Start the Conversation: Making your health care wishes known

Advance Directives and
Durable Power of Attorney
for Health Care

MICHIGAN MEDICINE
UNIVERSITY OF MICHIGAN

Advance Directive Toolkit

This toolkit has five parts. It lets you:

Before You Begin: **Learn about Advance Directives. (Page 3)**
This section helps you to learn about planning for health care and the forms that you need to complete.

Form Part A: **Make your health care wishes known. (Page 8)**
This form lets you write down the kind of health care you want to help guide your Patient Advocate. This way, those who care for you will not have to guess what you want if you are too sick to tell them yourself.

Form Part B: **Choose a Patient Advocate. (Page 14)**
A Patient Advocate is a person who can make medical decisions for you if you are too sick or unable to make them yourself.

Form Part C**: Sign the form. (Page 15)**
You must sign the form before it can be used.

Form Part D: **Ask your Patient Advocate to sign. (Page 17)**
Your Patient Advocate must sign on page 17 to agree to be your Patient Advocate.

Fill out only the parts you want.

- If you only want to list your own health care wishes go to Part A (Page 8).
- If you only want to name a Patient Advocate go to Part B (Page 14).
- If you want both then fill out Part A and Part B.

Always sign the form with 2 witnesses in Part C (Page 15).

Advance Directives Checklist

Use this checklist as a helpful guide when considering your preferences and completing the forms in this booklet.

- [ ] Read this toolkit cover to cover.
- [ ] Write down all your questions.
- [ ] Discuss your questions with your doctors, family, friends and spiritual advisers.
- [ ] Identify a person to serve as your Patient Advocate (and an alternate Patient Advocate).
- [ ] Talk with this person and make sure that they are willing to serve as your Patient Advocate. Tell them about your wishes.
- [ ] Complete Part A (Make Your Health Care Wishes Known) and Part B (Appoint a Patient Advocate) of this toolkit.
- [ ] Identify 2 people who are not your Patient Advocate, your family members or part of your health care team who can serve as witnesses.
- [ ] Sign the form in front of the witnesses.
- [ ] Have the witnesses sign the form.
- [ ] Have your Patient Advocate sign the form.
- [ ] Make several copies of the signed form.
- [ ] Save a copy for yourself. Keep it in a safe and easily accessible place.
- [ ] Give copies to your Patient Advocate, health care provider, family, and friends.
- [ ] Review this document regularly

Before You Begin

Why is planning for health care important?

You always have the right to be included in any decisions related to the health care you receive. However, no one knows what the future holds, and there may be a time when you are unable to make your own decisions. By reviewing this toolkit and stating your wishes for health care, you can make sure that people close to you and people who provide health care for you know what types of decisions you would make for yourself.

How can I start?

Writing down your preferences is a good way to start planning for your health care. An **Advance Directive** is a written statement about your wishes regarding medical treatment. In the State of Michigan, the **Durable Power of Attorney for Health Care (DPOA-HC)** form is the most widely used Advance Directive. **The DPOA-HC allows you to name your Patient Advocate and is a legal document in Michigan.**

What is a Patient Advocate?

A **Patient Advocate** is the person who can make medical decisions for you if you are too sick or unable to make them yourself. Naming a Patient Advocate is your DPOA-HC. A Patient Advocate can only make your medical decisions if **2 doctors** agree that you cannot make your own decisions and this is written in your record. Your Patient Advocate will make decisions that you would be asked to make if you were able.

Whom should I choose to be my Patient Advocate?

A family member or friend who:

- Is at least 18 years old.
- Knows you well.
- Can be there for you when you need them.
- You trust to do what is best for you and follow your wishes, even if they do not agree with your wishes.
- Can tell your doctors about your health care wishes.

What will happen if I do not choose a Patient Advocate?

- If you are too sick to make your own decisions, your doctors may ask your closest family members to make decisions for you.
- If your family members cannot make a decision or agree on a decision, then a judge may appoint someone to make decisions for you.
- You will receive care even if you do not choose a Patient Advocate.

What kind of decisions can my Patient Advocate make?

Based on your wishes, your Patient Advocate can: **agree to**, **say no to**, **change**, **stop** or **choose** any of the following:

- Doctors, nurses, social workers
- Hospitals or clinics
- Medications, tests, or treatments
- Whether or not you receive life support treatments
- Whether or not you receive surgery
- Whether or not to take you to a hospital or nursing home
- What kind of comfort care you receive, including hospice care

Your Patient Advocate may look at your medical records to help make these decisions.

The law defines your Patient Advocate named in your DPOA-HC as your **surrogate decision maker.** This means that they will make medical decisions for you. This is why it is very important to share your wishes with your Patient Advocate.

The preferences you write down on this form should serve as a guide for your Patient Advocate and doctors, but they are not legally binding.

A properly completed DPOA-HC is legally recognized and allows your Patient Advocate to make medical decisions for you when you cannot.

What do I do with the form after I fill it out and everyone has signed?

- Bring a copy of this form to your doctor's office or hospital so it can be scanned into your medical record.
- Share a copy of the form with others who care for you, such as:
    - Your Patient Advocate
    - All of your doctors
    - Nurses
    - Social workers
    - Family and friends
- Keep a copy for yourself in a safe and easy to find place.

Talk with your Patient Advocate about your choices.

Can I change my mind?

- You can change your mind at any time.
- Any spoken wish about a medical treatment must be honored by a Patient Advocate, even if it is different than what you put in your form.
- If you change your mind, it is best to fill out and sign a new form.
    - Tell those who care for you about your changes.
    - Give the new form to your Patient Advocate and your doctors.

What if I have questions about the form?

- Bring it to your doctors, nurses, social workers, Patient Advocate, family or friends to answer your questions.

What if I want to write down health care wishes that are not on this form?

- Write your wishes on a piece of paper, sign and date the paper.
- Keep the paper with this form.
- Share your wishes with those who care for you.

Where can I learn more?

Talk to your health care provider, such as your doctor or a social worker in the office. If you would like to speak with a social worker, please call the Guest Assistance Program at 800-888-9825 and they will assist you.

You can also visit the Advance Care Planning page on the U-M Patient Education Clearinghouse at http://careguides.med.umich.edu/advance-directives.
At the website, you can find more information on advance care planning and Advance Directives, including:

- Frequently Asked Questions on advance care planning and Advance Directives.

- Additional Advance Directive documents, including a Do Not Resuscitate (DNR) Declaration form, a Durable Power of Attorney (DPOA – HC) for Mental Health Care Choice, and a Funeral Representative Designation form.

- Additional resources to write down your wishes including, Living Will forms and conversation tools.

Making Your Wishes Known

and

Naming Your Patient Advocate (DPOA-HC)

Part A: Make Your Health Care Wishes Known

Use this section to state your preferences for health care.
This section is not legally binding in the state of Michigan, but it can serve as a helpful guide to your doctors and your Patient Advocate.
You may answer or skip any of the questions in Part A.

Your Thoughts on Life

When you think about the things that make life worth living, which of the following apply to you: (pick one)

- ☐ My life is always worth living, no matter how sick I am.
- ☐ My life is worth living only if I can do some of the things that are meaningful to me.
- ☐ I am not sure.

If you chose the second option, put an (X) next to all the sentences you most agree with:

- ☐ My life is only worth living if I can:
  - ○ Talk to family or friends.
  - ○ Wake up from a coma.
  - ○ Feed, bathe, or take care of myself.
  - ○ Be free from pain.
  - ○ Live without being hooked up to machines.
  - ○ Live at home (as opposed to a nursing home).
  - ○ Other: _____
  - ○ I am not sure.

If I am dying, I prefer to die: (pick one)

- ○ At home.
- ○ At a facility (hospital, hospice, or nursing home).
- ○ I am not sure.

Is religion or spirituality important to you?

O No O Yes

If you have one, what is your religion? _____

What should your doctors know about your religion or spirituality?

O I am not sure.

Do you have any hopes for your funeral or memorial service? You can include information on music, readings, or any other requests that you may have.

O I am not sure.

Do you have any other wishes or thoughts on life that you would like to share? You can include information on how you would like to be treated, made comfortable, or any other requests that you may have.

O I am not sure.

Your Wishes About Organ Donation

Your doctors may ask about organ donations after you die. Donating (giving) your organs can help save lives. Please tell us your wishes.
If your Patient Advocate is not next-of-kin and you would like your Patient Advocate to make choices on your behalf after you have died, please complete a Funeral Representative Designation Form.

Put an (X) next to the one choice you most agree with.

- ☐ I want to donate **all** my organs.
- ☐ I want to donate only these organs:

  _____

- ☐ I **do not want** to donate my organs.
- ☐ I want my **Patient Advocate** to decide. If you let your Patient Advocate decide, they can make that choice after you die.
- ☐ I am not sure.

Do you have any additional thoughts on donating your organs?
If you do, please write them here.

Making Your Wishes About Life Support Known

If you cannot speak for yourself, your Patient Advocate will make decisions about life support for you. Life support treatments are medical care to try and help you live longer.

Talk with your health care provider, your family members, and Patient Advocate about the kind of treatment you do and do not want.

Most medical treatments can be tried and then stopped if they do not help. It is important to talk with your health care providers about these choices.

If you are sick, your doctors and nurses will always try to keep you comfortable and minimize your pain. They will try to do what is best for you.

Please read all options below before you make your choice. Select one option.
If I am so sick that I am dying:

- ☐ I want doctors to try **all treatments** that they think might help, including life support even if it may not help me get better.

- ☐ I want doctors to do everything they think might help me, but, if I am very sick and have little hope of getting better, I do **not** want to stay on life support.

- ☐ I want to die a natural death. I want **no life support** treatments.

- ☐ I want my Patient Advocate to decide for me with the help of information from my doctors and my thoughts on life.

- ☐ I am not sure.

If you have any specific preferences for treatments, please write them here:

In the event you are dying, your Patient Advocate can:

- Call in a spiritual leader.
- Enroll you in hospice care.
- Decide if you die at home, if possible, or in the hospital.
- Ensure your comfort and pain control.

My other wishes for my health care:

Your Instructions to Your Patient Advocate

If you would like to let your Patient Advocate make decisions that might allow you to die when you are very sick, please sign under the statement below.

Michigan law allows your Patient Advocate to refuse or stop life support treatments or CPR only if you give your Patient Advocate that power**.**
If you would like to give your Patient Advocate that power, sign below. If you would prefer not to give your Patient Advocate that power, you may skip this section.

I want my Patient Advocate to make decisions about life support and treatments that would allow me to die when I am very sick. When making these decisions, I want my Patient Advocate to follow the guidelines I have provided.

Sign your name here to give this power to your Patient Advocate

Show your Patient Advocate this form.
Tell them what kind of medical care you want.

DURABLE POWER OF ATTORNEY (DPOA-HC)

Part B: Appoint a Patient Advocate

Your Name _____ Date of Birth _____

Your **Patient Advocate** is the person who can make medical decisions for you if you are too sick or unable to make them yourself.

If you are very sick and 2 doctors decide that you cannot make your own medical decisions, they will ask that your Patient Advocate make them for you. Select someone you trust to make the decisions you would want. You may also name one or more persons to make the decisions if your first choice cannot. These additional persons would be your successor or secondary Patient Advocates.

I want this person to be my Patient Advocate if I can no longer make my medical decisions for myself.

First Name _____ Last Name _____

Street Address _____ City _____ State _____ Zip _____

Home phone number _____ Work phone number _____ Cell phone number _____

If the first person cannot do it, then I want this person to make my medical decisions when I cannot and be my successor Patient Advocate.

First Name _____ Last Name _____

Street Address _____ City _____ State _____ Zip _____

Home phone number _____ Work phone number _____ Cell phone number _____

Part C: Signatures

Before this Advance Directive can be used, you must:

- Sign this form on page 16.
- Have 2 witnesses sign the form on page 16.

Your witnesses **must**:

- Be at least 18 years of age.
- See you sign this form and sign it on the same day.

Your witnesses **cannot**:

- Be your Patient Advocate.
- Be your health care provider.
- Work for your health care provider.
- Work at the place where you live (if you live in a nursing home or group home).
- Be your spouse, your parent, your child or grandchild, or your brother or sister.
- Benefit financially (get any money or property) after you die.
- Work for your insurance company.

Your 2 witnesses **do not** need to read this Advance Directive.
They **do need** to watch you sign the form and sign it themselves on the same day.

They sign to promise that while you signed the form, you appeared to be thinking clearly and were not forced to sign it. Some examples of whom your witnesses could be include neighbors, members of church, or friends.

You **do not** need a notary or a lawyer to complete this form.

1. Your Signature

Sign your name Date

Print Your First Name Print your Last Name

Street Address City State Zip

Date of Birth (Month/Day/Year)

2. Witnesses' Signatures

By signing, I promise that _____ signed this form while I watched.
(patient name)
They appeared to be thinking clearly and were not forced to sign it.

Witness #1

Sign your name Date

Print Your First Name Print your Last Name

Street Address City State Zip

Witness #2

Sign your name Date

Print Your First Name Print your Last Name

Street Address City State Zip

Part D: Acceptance by Patient Advocate

Your Patient Advocate must read and sign this form.

As the Patient Advocate:

- You should always act with the patient's best interests and not your own interests.
- You will only start making decisions for the patient after 2 doctors agree that the patient is too sick to make his or her own decisions.
- You will not be able to make decisions that the patient would not usually be able to make.
- You don't have the power to stop a pregnant patient's treatment if it would cause her to die.
- You can make a decision to stop or not start treatments and allow the patient to die naturally if they have made it clear that you can make that decision.
- You cannot be paid for your role as a Patient Advocate but you can get paid back for the money you spend on the patient's medical expenses.
- You should help to protect the patient's rights as defined by law.
- You cannot make decisions that go against the patient's wishes regarding organ donation.
- The patient can remove you as Patient Advocate whenever they want.
- You can remove yourself as Patient Advocate whenever you want.

By signing, I am saying that I understand what this document says and that I will be the Patient Advocate for _____ (name of patient).

Patient Advocate's Signature	Date
2nd Patient Advocate's Signature	Date

Advance Directives Final Checklist

Use this checklist as a helpful guide to make sure the you have:

- ☐ Chosen a trusted person to be your Patient Advocate.
- ☐ Identified 2 people who are not your Patient Advocate, your family members, or part of your health care team to be your witnesses.
- ☐ Signed the form in front of the witnesses.
- ☐ Had your witnesses signed the form.
- ☐ Had your Patient Advocate signed the form.

What do I do next?

- ☐ Make copies of your form.
- ☐ Give a copy to your health care provider.
- ☐ Ask your health care provider to put the form in your Medical Record.
- ☐ Give a copy to your Patient Advocate.
- ☐ Give copies to your family and friends.
- ☐ Keep your copy in a safe and easy to find location.
- ☐ Review the form once a year or as needed.

  If you **do not** agree with the information in your form, complete a new form.

  If you **do** agree, you can reaffirm the form in the space provided below:

  ○ Date _____ Initial_____ ○ Date _____ Initial_____

  ○ Date _____ Initial_____ ○ Date _____ Initial_____

- ☐ If you would like to, complete the card below and store it in your wallet:

Print your name Signature Date

☐ I have a Durable Power of Attorney for Health Care

I have discussed my care with my patient advocate, family, and doctor. If I am unable to speak for myself, please contact:

Advocate Name Telephone Number

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Discrimination is Against the Law!

Michigan Medicine complies with applicable federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability or sex.

Michigan Medicine does not exclude people or treat them differently because of race, color, national origin, age, disability or sex.

Michigan Medicine provides free aids and services to people with disabilities to help communicate effectively while receiving care, such as:

- Qualified sign language interpreters; and
- Written information in other formats (large print, audio, accessible electronic formats and other formats).

Michigan Medicine provides free language services to people whose primary language is not English, such as:

- Qualified language interpreters; and
- Information written in other languages.

If you need these services while at Michigan Medicine, contact Interpreter Services at 734-936-7021.

If you believe that Michigan Medicine has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability or sex, you can file a grievance with:

Patient Civil Rights Coordinator
Michigan Medicine
2901 Hubbard
Ann Arbor, Michigan 48109-2435
Phone - (734) 936-6439
Fax - (734) 347-0696
Email - MichMed_patients_rights@med.umich.edu

You can file a grievance in person, by mail, fax, or email. If you need help filing a grievance, the Patient Civil Rights Coordinator is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights. This can be done electronically, through then Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue SW
Room 509F, HHH Building
Washington, DC 20201
1-800-368-1019, 800-537-7607 (TDD)

Complaint forms are available at:

http://www.hhs.gov/ocr/office/file/index.html.

If you speak a language other than English, language assistance services, free of charge, are available to you. Call our Interpreter Services office at **734-936-7021** and identify your language. If you would like information regarding your rights and responsibilities as a patient, please ask your Michigan Medicine care provider.

Si usted habla **español** tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al **877-810-4719** y pida que le conecten con la oficina de los Servicios de Interpretación al 734-936-7021. Si desea usted obtener información con respecto a sus derechos y responsabilidades como paciente consulte, por favor, con su proveedor de atención médica de *Michigan Medicine*.

إذا كنت تتحدث **اللغة العربية،** فخدمات المساعدة اللغوية متوفرة مجاناً لك. أتصل على **855-800-9252** واطلب التواصل مع مكتب خدمات الترجمة الشفوية على الرقم 734-936-7021. إذا كنت ترغب في معلومات متعلقة بحقوقك ومسؤولياتك كمريض، يرجي أن تطلب من مقدمي رعايتك في "طب ميتشيجان."

如果您说**中文**，您可以获得语言协助的免费服务。请打 **877-810-4720**，请求连接到翻译服务办公室（734-936-7021）。如果您想获得关于病人权利和责任的资料，请向您的密西根医学部的提供者咨询。

Nếu bạn nói tiếng **Việt**, chúng tôi có dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Hãy gọi đến số **844-590-8944**, và yêu cầu được kết nối với văn phòng Dịch Vụ Thông Dịch theo số 734-936-7021. Nếu bạn muốn thông tin về quyền và trách nhiệm của mình với tư cách là bệnh nhân, vui lòng hỏi bác sĩ chăm sóc Michigan Medicine của bạn.

Nëse ju flisni **shqip**, atëherë ju ofrohen shërbime gjuhësore, pa pagesë. Thirrni numrin **844-562-3982** dhe kërkoni që t'ju lidhin me zyrën e përkthyesve në numrin 734-936-7021 dhe tregoni se cilën gjuhë e flisni. Nëse dëshironi informacion në lidhje me të drejtat dhe përgjegjësitë tuaja si pacient, ju lutemi kontaktoni dhe pyesni ofruesin e kujdesit shëndetësorë të Michigan Medicine.

한국어를 하시는 분들께 통역 서비스가 무료로 제공됩니다. **855-938-0571** 로 전화하셔서, 통역 서비스 사무실 전화 번호인 734-936-7021 로 연결해주도록 요청하십시오. 환자로서의 권리와 책임에 관한 정보를 원하시면, 미시간 메디신 (Michigan Medicine) 의 의료진에게 문의하십시오.

আপনি **বাংলায়** কথা বললে, বিনামূল্যে দোভাষী পরিষেবা পাবেন। **734-936-7021** নম্বরে আমাদের দোভাষী পরিষেবার অফিসে ফোন করে আপনার ভাষার (Bengali) নাম বলুন। অংশগ্রহণকারী হিসাবে আপনার অধিকার ও কর্তব্যের সম্পর্কে জানতে চাইলে আমাদের মিশিগান মেডিসিন কেয়ার প্রোভাইডারের সঙ্গে যোগাযোগ করুন।

Jeśli mówisz **po polsku**, możesz skorzystać z bezpłatnych usług tłumaczeniowych. Zadzwoń pod nr **844-562-3986** i poproś o połączenie z biurem usług tłumaczeniowych pod nr 734-936-7021. W przypadku chęci uzyskania informacji dotyczących praw i obowiązków pacjenta zwróć się do dostawcy usług medycznych Michigan Medicine.

Wenn Sie **Deutsch** sprechen, stehen für Sie kostenlos Sprachassistenzdienste zur Verfügung. Rufen Sie **844-562-3984** an und lassen Sie sich mit dem Dolmetscherdienst unter der Rufnummer 734-936-7021 verbinden. Informationen über Ihre Rechte und Pflichten als Patient erhalten Sie über Ihren Gesundheitsdienstleister bei Michigan Medicine.

Si parla **italiano**, avrà gratuitamente a disposizione servizi gratuiti di assistenza linguistica. Chiami il numero **844-562-3985** e chieda di essere messo in contatto con l'ufficio per i servizi di interpretariato (Interpreter Services) al numero 734-936-7021. Se desidera informazioni sui suoi diritti e responsabilità come paziente, consulti il suo referente sanitario Michigan Medicine.

日本語をお話になる方は、無料で言語支援サービスをご利用になれます。**855-322-5032** に電話をかけ、通訳サービス課 734-936-7021 につなぐようお伝えください。患者としての権利と責任に関する情報をお望みの場合は、ミシガン・メディスンの医療提供者にお問い合わせください。

Если Вы говорите **по-русски**, услуги переводчиков будут предоставлены Вам бесплатно. Звоните по телефону **855-938-0572** и попросите, чтобы Вас соединили со службой переводчиков по телефону 734-936-7021. Если Вы хотите получить информацию о правах и обязанностях пациента, попросите об этом Вашего врача из системы Мичиганской Медицины.

Ako govorite **hrvatski/srpski**, dostupna Vam je besplatna podrška na Vašem jeziku. Kontaktirajte našu prevoditeljsku službu na broj **734-936-7021** i recite kojim jezikom govorite (Serbo-Croatian). Ako se želite informirati o svojim pravima i obvezama kao pacijenta, molimo Vas da se obratite pružatelju skrbi u sklopu Sveučilišta Michigan.

Kung nagsasalita ka ng **Tagalog**, may mga magagamit kang libreng serbisyo sa tulong sa wika. Magtanong sa tanggapan ng aming Mga Serbisyo ng Interpreter sa **734-936-7021** at tukuyin ang iyong wika (Tagalog). Kung gusto mong makakuha ng impormasyon tungkol sa iyong mga karapatan at responsibilidad bilang isang pasyente, mangyaring tumawag sa iyong provider ng pangangalaga sa Michigan Medicine.

Si vous parlez **français**, les services d'aide pour les langues sont à votre disposition et sont gratuits. Appelez le **855-800-9253** et demandez à être mis en relation avec le bureau du Service des interprètes au 734-936-7021. Si vous souhaitez des informations concernant vos droits et responsabilités en tant que patient, veuillez les demander à votre professionnel de santé de Michigan Medicine.

اگر شما به زبانی غیر از انگلیسی صحبت میکنید. سرویس ترجمه ی رایگان با شماره **844-562-3983** در دسترس شما میباشد. بعد از اینکه با این شماره تماس گرفتید. بلافاصله با شماری ه دفتر ترجمه ی ما با 734-936-7021 تماس بگیرید و زبانی که صحبت میکنید را با ما در میان بگذارید. اگر میخواهید اطلاعات مربوط به حقوق و تکالیف خود را به عنوان یک بیمار دریافت کنید. لطفاً از کسی که شما را معالجه میکند در Michigan Medicine آنها رقت اضا کنید.

अगर आप हिंदी बोलते हैं, तो भाषा सहायता सेवाएँ आपके लिए निःशुल्क उपलब्ध होंगी। **734-936-7021** पर हमारे व्याख्याकार सेवा अधिकारी को कॉल करें और अपनी भाषा (Hindi) की पहचान करें। अगर मरीज़ के रूप में आपको अपने अधिकारों और ज़िम्मेदारियों के बारे में जानकारी चाहिए, तो कृपया अपने मिशिगन चिकित्सा देखभाल प्रदाता से पूछें।