

MICHIGAN

Advance Directive

Planning for Important Healthcare Decisions

Courtesy of CaringInfo
www.caringinfo.org

CaringInfo, a program of the National Alliance for Care at Home (the Alliance), is a national consumer engagement initiative to improve care and the experience of caregiving during serious illness and at the end of life. As part of that effort, CaringInfo provides detailed guidance for completing advance directive forms in all 50 states, the District of Columbia, and Puerto Rico.

This package includes:

- Instructions for preparing your advance directive. Please read all the instructions.
- Your state-specific advance directive forms, which are the pages with the gray instruction bar on the left side.

BEFORE YOU BEGIN

Check to be sure that you have the materials for each state in which you may receive healthcare. Because documents are state-specific, having a state-specific document for each state where you may spend significant time can be beneficial. A new advance directive is not necessary for ordinary travel into other states. The advance directives in this package 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.

ACTION STEPS

1. You may want to photocopy or print a second set of these forms before you start so you will have a clean copy if you need to start over.
2. When you begin to fill out the forms, refer to the gray instruction bars — they will guide you through the process.
3. 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.
4. Once the form is completed and signed, photocopy, scan, or take a photo of 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.

5. You may also want to save a copy of your form in your electronic healthcare record, or an online personal health records application, program, or service that allows you to share your medical documents with your physicians, family, and others who you want to take an active role in your advance care planning.

INTRODUCTION TO YOUR MICHIGAN ADVANCE HEALTH CARE DIRECTIVE

This packet contains a legal document, a **Michigan 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.

Your Michigan Advance Directive has two parts. The **Michigan Patient Advocate Designation** lets you name someone to make decisions about your medical care—including decisions about life support, mental health treatment and anatomical gifts—if you can no longer speak for yourself. The patient advocate designation is especially useful because it appoints someone to speak for you any time you are unable to make your own healthcare treatment decisions, not only at the end of life. Following the patient advocate designation form is an **Organ Donation** form.

How do I make my Michigan advance health care directive legal?

You must sign and date your **Patient Advocate Designation** form or direct an adult to do so for you if you are unable to sign it yourself in the presence of two adult witnesses (18 years of age or older).

Your two adult witnesses **cannot** be:

- your spouse, parent, child, grandchild, or sibling,
- a person who stands to inherit from your estate,
- your physician or patient advocate,
- an employee of a healthcare or mental healthcare facility where you are being treated, or
- an employee of a home for the aged, if you are a patient at that facility.

The law requires that you sign your **Organ Donation** form in the presence of two adult witnesses. At least one of the witnesses must be a disinterested party, meaning that the witness has no interest in your estate or any potential anatomical gift.

Whom should I appoint as my agent?

Your patient advocate is the person you appoint to make decisions about your healthcare 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

should clearly understand your wishes and be willing to accept the responsibility of making healthcare decisions for you.

You can appoint a second person as an alternate advocate. An alternate advocate will step in if the person you name as advocate is unable, unwilling, or unavailable to act for you.

Should I add personal instructions to my advance directive?

Yes! One of the most important reasons to execute an advance directive is to have your voice heard. When you name an agent and clearly communicate to them what you want and don't want, they are in the strongest position to advocate for you. Because the future is unpredictable, be careful that you do not unintentionally restrict your agent's power to act in your best interest. Be especially careful with the words "always" and "never." In any event, be sure to talk with your agent and others about your future healthcare and describe what you consider to be an acceptable "quality of life."

When does my agent's authority become effective?

Your patient advocate's powers go into effect when your doctor determines that you are no longer able to make or communicate your healthcare decisions.

Your patient advocate designation form will be valid after you and your witnesses sign it. However, your patient advocate and alternate (if any) must receive a copy of your document and date and sign an acceptance of his or her responsibilities before making any decision on your behalf. An acceptance form is included as pages 5 and 6 of the Michigan Advance Directive, in the event you want to obtain your advocate's acceptance now.

Advocate Limitations

Your agent will be bound by the current laws of Michigan as they regard pregnancy and termination of pregnancies.

What if I change my mind?

You may revoke your designation at any time and in any manner, regardless of your ability to make medical and/or mental health treatment decisions, so long as you are able to communicate your intent to revoke the designation.

You should sure that your physician and patient advocate(s) receive notice of your revocation to ensure it is effective.

Your designation will be automatically revoked if:

- You designate your spouse as your patient advocate and there is an entry by a judge of an order for alimony, divorce, or annulment of your marriage. Your patient advocate's designation will be suspended during any legal proceedings that could result in such an

order. The designation of an alternate patient advocate, if you have named one, will not be affected by the end of your marriage;

- Your patient advocate resigns his or her responsibilities; or
- You die, unless you have given your patient advocate authority to donate your organs on page 3 of the form.

Mental Health Issues

These forms do not *expressly* address mental illness, although you can state your wishes and grant authority to your agent regarding mental health issues. The National Resource Center on Psychiatric Advance Directives maintains a website (<https://nrc-pad.org/>) with links to each state's psychiatric advance directive forms. If you would like to make more detailed advance care plans regarding mental illness, you could talk to your physician and an attorney about a durable power of attorney tailored to your needs.

What other important facts should I know?

Michigan does not currently recognize a separate 'living will' document. You may, however, state your end-of-life choices in your patient advocate designation form. This form also allows you to state your desires regarding your healthcare and other advance planning decisions to help guide your patient advocate and others who may make decisions for you when you are no longer able to do so.

Be aware that your advance directive will not be effective in the event of a medical emergency, except to identify your agent. Ambulance and hospital emergency department personnel are required to provide cardiopulmonary resuscitation (CPR) unless you have a separate physician's order, which are typically called "prehospital medical care directives" or "do not resuscitate orders." DNR forms may be obtained from your state health department or department of aging (<https://www.hhs.gov/aging/state-resources/index.html>). Another form of orders regarding CPR and other treatments are state-specific POLST (portable orders for life sustaining treatment) (<https://polst.org/form-patients/>). Both a POLST and a DNR form MUST be signed by a healthcare provider and MUST be presented to the emergency responders when they arrive. These directives instruct ambulance and hospital emergency personnel not to attempt CPR (or to stop it if it has begun) if your heart or breathing should stop.

MICHIGAN PATIENT ADVOCATE DESIGNATION – PAGE 1 OF 6

PRINT YOUR NAME
AND ADDRESS

I _____
(name)

(address)

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

I designate _____
(name of primary patient advocate)

residing at _____
(address)

(home phone number)

(work phone number)

as my patient advocate to make care, custody, medical, or mental health treatment decisions for me in the event that I become unable to participate in medical treatment decisions. The determination of when I am unable to participate in medical and/or mental health treatment decisions shall be made by my attending physician and another physician or licensed psychologist.

If my first choice is unable, unwilling, or not reasonably available to serve as my patient advocate, then I designate:

(name of alternate patient advocate)

residing at _____
(address)

(home phone number)

(work phone number)

to serve as my patient advocate.

PRINT THE NAME,
ADDRESS AND
PHONE NUMBERS
OF YOUR PATIENT
ADVOCATE

PRINT THE NAME,
ADDRESS AND
PHONE NUMBERS
OF YOUR
ALTERNATE
PATIENT ADVOCATE

YOU MAY CROSS
OUT AND INITIAL
ANY PARTS OF THIS
FORM THAT YOU
DO NOT AGREE
WITH

I authorize my patient advocate to decide to withhold or withdraw medical and mental health treatment, including the provision of artificial nutrition and hydration, which could or would allow me to die. I am fully aware that such a decision could or would lead to my death.

In making decisions for me, my patient advocate shall be guided by my wishes, whether expressed orally, in this designation, or in another document. If my wishes as to a particular situation have not been expressed, my patient advocate shall be guided by his or her best judgment of my probable decision, given the benefits, burdens and consequences of the decision, even if my death, or the chance of my death, is one consequence.

My patient advocate shall have the same authority to make care, custody, and medical and mental health treatment decisions as I would if I had the capacity to make them, including admission to a hospital or nursing care facility and paying for such services with my funds, EXCEPT (here list the limitations, if any, you wish to place on your patient advocate's authority):

(Attach additional pages, if needed)

This designation of patient advocate shall not be affected by my disability or incapacity. This designation of patient advocate is governed by Michigan law, although I request that it be honored in any state in which I may be found. I reserve the power to revoke this designation at any time by communicating my intent to revoke it in any manner in which I am able to communicate.

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

LIST INSTRUCTIONS
HERE ONLY IF YOU
WANT TO LIMIT
YOUR PATIENT
ADVOCATE'S
AUTHORITY

CROSS OUT AND
INITIAL THIS
STATEMENT IF YOU
DO NOT
AUTHORIZE YOUR
PATIENT ADVOCATE
TO MAKE AN
ANATOMICAL GIFT

INITIAL YOUR
CHOICES

REGARDING ORGAN
DONATION

LIST LIMITATIONS
OR SPECIAL

WISHES, IF ANY

ADD OTHER
INSTRUCTIONS, IF
ANY, REGARDING

YOUR ADVANCE
CARE PLANS

THESE
INSTRUCTIONS CAN
FURTHER ADDRESS
YOUR HEALTH CARE
PLANS, SUCH AS
YOUR WISHES
REGARDING
HOSPICE
TREATMENT, BUT

CAN ALSO ADDRESS
OTHER ADVANCE
PLANNING ISSUES,
SUCH AS YOUR
BURIAL WISHES

ATTACH
ADDITIONAL PAGES
IF NEEDED

© 2005 National
Alliance for Care at
Home. 2023
Revised.

In the hope that I may help others, I authorize my patient advocate to make this anatomical gift if medically acceptable, to take effect upon my death and to resolve any conflict between the terms of this Designation and the administration of means necessary to ensure the medical suitability of my anatomical gift. 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 (list any limitations or special wishes here, if any):

I further direct that:

(Attach additional pages, if needed)

SIGN AND DATE
YOUR DOCUMENT
AND PRINT YOUR
ADDRESS

I voluntarily sign this designation of patient advocate after careful consideration. I accept its meaning and I accept its consequences.

Your signature: _____

Date: _____

(your street address)

(city, Michigan, zip code)

Statement of Witnesses

We sign below as witnesses. This designation was signed in our presence. The designator appears to be of sound mind, and to be making this designation voluntarily, and under no duress, fraud, or undue influence.

YOUR WITNESSES
MUST SIGN AND
DATE HERE AND
PRINT THEIR
NAMES AND
ADDRESSES

Witness 1: _____
(signature)

Date: _____

(print or type full name)

(address)

Witness 2: _____
(signature)

Date: _____

(print or type full name)

(address)

**Acceptance by Patient Advocate and Alternate Patient Advocate
(If Any)**

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 if 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.

NOTE: YOUR
PATIENT ADVOCATE
MUST SIGN AN
ACCEPTANCE FORM
BEFORE HAVING
AUTHORITY TO
MAKE DECISIONS
ON YOUR BEHALF

THIS ACCEPTANCE
MAY BE OBTAINED
NOW TO
STREAMLINE THE
PROCESS

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 understand the above conditions, terms and responsibilities and I accept the designation as patient advocate.

(name of primary patient advocate)

Dated _____ Signed _____

I understand the above conditions and I accept the designation of successor patient advocate.

(name of alternate patient advocate)

Dated _____ Signed _____

YOUR PATIENT
ADVOCATE MUST
SIGN AND DATE
YOUR DOCUMENT
HERE BEFORE
MAKING DECISIONS
ON YOUR BEHALF

YOUR ALTERNATE

PATIENT ADVOCATE
MUST SIGN AND
DATE YOUR
DOCUMENT
HERE BEFORE
MAKING DECISIONS
ON YOUR BEHALF

MICHIGAN ORGAN DONATION FORM - PAGE 1 OF 1

ORGAN DONATION
(OPTIONAL)

Initial the line next to the statement below that best reflects your wishes. You do not have to initial any of the statements. If you do not initial any of the statements, your attorney for health care, proxy, or other agent, or your family, may have the authority to make a gift of all or part of your body under Michigan law.

INITIAL THE
OPTION THAT

____ I do not want to make an organ or tissue donation and I do not want my attorney for health care, proxy, or other agent or family to do so.

REFLECTS YOUR
WISHES

____ I have already signed a written agreement or donor card regarding organ and tissue donation with the following individual or institution:

Name of individual/institution: _____

ADD NAME OR
INSTITUTION (IF
ANY)

____ Pursuant to Michigan law, I hereby give, effective on my death:

____ Any needed organ or parts.

____ The following part or organs listed below:

For (initial one):

____ Any legally authorized purpose.

____ Transplant or therapeutic purposes only.

PRINT YOUR NAME,
SIGN, AND DATE
THE DOCUMENT

Declarant name: _____

Declarant signature: _____, Date: _____

The declarant voluntarily signed or directed another person to sign this writing in my presence.

Witness _____ Date _____

Address _____

YOUR
WITNESSES
MUST SIGN AND
PRINT THEIR
ADDRESSES

I am a disinterested party with regard to the declarant and his or her donation and estate. The declarant voluntarily signed or directed another person to sign this writing in my presence.

Witness _____ Date _____

Address _____

AT LEAST ONE
WITNESS MUST BE
A DISINTERESTED
PARTY