~ Michigan ~

Durable Power of Attorney for Health Care Christian Version

NOTICE TO PERSON MAKING THIS DOCUMENT

You have the right to make decisions about your health care. No health care may be given to you over your objection, and necessary health care may not be stopped or withheld if you object.

Because your health care providers in some cases may not have had the opportunity to establish a long–term relationship with you, they are often unfamiliar with your beliefs and values and the details of your family relationships. This poses a problem if you become physically or mentally unable to make decisions about your health care.

In order to avoid this problem, you may sign this legal document to specify the person whom you wish to make health care decisions for you if you are unable to participate in medical treatment decisions and make those decisions personally. That person is known as your patient advocate. You should take some time to discuss your thoughts and beliefs about medical treatment with the person or persons whom you have specified. You may state in this document any types of health care that you do or do not desire, and you may limit the authority of your patient advocate. If your patient advocate is unaware of your desires with respect to a particular health care decision, he or she is required to determine what would be in your best interests in making the decision.

This is an important legal document. It gives your patient advocate broad powers to make health care decisions for you. It revokes any prior durable power of attorney for health care documents that you may have made. If you wish to change your Durable Power of Attorney for Health Care, you may revoke this document at any time by destroying it, by directing another person to destroy it in your presence, by signing a written and dated statement or by stating that it is revoked in the presence of two witnesses. If you revoke, you should notify your patient advocate, your health care provider(s), and any other person(s) to whom you have given a copy. If your patient advocate is your spouse and your marriage is annulled or you are divorced after signing this document, the document is invalid.

Do not sign this document unless you clearly understand it. It is suggested that you keep the original of this document with your personal papers where it can be easily accessed by your patient advocate, close family, or friends, if needed.

STATE OF MICHIGAN DURABLE POWER OF ATTORNEY FOR HEALTH CARE

Written in accordance with Michigan §700.5507

APPOINTMENT OF PATIENT ADVOCATE

I, _____ of _____,
Principal Street

_____, _____, _____, appoint _____ residing at
City State Zip Code Patient advocate

_____, _____, _____, _____,
Street City State Zip Code

and whose telephone number is (_____) _____ as my patient advocate with the following power to be exercised in my name and for my benefit, for the purpose of making decisions regarding my care, custody, and medical and/or mental health treatment. This designation of patient advocate shall not be affected by my disability or incapacity, and is governed by section 700.5506-700.5515 of the *Michigan Compiled Laws*.

The State of Michigan does not require the selection of a successor advocate, but we suggest you select one anyway. The successor advocate will assume the role of patient advocate when the primary advocate is unable or unwilling to assume the duties as outlined in this durable power of attorney for health care document.

I appoint _____ whose address is _____,
Successor advocate Street

_____, _____, _____, and whose telephone number is
City State Zip Code

(_____) _____ as my successor advocate for health care.

This Durable Power of Attorney for Health Care - Christian Version designates my patient advocate, without substitution, with lawful authority to execute a directive on my behalf under Michigan §700.496, governing the care and treatment to be administered to or withheld from me at any time after I incur an injury, disease, or illness which render me unable to give current directions to attending physicians and other providers of medical services.

I have carefully selected my above–named advocate with confidence in the belief that this person's familiarity with my desires, beliefs, and attitudes will result in directions to attending physicians and providers of medical services which would probably be the same as I would give if able to do so.

This Durable Power of Attorney for Health Care shall be and remain in effect from the time my attending physician certifies that I have incurred a physical or mental condition rendering me unable to give current directions to attending physicians and other providers of medical services as to my care and treatment.

SIGNATURE OF PRINCIPAL

I HAVE READ THIS DURABLE POWER OF ATTORNEY FOR HEALTH CARE. I UNDERSTAND THAT IT ALLOWS ANOTHER PERSON TO MAKE LIFE AND DEATH DECISIONS FOR ME IF I AM INCAPABLE OF MAKING SUCH DECISIONS. I ALSO UNDERSTAND THAT I CAN REVOKE THIS DURABLE POWER OF ATTORNEY FOR HEALTH CARE AT ANY TIME BY NOTIFYING MY PATIENT ADVOCATE, MY PHYSICIAN, OR THE FACILITY IN WHICH I AM A PATIENT OR RESIDENT. I ALSO UNDERSTAND THAT I CAN REQUIRE IN THIS DURABLE POWER OF ATTORNEY FOR HEALTH CARE THAT THE FACT OF MY INCAPACITY IN THE FUTURE BE CONFIRMED BY A SECOND PHYSICIAN.

Signature: _____ Date: _____

DECLARATION OF WITNESSES

We declare that the principal is personally known to us, that the principal signed or acknowledged his or her signature on this Durable Power of Attorney for Health Care in our presence, that the principal appears to be of sound mind and not under duress or undue influence, and that neither of us is the person appointed as patient advocate or successor advocate by this document.

Witness #1

Signature: _____ Date: _____

Print or type name: _____

Print or type address: _____

Witness #2

Signature: _____ Date: _____

Print or type name: _____

Print or type address: _____

PATIENT ADVOCATE ACCEPTANCE OF DURABLE POWER OF ATTORNEY

I understand that _____ has designated me,
Principal

_____, to be his or her patient advocate if he or she is ever found to have
Patient advocate
incapacity and unable to participate in making health care decisions himself or herself. This designation shall not become effective unless the principal is unable to participate in medical treatment decisions. I willingly accept the responsibilities conferred upon me as explained in this power of attorney document and accompanying Addendum.

The following requirements of Michigan law pertain to the execution of a durable power of attorney for health care:

1. This designation shall not be 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 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 or mental health 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 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.
9. A patient advocate may revoke his or her acceptance to the 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, Act No. 368 of the Public Acts of 1978, being Section 333.20201 of the *Michigan Compiled Laws*.

By signing this document I am acknowledging that I have read and understand the medical directive as expressed by the principal and the listed requirements of Michigan law pertaining to the execution of a durable power of attorney. I also maintain the right to revoke this acceptance at any time, and by any means whereby I may communicate a desire to revoke it.

Patient advocate's signature: _____ Phone: (____) _____

Address: _____

SUCCESSOR ADVOCATE

The State of Michigan does not require you to choose a successor advocate, but we recommend that you do. The successor advocate will assume the role of patient advocate in the event your primary advocate is not able or willing to carry out the duties as described. By signing this document, the successor advocate is acknowledging the medical directives that are stated in this document and agreeing to serve as your successor advocate. If your primary advocate is unable or unwilling to serve as patient advocate, then your successor advocate will be asked to assume the responsibilities of patient advocate. At that time, your successor advocate will need to sign an acceptance similar to the primary advocate. The form on page 5 of this document is provided for that purpose.

THE FOLLOWING FORM IS TO BE USED ONLY IF YOUR PRIMARY ADVOCATE IS UNABLE OR UNWILLING TO SERVE AS PATIENT ADVOCATE. BEFORE YOUR SUCCESSOR ADVOCATE ASSUMES THE RESPONSIBILITY OF PATIENT ADVOCATE, HE OR SHE IS REQUIRED TO SIGN THIS ACCEPTANCE.

SUCCESSOR ADVOCATE ACCEPTANCE OF DURABLE POWER OF ATTORNEY

I understand that _____ has designated me, _____,
Principal Successor advocate
to be his or her patient advocate if the original patient advocate is unable or unwilling to serve as patient advocate. This designation shall not become effective unless the principal is unable to participate in medical treatment decisions. I willingly accept the responsibilities conferred upon me as explained in this power of attorney document and accompanying Addendum.

The following requirements of Michigan law pertain to the execution of a durable power of attorney for health care:

1. This designation shall not be 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 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 or mental health 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 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.
9. A patient advocate may revoke his or her acceptance to the 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, Act No. 368 of the Public Acts of 1978, being Section 333.20201 of the *Michigan Compiled Laws*.

By signing this document I am acknowledging that I have read and understand the medical directive as expressed by the principal and the listed requirements of Michigan law pertaining to the execution of a durable power of attorney. I also maintain the right to revoke this acceptance at any time, and by any means whereby I may communicate a desire to revoke it.

Successor advocate's signature: _____ Phone: (____) _____

Address: _____

ANATOMICAL GIFTS

Optional

Upon my death:

_____ I wish to donate only the following organs or parts:

_____

_____

_____ I wish to donate any needed organ or part.

_____ I wish to donate my body for anatomical study if needed.

_____ I refuse to make an anatomical gift. (If this revokes a prior commitment that I have made to make an anatomical gift to a designated donee, I will attempt to notify the donee to which or to whom I agreed to donate.)

Failure to check any of the lines immediately above creates no presumption about my desire to make or refusal to make an anatomical gift.

Signature: _____ Date: _____

ADDENDUM TO THE STATE OF MICHIGAN DURABLE POWER OF ATTORNEY FOR HEALTH CARE

GENERAL STATEMENT OF AUTHORITY GRANTED

As the declarant of this document, I desire to have my health care decisions made in accordance with this Addendum to the Durable Power of Attorney for Health Care – Christian Version. The purposes of this Addendum are to provide a witness to my Christian belief that life is a gift from God, and to provide direction for my patient advocate to make decisions that are consistent with my Christian faith.

Unless I have specified otherwise in this document, if I ever have incapacity I instruct my health care provider to obtain the health care decision of my patient advocate, if I need treatment, for all of my health care and treatment. I have discussed my desires thoroughly with my patient advocate and believe that he or she understands any philosophy regarding the health care decisions I would make if I were able. I desire that my wishes be carried out through the authority given to my patient advocate under this document.

If I am unable, due to my incapacity, to participate in making a health care decision, my advocate is instructed to make the health care decision for me, but my advocate should try to discuss with me any specific proposed health care if I am able to communicate in any manner, including by blinking my eyes. If this communication cannot be made, my patient advocate shall base his or her decision on any health care choices that I have expressed prior to the time of the decision. If I have not expressed a health care choice about the health care in question and communication cannot be made, my advocate shall base his or her health care decision on what he or she believes to be in my best interest.

MY HEALTH CARE STATEMENT OF BELIEFS

My philosophy regarding the health care decisions I would make, if I were able to participate in medical treatment decisions, is based on my belief that life is a gift from God and in the inherent value of human life. It is my desire that all reasonable efforts be made to sustain my life and health.

I believe that death is the normal end of earthly life and that God takes life by his decision. Therefore, I reject any attempt to end my life when God would sustain it, regardless of any diminished state of quality to my life, even if I have a disability. Similarly, I reject any attempt to lengthen my life when it is clear God intends to take it.

I believe life begins at conception. Therefore, if I have been diagnosed as pregnant and my physician knows of this diagnosis, I request that every effort be made to save the life of my unborn child in full recognition that two lives are at stake, both equal in value and worthy of protection.

HEALTH CARE DIRECTIVES

1. I direct my patient advocate to consent to the following health care:
   a. Health care that is intended to relieve pain or to make me comfortable.
   b. Health care to cure or improve any physical or mental condition which can be cured or improved. This includes health care that is intended to be used temporarily or because it is potentially effective.

2. My patient advocate has no authority to consent to any act or omission intended to cause or hasten my death.

3. I instruct my patient advocate to ensure that my attending physician and other health care providers provide my health care based on my health care philosophy and my health care directives as set forth in this document.

4. Should it become clear that God wishes to take my life, namely that I am diagnosed to have a terminal illness or injury where death is imminent, I direct that life–sustaining procedures be withheld or withdrawn, and that I be permitted to die in God's time. I do *not* give consent for the withholding or withdrawal of nutrition or hydration, even if I am diagnosed to have a terminal illness or injury, if doing so would cause my death by starvation or dehydration rather than from the terminal condition or injury.

5. If God allows the quality of my life to be diminished but gives me strength to continue living for an indeterminate amount of time, I request that reasonable care be administered to me to sustain my life and ease discomfort as much as possible.

EXCEPTIONS TO HEALTH CARE DIRECTIVES

1. My patient advocate may refuse consent to health care that would not be effective in terms of my survival.

2. If I have an incurable terminal illness or injury where I am in the final stages of dying, and it is medically certain that my death will occur within hours or a few days, my patient advocate may consent to the withholding or withdrawal of any health care that is not intended to relieve pain or make me comfortable.

3. If I have an incurable terminal illness or injury, and it is medically certain that my death will occur within six (6) months, my patient advocate may consent to the withholding or withdrawal of life-sustaining health care. However, I still desire health care for easily treatable acute and chronic conditions, and health care that is intended to relieve pain or make me comfortable.

4. If I have a total, chronic, and irreversible loss of consciousness, this condition must be diagnosed with medical certainty by two physicians, one of whom is my attending physician and the other is an expert in diagnosing my condition. Upon such diagnosis, my patient advocate may consent to the withholding or withdrawal of certain life–sustaining health care, remaining faithful to the directives found in the rest of this document. I still desire health care for easily treatable acute and chronic conditions and health care that is intended to relieve pain or make me comfortable.

NUTRITION AND HYDRATION

Food and fluids

1. I believe that nutrition and hydration are basic human needs which should be provided to me even though providing them may require medical expertise and technology.

2. If I check "Yes" to the "Withhold or withdraw a feeding tube" option in the next section, then a feeding tube may only be withheld or withdrawn from me if:
   a. I have an incurable terminal illness or injury where I am in the final stage of dying, and it is medically certain that my death will occur within hours or a few days, and
   b. The withholding or withdrawal of the feeding tube would not result in my death from malnutrition or dehydration, or complications of malnutrition or dehydration, rather than from my underlying terminal illness or injury.

PROVISION OF FEEDING TUBE

If I have checked "Yes" to the following, my patient advocate may have a feeding tube withheld or withdrawn from me, unless my physician has advised that, in his or her professional judgment, this will cause me pain or will reduce my comfort. If I have checked "No" to the following, my patient advocate may not have a feeding tube withheld or withdrawn from me.

My patient advocate may not have orally ingested nutrition or hydration withheld or withdrawn from me unless provision of the nutrition or hydration is medically contraindicated.

Withhold or withdraw a feeding tube **Yes** ❑ **No** ❑

If I have not checked either "Yes" or "No" immediately above, my patient advocate may not have a feeding tube withheld or withdrawn from me.

PREGNANT WOMEN

If I am pregnant, the following applies:

1. My patient advocate is authorized to make health care decisions on behalf of my unborn child as an individual patient.

2. Health care necessary to sustain the life or health of my unborn child should be provided unless it is medically certain that my unborn child would not survive even if the health care were provided.

3. It is my desire that all reasonable efforts be made to sustain both my life and health and the life and health of my unborn child.

4. Even if I have an incurable illness or injury, or I am legally determined to be brain dead, it is my desire to receive all health care, to remain on any necessary life support systems, and to receive nutrition and hydration until my unborn child can sustain life apart from my body, unless it is medically certain that my unborn child would not survive even if I receive such health care.

5. No one is authorized to consent to an abortion for me unless it is directly and medically necessary to prevent my death.

PROVISION FOR PREGNANT WOMEN

If I have checked "Yes" to the following, my patient advocate may make health care decisions for me if he/she knows I am pregnant. If I have checked "No" to the following, my patient advocate may not make health care decisions for me if he/she knows I am pregnant.

Health care decisions if I am pregnant **Yes** ❑ **No** ❑

If I have not checked either "Yes" or "No" immediately above, my patient advocate may not make health care decisions for me if he or she knows I am pregnant.

In no event is my patient advocate authorized to make medical treatment decisions to withhold or withdraw treatment for me if I am pregnant that would result in my death.

LIMITATIONS ON MENTAL HEALTH TREATMENT

My patient advocate may not admit or commit me on an inpatient basis to an institution for mental diseases, a state treatment facility, or a treatment facility. My patient advocate may not consent to experimental mental health research or psycho surgery, electroconvulsive treatment, or drastic mental health treatment procedures for me.

INSPECTION AND DISCLOSURE OF INFORMATION RELATING TO MY PHYSICAL OR MENTAL HEALTH

Subject to any limitations in this document, my patient advocate has the authority to do all of the following:

1. Request, review, and receive any information, verbal or written, regarding my physical or mental health, including medical and hospital records.

2. Execute on my behalf any documents that may be required in order to obtain this information.

3. Consent to the disclosure of this information.

HIPAA RELEASE STATEMENT

I intend for my patient advocate to be treated as I would with respect to my rights regarding the use and disclosure of my individual protected health information or other medical records. I grant to my advocate the right to receive, disclose, or release, without restriction, all of my protected health information. This release statement applies to any information that is governed by the Health Insurance Portability and Accountability Act (HIPAA) of 1996.

ADMISSION TO NURSING HOMES

My patient advocate may admit me to a nursing home for short–term stays for recuperative care or respite care.

If I have checked "Yes" to the following, my patient advocate may admit me for a purpose other than recuperative care or respite care, but if I have checked "No" to the following, my patient advocate may not so admit me:

A nursing home **Yes ❑** **No ❑**

If I have not checked either "Yes" or "No" immediately above, my patient advocate may only admit me for short–term stays for recuperative care or respite care.

STATEMENT OF DESIRES, SPECIAL PROVISIONS, OR LIMITATIONS

In exercising authority under this document, my patient advocate shall act consistently with the directives in this statement and the following specific desires, provisions, or limitations that I wish to add (add more items as appropriate):

1. I request that the attached Addendum (pages 6-12) be included as a valid part of this Durable Power of Attorney for Health Care document.

2. I request, but not as a requirement, that my patient advocate consult my clergy regarding health care decisions.

3. _____

_____

_____

_____

_____

(*Attach additional pages, if needed)*

SIGNATURE OF PRINCIPAL

I HAVE READ THIS ADDENDUM TO THE MICHIGAN DURABLE POWER OF ATTORNEY FOR HEALTH CARE - CHRISTIAN VERSION. I UNDERSTAND THAT IT ALLOWS ANOTHER PERSON TO MAKE LIFE AND DEATH DECISIONS FOR ME IF I AM INCAPABLE OF MAKING SUCH DECISIONS. I ALSO UNDERSTAND THAT I CAN REVOKE THIS POWER OF ATTORNEY FOR HEALTH CARE AT ANY TIME BY NOTIFYING MY PATIENT ADVOCATE, MY PHYSICIAN, OR THE FACILITY IN WHICH I AM A PATIENT OR RESIDENT. I ALSO UNDERSTAND THAT I CAN REQUIRE IN THIS DURABLE POWER OF ATTORNEY FOR HEALTH CARE THAT THE FACT OF MY INCAPACITY IN THE FUTURE BE CONFIRMED BY A SECOND PHYSICIAN.

Signature: _____ Date: _____

DECLARATION OF WITNESSES

We declare that the principal is personally known to us, that the principal signed or acknowledged his or her signature on this Addendum in our presence, that the principal appears to be of sound mind and not under duress or undue influence, and that neither of us is the person appointed as patient advocate or successor advocate by this document.

Witness #1

Signature: _____ Date: _____

Print or type name: _____

Witness #2

Signature: _____ Date: _____

Print or type name: _____

PATIENT ADVOCATE ACCEPTANCE OF ADDENDUM TO THE DURABLE POWER OF ATTORNEY FOR HEALTH CARE

I understand that _____ has designated me, _____,
Principal Patient advocate
to be his or her patient advocate if he or she is ever found to have incapacity and unable to participate in making health care decisions himself or herself. This designation shall not become effective unless the principal is unable to participate in medical treatment decisions. I willingly accept the responsibilities conferred upon me as explained in this Durable Power of Attorney for Health Care document and accompanying Addendum.

By signing this Addendum I am acknowledging that I have read and understand the medical directive as expressed by the principal and the listed requirements of Michigan law pertaining to the execution of a durable power of attorney. I also maintain the right to revoke this acceptance at any time, and by any means whereby I may communicate a desire to revoke it.

Patient advocate's signature: _____ Phone: (____) _____

Address: _____

SUCCESSOR ADVOCATE ACCEPTANCE OF ADDENDUM TO THE DURABLE POWER OF ATTORNEY FOR HEALTH CARE

I understand that _____ has designated me, _____,
Principal Successor advocate
to be his or her patient advocate if the original patient advocate is unable or unwilling to serve as patient advocate. This designation shall not become effective unless the principal is unable to participate in medical treatment decisions. I willingly accept the responsibilities conferred upon me as explained in this power of attorney document and accompanying Addendum.

Successor advocate's signature: _____ Phone: (____) _____

Address: _____

CLERGY
Optional

The declarant has requested that the patient advocate consult me, as the declarant's clergy, regarding any health care decisions. I understand that this request has been made and am willing to work with the advocate to help meet the directives as described in this Durable Power of Attorney for Health Care document and attached Addendum.

Clergy's Signature: _____

Church Name: _____ Phone: (____) _____

Church Address: _____

I have given copies of this Durable Power of Attorney for Health Care – Christian Version to:

_____

_____

_____

_____

_____

_____

_____