# ~ Missouri ~

# 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 health care agent. 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 health care agent. If your health care agent 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 agent broad powers to make health care decisions for you. It revokes any prior durable power of attorney 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 agent, your health care provider(s), and any other person(s) to whom you have given a copy. If your agent 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 health care agent, close family, or friends, if needed.

# STATE OF MISSOURI DURABLE POWER OF ATTORNEY FOR HEALTH CARE

This document has been written in accordance to the Missouri Statutes §§404.800-404.865.

## DESIGNATION OF HEALTH CARE AGENT AND ALTERNATE HEALTH CARE AGENT(S)

I, _____, appoint
Print your full name here

Name: _____
Health care agent

Address, City, State, Zip: _____

Phone(s): _____ _____

as my attorney-in-fact ("agent") for health care when I am unable to make decisions or communicate my wishes. In the case the person above resigns or is unable to or unavailable to make health care decisions for me, or if an agent named by me is divorced from me or is legally separated from me, I appoint the following persons in the order named below to serve as my alternate agent(s) and to have the same powers as my agent listed above.

### Alternate Health Care Agent #1:

Name: _____
1st alternate health care agent

Address, City, State, Zip: _____

Phone(s): _____ _____

### Alternate Care Health Agent #2:

Name: _____
2nd alternate health care agent

Address, City, State, Zip: _____

Phone(s): _____ _____

## DURABILITY

This is a Durable Power of Attorney for Health Care, and the authority of my agent, when effective, shall not terminate or be void or voidable if I am or become disabled or incapacitated or in the event of later uncertainty as to whether I am dead or alive.

## EFFECTIVE DATE

This Durable Power of Attorney for Health Care is effective as to health care decision making when I am incapacitated and unable to make and communicate a health care decision as certified by: ***(check one of the following boxes)*** ☐ One physician **OR** ☐ Two physicians

## AGENT'S POWERS

By completing this Durable Power of Attorney for Health Care, I authorize my agent to make all decisions for me regarding my health care. This includes the power to:

- Consent, refuse, or withdraw consent to artificially supplied nutrition and hydration.
- Make all necessary arrangements for health care on my behalf. This includes admitting me to any hospital, psychiatric treatment facility, hospice, nursing home, or other health care facility.
- Hire or fire health care personnel on my behalf.
- Request, receive, and review my medical and hospital records.
- Take legal action if necessary to do what I have directed.
- Carry out my wishes regarding autopsy and organ donation, and decide what should be done with my body.

## EFFECTIVE DATE AS TO OTHER AUTHORITY

In addition to the powers set forth above, I authorize effective upon my signature and without the need for a physician's certification of incapacity that my agent be authorized to have one or more of the following powers ***(initial your desired choices):***

_____ Determine what happens to my body after my death (authority for "right of sepulcher");
*(Initial)*

_____ Give consent after my death to an autopsy or postmortem examination of my remains;
*(Initial)*

_____ Delegate health care decision-making power to another person ("Delegee") as selected by my agent, and the
*(Initial)* delegee shall be identified in writing by my agent.

## AGENT'S FINANCIAL LIABILITY AND COMPENSATION

My agent, acting under this Durable Power of Attorney for Health Care, will not incur any personal financial liability. My agent shall not be entitled to compensation for services performed under this Durable Power of Attorney for Health Care, but my agent shall be entitled to reimbursement for reasonable expenses incurred as a result of carrying out any provisions hereof.

**Your Durable Power of Attorney for Health Care must be notarized. If you grant your agent power to direct your burial or cremation, your document must be signed in front of two witnesses AND notarized. If you do not grant this power, only the notary is necessary.**

## SIGNATURE OF PRINCIPAL

(Person creating this Durable Power of Attorney for Health Care)

IN WITNESS THEREOF, I signed this document on this _____ of _____, _____.
Day Month Year

**Signature:** _____

Print name: _____

(The signing of this document by the principal revokes all previous durable power of attorney for health care documents)

## NOTARY PUBLIC ACKNOWLEDGMENT

***Required***

**STATE OF MISSOURI )**
**) SS**
**COUNTY OF _____)**

On this _____ of _____, _____, before me personally appeared
Day Month Year

_____, to me known to be the person described in
Name of principal

and who executed the foregoing instrument and acknowledged that he/she executed the same as his/her free act and deed.

IN WITNESS WHEREOF, I have hereunto set my hand and affixed my official seal in the County or City and state aforementioned, on the day and year first above written.

_____

_____, Notary Public
(Name Printed)

My Commission Expires: _____

## STATEMENT OF WITNESSES

***(If you grant your agent power to direct your burial, cremation, or final disposition of your body, you must sign this document in front of two adult witnesses.)***

The person who signed this document is of sound mind and voluntarily signed this document in our presence. Each of the undersigned witnesses is at least 18 years of age.

### Witness #1

Print name: _____ Date: _____

Address: _____

**Signature:** _____

### Witness #2

Print name: _____ Date: _____

Address: _____

**Signature:** _____

## STATEMENT OF AGENT AND ALTERNATE AGENT(S)

I understand that _____ has designated me to be his or her
Name of principal
agent or alternate agent(s) 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.

_____ has discussed his or her desires regarding health care
Name of principal
decisions with me.

**Signature of agent:** _____

Address: _____

**Signature of alternate agent #1:** _____

Address: _____

**Signature of alternate agent #2:** _____

Address: _____

# ADDENDUM TO THE STATE OF MISSOURI DURABLE POWER OF ATTORNEY FOR HEALTH CARE

## GENERAL STATEMENT OF AUTHORITY GRANTED

As the principal 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. 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 agent 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 agent, if I need treatment, for all of my health care and treatment. I have discussed my desires thoroughly with my agent 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 agent under this document.

If I am unable, due to my incapacity, to participate in making a health care decision, my agent is instructed to make the health care decision for me, but my agent 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 agent 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 agent 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 in the inherent value of human life and that life is a gift from God. 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 agent 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 agent has no authority to consent to any act or omission intended to cause or hasten my death.

3. I instruct my agent 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 agent 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 agent 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 agent 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, and this condition has been diagnosed with medical certainty by two physicians, one of whom is my attending physician and the other is an expert in diagnosing my condition, my agent may consent to the withholding or withdrawal of certain 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.

## 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 agent 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 agent may not have a feeding tube withheld or withdrawn from me.

My agent 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 agent may not have a feeding tube withheld or withdrawn from me.

## PREGNANT WOMEN

If I am pregnant, the following applies:

1. My agent 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 agent may make health care decisions for me even if my agent knows I am pregnant. If I have checked "No" to the following, my agent may not make health care decisions for me if my agent knows I am pregnant.

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

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

In no event is my agent 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 agent 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 agent may not consent to experimental mental health research or psychosurgery, 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 agent 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.

## ADMISSION TO NURSING HOMES

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

A nursing home **Yes** ❑ **No** ❑

If I have not checked either "Yes" or "No" immediately above, my agent 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 agent shall act consistently with my following stated desires, if any, and is subject to any special provisions or limitations that I specify. The following are any specific desires, provisions, or limitations that I wish to state (add more items as appropriate):

1. I request that this attached Addendum (pages 6-13) 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 agent consult my clergy regarding health care decisions.

3. _____

_____

_____

_____

_____

*(Attach additional pages, if needed)*

## HIPAA RELEASE STATEMENT

I intend for my health care agent 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 agent 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.

## 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: _____

**Your Durable Power of Attorney for Health Care must be notarized. If you grant your agent power to direct your burial or cremation, your document must be signed in front of two witnesses AND notarized. If you do not grant this power, only the notary is necessary.**

## SIGNATURE OF PRINCIPAL

(Person creating this Durable Power of Attorney for Health Care)

IN WITNESS THEREOF, I signed this document on this _____ of _____, _____.
Day Month Year

**Signature:** _____

Print name: _____

(The signing of this document by the principal revokes all previous durable power of attorney for health care documents)

## NOTARY PUBLIC ACKNOWLEDGMENT

***Required***

**STATE OF MISSOURI )**
**) SS**
**COUNTY OF _____)**

On this _____ of _____, _____, before me personally appeared
Day Month Year

_____, to me known to be the person described in
Name of principal

and who executed the foregoing instrument and acknowledged that he/she executed the same as his/her free act and deed.

IN WITNESS WHEREOF, I have hereunto set my hand and affixed my official seal in the County or City and state aforementioned, on the day and year first above written.

_____

_____, Notary Public
(Name Printed)

My Commission Expires: _____

## STATEMENT OF WITNESSES

***(If you grant your agent power to direct your burial, cremation, or final disposition of your body, you must sign this document in front of two adult witnesses.)***

The person who signed this document is of sound mind and voluntarily signed this document in our presence. Each of the undersigned witnesses is at least 18 years of age.

### Witness #1

Print name: _____ Date: _____

Address: _____

**Signature:** _____

### Witness #2

Print name: _____ Date: _____

Address: _____

**Signature:** _____

## STATEMENT OF AGENT AND ALTERNATE AGENT(S)

I understand that _____ has designated me to be his or her
Name of principal
agent or alternate agent(s) 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.

_____ has discussed his or her desires regarding health care
Name of principal
decisions with me.

**Signature of agent:** _____

Address: _____

**Signature of alternate agent #1:** _____

Address: _____

**Signature of alternate agent #2:** _____

Address: _____

## CLERGY
***Optional***

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

**Signature of clergy:** _____ Phone: ( _____ ) _____

Church name: _____

Address: _____

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

_____

_____

_____

_____

_____

_____