and under no duress, fraud or undue influence. Neither of your witnesses can be:
 - the person you appointed as your agent,
 - a healthcare provider, or an employee of a healthcare provider or facility.

In addition, one of your witnesses **cannot** be:

- related to you by blood or marriage or adoption,
- entitled to any part of your estate either under your last will and testament or by operation of law.

OR

2. Sign your document in the presence of a notary public.

Should I add personal instructions to my Advance Healthcare Directive?

One of the strongest reasons for naming a patient advocate is to have someone who can respond flexibly as your medical and/or mental health situation changes and deal with situations that you did not foresee. If you add limitations to this document, you might unintentionally restrict your patient advocate's power to act in your best interest.

Instructions for Completing Your Mississippi Advance Healthcare Directive (continued)

What if I change my mind?

1. To revoke the designation of an agent in Part 1 of your Mississippi Advance Healthcare Directive, you must do so in a signed writing or by personally informing your primary physician or the provider who has undertaken primary responsibility for your healthcare.

Unless you provide otherwise, a decree of annulment, divorce, dissolution of marriage, or legal separation automatically revokes a previous designation of a spouse as your agent.

2. You may revoke all or part of your Advance Healthcare Directive, other than the designation of an agent, at any time and in any manner that communicates an intent to revoke by, for example, destroying the Advance Healthcare Directive and all copies. A later advance directive that conflicts with an earlier advance directive will revoke the earlier advance directive to the extent of the conflict.

Explanation

You have the right to give instructions about your own health care. You also have the right to name someone else to make health care decisions for you. This form lets you do either or both of these things. It also lets you express your wishes regarding the designation of your primary physician. If you use this form, you may complete or modify all or any part of it. You are free to use a different form.

Part 1 of this form is a power of attorney for health care. Part 1 lets you name another individual as agent to make health care decisions for you if you become incapable of making your own decisions or if you want someone else to make those decisions for you now even though you are still capable. You may name an alternate agent to act for you if your first choice is not willing, able or reasonably available to make decisions for you. Unless related to you, your agent may not be an owner, operator, or employee of a residential long-term healthcare institution at which you are receiving care.

Unless the form you sign limits the authority of your agent, your agent may make all healthcare decisions for you. This form has a place for you to limit the authority of your agent. You need not limit the authority of your agent if you wish to rely on your agent for all health care decisions that may have to be made. If you choose not to limit the authority of your agent, your agent will have the right to:

- (a) Consent or refuse consent to any care, treatment, service, or procedure to maintain, diagnose, or otherwise affect a physical or mental condition;
- (b) Select or discharge health care providers and institutions;
- (c) Approve or disapprove diagnostic tests, surgical procedures, programs of medication, and orders not to resuscitate; and
- (d) Direct the provision, withholding, or withdrawal of artificial nutrition and hydration and all other forms of health care.

Part 2 of this form lets you give specific instructions about any aspect of your health care. Choices are provided for you to express your wishes regarding the provision, withholding, or withdrawal of treatment to keep you alive, including the provision of artificial nutrition and hydration, as well as the provision of pain relief. Space is provided for you to add to the choices you have made or for you to write out any additional wishes.

Part 3 of this form lets you designate a physician to have primary responsibility for your health care.

Part 4 of this form lets you authorize your agent to make an anatomical gift on your behalf in accordance with your wishes if you have not done so yourself.

After completing this form, sign and date the form at the end and have the form witnessed by one of the two alternative methods listed below. Give a copy of the signed and completed form to your physician, to any other health care providers you may have, to any health care institution at which you are receiving care, and to any health care agents you have named. You should talk to the person you have named as agent to make sure that he or she understands your wishes and is willing to take the responsibility.

You have the right to revoke this Advance Health-Care Directive or replace this form at any time.

**PART 1
POWER OF ATTORNEY FOR HEALTH CARE**

(1) **DESIGNATION OF AGENT:** I designate the following individual as my agent to make health care decisions for me:

PRINT THE NAME,
HOME ADDRESS
AND HOME AND
WORK TELEPHONE
NUMBERS OF YOUR
PRIMARY
AGENT

(Name of individual you choose as agent)

(address) (city) (state) (zip code)

(home phone) (work phone)

OPTIONAL: If I revoke my agent's authority or if my agent is not willing, able, or reasonably available to make a health care decision for me, I designate as my first alternate agent:

PRINT THE NAME,
HOME ADDRESS
AND HOME AND
WORK TELEPHONE
NUMBERS OF YOUR
FIRST ALTERNATE
AGENT

(Name of individual you choose as first alternate agent)

(address) (city) (state) (zip code)

(home phone) (work phone)

OPTIONAL: If I revoke the authority of my agent and first alternate agent or if neither is willing, able, or reasonably available to make a healthcare decision for me, I designate as my second alternate agent:

PRINT THE NAME,
HOME ADDRESS
AND HOME AND
WORK TELEPHONE
NUMBERS OF YOUR
SECOND
ALTERNATE AGENT

(Name of individual you choose as second alternate agent)

(address) (city) (state) (zip code)

(home phone) (work phone)

2) **AGENT'S AUTHORITY:** My agent is authorized to make all healthcare decisions for me, including decisions to provide, withhold, or withdraw artificial nutrition and hydration, and all other forms of health care to keep me alive, except as I state here:

(Add additional sheets if needed.)

(3) **WHEN AGENT'S AUTHORITY BECOMES EFFECTIVE:** My agent's authority becomes effective when my primary physician determines that I am unable to make my own health-care decisions unless I mark the following box. If I mark this box [], my agent's authority to make health care decisions for me takes effect immediately.

(4) **AGENT'S OBLIGATION:** My agent shall make health care decisions for me in accordance with this power of attorney for health care, any instructions I give in Part 2 of this form, and my other wishes to the extent known to my agent. To the extent my wishes are unknown, my agent shall make health care decisions for me in accordance with what my agent determines to be in my best interest. In determining my best interest, my agent shall consider my personal values to the extent known to my agent.

(5) **NOMINATION OF GUARDIAN:** If a guardian of my person needs to be appointed for me by a court, I nominate the agent designated in this form. If that agent is not willing, able, or reasonably available to act as guardian, I nominate the alternate agents whom I have named, in the order designated.

ADD PERSONAL INSTRUCTIONS ONLY IF YOU WANT TO LIMIT THE POWER OF YOUR AGENT

INITIAL THE BOX IF YOU WISH YOUR AGENT'S AUTHORITY TO BECOME EFFECTIVE IMMEDIATELY

CROSS OUT AND INITIAL ANY STATEMENTS IN PARAGRAPHS 3, 4 OR 5 THAT DO NOT REFLECT YOUR WISHES

**PART 2
INSTRUCTIONS FOR HEALTH CARE**

INITIAL THE
PARAGRAPH THAT
BEST REFLECTS
YOUR WISHES
REGARDING
LIFE-SUPPORT
MEASURES

If you are satisfied to allow your agent to determine what is best for you in making end-of-life decisions, you need not fill out this part of the form. If you do fill out this part of the form, you may strike any wording you do not want.

(6) **END-OF-LIFE DECISIONS:** I direct that my health care providers and others involved in my care provide, withhold or withdraw treatment in accordance with the choice I have marked below:

[] (a) **Choice NOT To Prolong Life**

I do not want my life to be prolonged if (i) I have an incurable and irreversible condition that will result in my death within a relatively short time, (ii) I become unconscious and, to a reasonable degree of medical certainty, I will not regain consciousness, or (iii) the likely risks and burdens of treatment would outweigh the expected benefits, or

[] (b) **Choice To Prolong Life**

I want my life to be prolonged as long as possible within the limits of generally accepted health-care standards.

(7) **ARTIFICIAL NUTRITION AND HYDRATION:** Artificial nutrition and hydration must be provided, withheld or withdrawn in accordance with the choice I have made in paragraph (6) unless I mark the following box. If I mark this box [], artificial nutrition and hydration must be provided regardless of my condition and regardless of the choice I have made in paragraph (6).

(8) **RELIEF FROM PAIN:** Except as I state in the following space, I direct that treatment for alleviation of pain or discomfort be provided at all times, even if it hastens my death:

(9) **OTHER WISHES:** (If you do not agree with any of the optional choices above and wish to write your own, or if you wish to add to the instructions you have given above, you may do so here.) I direct that:

INITIAL THE BOX
ONLY IF YOU WANT
ARTIFICIAL
NUTRITION AND
HYDRATION
REGARDLESS OF
YOUR MEDICAL
CONDITION

ADDITIONAL
INSTRUCTIONS
(IF ANY)

**PART 3
PRIMARY PHYSICIAN
(OPTIONAL)**

(10) I designate the following physician as my primary physician:

(name of physician)

(address) (city) (state) (zip code)

(phone)

OPTIONAL: If the physician I have designated above is not willing, able, or reasonably available to act as my primary physician, I designate the following physician as my primary physician:

(name of physician)

(address) (city) (state) (zip code)

(phone)

**PART 4
AUTHORIZATION FOR ORGAN DONATION
(OPTIONAL)**

(11) I authorize my agent to make this anatomical gift if medically acceptable, to take effect upon my death. The words and marks below indicate my desires.

Upon my death, I wish to donate:
_____ My body for anatomical study if needed.
_____ Any needed organs, tissues, or eyes.
_____ Only the following organs, tissues, or eyes:

I authorize the use of my organs, tissues, or eyes:
_____ For transplantation
_____ For therapy
_____ For research
_____ For medical education
_____ For any purpose authorized by law.

This authority granted to my patient advocate to make an anatomical gift is limited as follows (*here list limitations or special wishes, if any*):

PRINT THE NAME,
ADDRESS AND
TELEPHONE
NUMBER OF YOUR
PRIMARY
PHYSICIAN

PRINT THE NAME,
ADDRESS AND
TELEPHONE
NUMBER OF YOUR
ALTERNATE
PRIMARY
PHYSICIAN

CROSS OUT THIS
STATEMENT IF YOU
DO NOT
AUTHORIZE YOUR
AGENT TO MAKE AN
ANATOMICAL GIFT
OF YOUR ORGANS
OR PHYSICAL
PARTS

(12) **EFFECT OF COPY:** A copy of this form has the same effect as the original.

(13) **SIGNATURES:** Sign and date the form here:

(date) (sign your name)

(print your name)

(address)

(city) (state) (zip code)

(14) **WITNESSES:** This power of attorney will not be valid for making health care decisions unless it is either:

- (a) signed by two (2) qualified adult witnesses who are personally known to you and who are present when you sign or acknowledge your signature: or
- (b) acknowledged before a notary public in the state.

ALTERNATIVE NO. 1

WITNESS

I declare under penalty of perjury pursuant to Section 97-9-61, Mississippi Code of 1972, that the principal is personally known to me, that the principal signed or acknowledged this power of attorney in my presence, that the principal appears to be of sound mind and under no duress, fraud or undue influence, that I am not the person appointed as agent by this document, and that I am not a health-care provider, nor an employee of a health care provider or facility. I am not related to the principal by blood, marriage or adoption, and to the best of my knowledge, I am not entitled to any part of the estate of the principal upon the death of the principal under a will now existing or by operation of law.

(date) (signature of witness)

(printed name of witness)

(address)

(city) (state) (zip code)

SIGN AND DATE THE DOCUMENT

PRINT YOUR NAME AND ADDRESS

WITNESSING PROCEDURE FOR ADVANCE HEALTH CARE DIRECTIVE

WITNESS #1 ONE OF YOUR WITNESSES MUST AGREE WITH THIS STATEMENT HAVE YOUR WITNESS SIGN AND DATE THE DOCUMENT AND THEN PRINT THEIR NAME AND ADDRESS

WITNESS

I declare under penalty of perjury pursuant to Section 97-9-61, Mississippi Code of 1972, that the principal is personally known to me, that the principal signed or acknowledged this power of attorney in my presence, that the principal appears to be of sound mind and under no duress, fraud or undue influence, that I am not the person appointed as agent by this document, and that I am not a health care provider, nor an employee of a health care provider or facility.

_____ (date) _____ (signature of witness)

_____ (printed name of witness)

_____ (address)

_____ (city) _____ (state) _____ (zip code)

WITNESS #2
ONE OF YOUR
WITNESSES MUST
AGREE WITH THIS
STATEMENT
HAVE YOUR
WITNESS SIGN AND
DATE THE
DOCUMENT AND
THEN PRINT THEIR
NAME AND
ADDRESS

OR

A NOTARY
PUBLIC SHOULD
FILL OUT THIS
SECTION OF YOUR
DOCUMENT

ALTERNATIVE NO. 2

State of _____

County of _____

On this _____ day of _____, in the year _____,

before me, _____ (insert name of notary public)

appeared _____, personally known to me (or proved to me on the basis of satisfactory evidence) to be the person whose name is subscribed to this instrument, and acknowledged that he or she executed it. I declare under the penalty of perjury that the person whose name is subscribed to this instrument appears to be of sound mind and under no duress, fraud or undue influence.

Notary Seal

(Signature of Notary Public)

You Have Filled Out Your Advance Directive, Now What?

1. Your Mississippi Advance Health-Care Directive is an important legal document. Keep the original signed document in a secure but accessible place. Do not put the original document in a safe deposit box or any other security box that would keep others from having access to it.
2. Give photocopies of the signed original to your agent and alternate agent(s), doctor(s), family, close friends, clergy and anyone else who might become involved in your healthcare. If you enter a nursing home or hospital, have photocopies of your document placed in your medical records.
3. Be sure to talk to your agent and alternate agent(s), doctor(s), clergy, family and friends about your wishes concerning medical treatment. Discuss your wishes with them often, particularly if your medical condition changes.
4. If you want to make changes to your document after it has been signed and witnessed, you should complete a new document.
5. Remember, you can always revoke one or both sections of your Mississippi Advance Health-Care Directive.
6. Be aware that your Mississippi documents will not be effective in the event of a medical emergency. Ambulance personnel are required to provide cardiopulmonary resuscitation (CPR) unless they are given a separate order that states otherwise. These orders, commonly called "non-hospital do-not-resuscitate orders," are designed for people whose poor health gives them little chance of benefiting from CPR. These orders must be signed by your physician and instruct ambulance personnel not to attempt CPR if your heart or breathing should stop.

Currently not all states have laws authorizing non-hospital do-not-resuscitate orders. We suggest you speak to your physician for more information. **Caring Connections does not distribute these forms.**