



Affiliated with the Sparrow Health System

Durable Power of Attorney For Health Care

Dear Patient:

The "Patient Self-Determination Act", recognizes the rights of patients to make choices concerning their medical care, including the right to accept, refuse or withdraw medical and surgical treatment, and to write advance directives for medical care in the event that they are unable to express their wishes. Patients may appoint a friend or relative who will speak for them, and who will make sure that their wishes are carried out. This document is referred to as a Durable Power of Attorney For Health Care.

A Durable Power of Attorney For Health Care is a document in which a person 18 years or older, can appoint a trusted friend or relative to speak on their behalf, if they lose their communication abilities or decision-making abilities. The appointed friend or relative may make medical

choices only when the patient is unable to express medical wishes, or unable to make personal medical choices. The choices made by the trusted friend or relative reflect the patient's wishes.

If you choose to have a Medical Durable Power of Attorney, forms are available at Carson City Hospital, or you may set up a different form with an attorney. Having a Durable Power of Attorney for health care is your choice.

If you decide to have a Durable Power of Attorney For Health Care (after talking to your family, and physician about your health care wishes), choose someone you trust to be your "patient advocate". Fill out the forms in the presence of two witnesses (they may not be hospital staff members), sign it and have the witnesses sign it.

Your advocate may not make health care, custody, or medical treatment choices on your behalf unless your attending physician and another physician or licensed psychologist determine that you are unable to do so.

If you would like a copy of the Medical Durable Power of Attorney booklet or more information, please contact the Carson City Hospital's Discharge Planning Department at 989-584-3971, ext. 250.

Sincerely,

A handwritten signature in black ink that reads "Bruce L. Traverse". The signature is written in a cursive style with a large, prominent "B" and "T".

Bruce L. Traverse
President
Carson Health Network

A Step-By-Step Guide To Establishing A Durable Power Of Attorney

Anyone who is 18 years old and of sound mind may write a Durable Power of Attorney For Health Care. This means you may voluntarily elect an advocate to make medical care, custody and treatment decisions for you if you become unable to express your medical care wishes.

Step 1 ...

Let people know about your feelings and your use of the Durable Power Of Attorney. Talk to family, friends, your physician, your attorney (if you have one), or anyone else who might be affected by your decision to use the Durable Power Of Attorney.

Step 2 ...

Consider the kinds of treatment decisions which might need to be made for you in the future, and what your wishes would be. You can say what kinds of treatments you want or don't want after talking to your physician.

Step 3 ...

Name a person you trust to speak on your behalf when you can't express your health care wishes. Your advocate will work with your doctors or other care providers to make the same kinds of decisions that you could have made for yourself, based on your "Successor Advocate" if the first person you name is unable to act as your advocate when the time comes.

Step 4 ...

Fill out a form. You don't need an attorney to fill out the Durable Power Of Attorney Form; however, you might want to consult an attorney experienced in probate law.

Continue on back page ...

**DURABLE POWER OF ATTORNEY FOR HEALTH CARE
FOR CARE, CUSTODY AND MEDICAL TREATMENT DECISIONS**

I, _____
(Print or Type your Full Name)

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

I designate _____
(Insert Name Of Patient Advocate)

residing at: _____
(Insert Address And Phone Number Of Patient Advocate)

as my patient advocate, with the following power to be exercised in my name and for my benefit, to make decisions regarding care, custody or medical treatment if I become unable to participate in care, custody and medical treatment decisions. The determination of when I am unable to participate in care, custody and medical treatment decisions shall be made by my attending physician and another physician or licensed psychologist.

[(Optional) If the first individual is unable, unwilling or unavailable to serve as my patient advocate, then I designate

(Insert Name Of Successor)

residing at: _____
(Insert Address And Phone Number Of Successor)

to serve as my patient advocate.]

With respect to my care, custody and medical treatment, my advocate shall have the power to make each and every judgement necessary for the proper and adequate care and custody of my person, including, but not limited to:

- ◀ to have access to and control over my medical and personal information
- ◀ to employ and discharge physician, nurses, therapists and any other care providers, and to pay them reasonable compensation with my funds
- ◀ to give an informed consent or an informed refusal on my behalf with respect to any medical care; diagnostic, surgical or therapeutic procedure: or other treatment of any type or nature
- ◀ to execute waivers, medical authorizations and such other approval as may be required to permit or authorized care which I may need, or to discontinue care that I am receiving

My advocate shall be guided in making such decisions by what I have told my advocate about personal preferences regarding such care. **My wishes concerning care are the following:**

[(Optional) I authorize my patient advocate to make a decision to withhold or withdraw treatment which could or would allow me to die. I acknowledge that such a decision could or would allow me to die.]

(Your Name and Date)

Sign this statement if you wish to give this authority to your advocate.

This Durable Power Of Attorney shall not be affected by my disability or incapacity. This **Durable Power Of Attorney** is governed by Michigan law. I may revoke this designation at any time and by communicating in any manner that this designation does not reflect my wishes.

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

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

I voluntarily sign this **Durable Power Of Attorney For Health Care** after careful consideration. I accept its meaning and I accept its consequences.

(Your Signature)

(Your Street Address)

(City, State, Zip Code)

(Date)

NOTICE REGARDING WITNESSES

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

STATEMENT OF WITNESSES

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

WITNESS 1 SIGNATURE:

(Full Name)

(Address)

(City, State, Zip Code)

WITNESS 2 SIGNATURE:

(Full Name)

(Address)

(City, State, Zip Code)

ACCEPTANCE BY PATIENT ADVOCATE

- ◀ This designation shall not become effective unless the patient is unable to participate in medical treatment decision.
- ◀ 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 decisions, could not have exercised on his or her own behalf.
- ◀ 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.
- ◀ A patient advocate may make a decision to withhold or withdraw treatment which would allow that 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.
- ◀ 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 priority, rights and responsibilities.
- ◀ 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.
- ◀ A patient or patient advocate may revoke his or her designation at any time and in any manner sufficient to communicate an intent to revoke.
- ◀ A patient admitted to a health facility or agency has the rights enumerated in Section 20201 of the Public Health Code, Act No. 368 of the Public Acts of 1978, being Section 333.20201 of the Michigan Compiled Laws.

I understand the above conditions and I accept the designation as patient advocate for:

(Patient's Name)

(Patient Advocate Signature)

(Patient Advocate Successor Signature)

(Date)

Step 5 ...

If you want to empower your advocate to make decisions to withhold or withdraw treatment, thus allowing you to die, your Durable Power Of Attorney For Health Care must specifically say that, and you should sign the statement to this effect that appears at the bottom of the first page of the form. Record any other personal preferences regarding care, custody and medical treatment in the space provided. You may want to specify life-sustaining treatment you want or do not want, including artificial nutrition and hydration.

Step 6 ...

Your Durable Power Of Attorney designation must be in writing, signed by you, witnessed by people who are not relatives or interested parties to your will or estate, dated, and executed voluntarily. The witnesses only sign the Durable Power Of Attorney if you are of sound mind and are not under duress, fraud or undue influence to designate a Durable Power Of Attorney. Witness by a Notary Public is not required.

Step 7 ...

Before acting as a patient advocate, the proposed patient advocate must sign an acceptance to your Durable Power Of Attorney. Make your Durable Power Of Attorney and the advocate acceptance statement part of your medical record.

Step 8 ...

Give an original signed copy to your advocate (not a photocopy), and give a copy to your physician. Bring a copy to the hospital each time you are admitted.
