LEGAL DOCUMENT - ***Abbreviated Form for Hospitalized Patients***

Durable Power of Attorney for Health Care – Patient Advocate Designation

This is a legal document. I am naming a patient advocate who will speak on my behalf only if I cannot speak for myself or become unable to participate in making medical (as determined by my physician and one other physician or licensed psychologist) or mental health (as determined by my physician and mental health practitioner) decisions. My patient advocate has no authority to make decisions on my behalf, at any time, if I am able to make decisions for myself. I authorize this document to be included as part of my medical record and given to my patient advocate and my health care provider as well as to successor advocates and health care systems where I receive care.

Patient Advocate Designation

I _____, living at _____
(patient's full name) *(patient's address)*

am over the age of 18, of sound mind and I voluntarily choose the following as my patient advocate or successor advocate to make health and care decisions for me if, and only if, I am unable to participate in these decisions myself. I understand I can change my mind at any time by communicating in any manner that this choice no longer reflects my wishes.

I choose the following person as my patient advocate: Phone #: _____

Name: _____ Relationship: _____

Address: _____ City: _____ State: ____ Zip: _____

If my Patient Advocate does not accept the appointment, is unwilling, unavailable or unable to act as my Patient Advocate then I want this person to be my:

Alternate (successor) patient advocate: Phone #: _____

Name: _____ Relationship: _____

Address: _____ City: _____ State: ____ Zip: _____

Power Regarding Life Sustaining Treatment-Optional:

I expressly authorize my patient advocate to make decisions to withhold or withdraw treatment which would allow me to die, and I acknowledge such decisions could or would allow my natural death.

PATIENT SIGNATURE: _____ **Date:** _____
(sign your name if you wish to give your patient advocate this authority)

Witness Statement

I declare that the person who signed this document signed it in my presence, and that he/she appears to be of sound mind and under no duress, fraud or undue influence.

I am not the person appointed as the patient advocate by this document, under the age of 18 years, related to the patient by blood, marriage or adoption, the patient's physician or health care provider, an employee of a healthcare facility or community mental health program that is treating or caring for the patient, or to the best of my knowledge, a creditor of the patient or entitled to any of his/her estate under a will now existing or by operation of law.

Patient Signature: _____ **Date:** _____

_____ _____
(Witness 1 Signature) *(Witness 2 Signature)*

_____ _____
(Print/Type Full Name) *(Print/Type Full Name)*

_____ _____
(Address) *(Address)*

Acceptance by Patient Advocate and Alternate (Successor) Patient Advocates

I agree to be the patient advocate for_____ , I accept the responsibility
(patient's name)

and agree to take reasonable steps to follow the desires and instructions of the patient as outlined in this document and as I may have discussed verbally with the patient. If I am unable to act after reasonable efforts to contact me, a successor patient advocate, in the order designated by the patient, shall act until I become available.

By signing this acceptance, I acknowledge that I am accepting the responsibility to act on behalf of the patient and make decisions consistent with the patient's expressed wishes and best interests. I also understand that signing this acceptance does not obligate me to become financially responsible for the patient or for the cost of the patient's care. Further, I understand and agree that as patient advocate:

A. My authority shall not become effective unless the patient is declared by physicians to be unable to make medical and/or mental health treatment decisions.

B. I cannot exercise any powers concerning the patient's care, custody, medical or mental health treatment that the patient could not have exercised for himself/herself.

C. I cannot make a decision to withhold or withdraw care from a patient who is pregnant if that decision would result in the patient's death.

D. I may make a decision to withhold or withdraw treatment which would allow the patient to die only if the patient has expressed in a clear and convincing manner that I am authorized to make such a decision, and that the patient acknowledges that such a decision could or would allow the patient's death.

E. I cannot receive compensation for serving as patient advocate, but I may be reimbursed for any actual and necessary expenses incurred on behalf of the patient.

F. The patient can revoke my authority to act as patient advocate at any time and in any manner sufficient to communicate an intent to revoke.

G. If the patient has waived his or her right to revoke my authority to make mental health treatment decisions, then revocation as to any mental health treatment will be delayed for 30 days after the patient expresses his or her intent to revoke.

H. I may revoke this acceptance at any time and in any manner sufficient to communicate my intent to stop acting as patient advocate.

I. I must act in accordance with medical and legal standards that require me to make decisions in the best interests and for the benefit of the patient. The known desires of the patient expressed or evidenced while the patient is able to participate in making his or her medical and/or mental health treatment decisions are presumed to be in his or her best interests.

J. If authorized by this document to make an anatomical gift, my authority remains exercisable after the patient's death.

K. A patient admitted to the hospital has the rights enumerated in section 20201 of the Michigan Public Health Code (MCL 333.20201).

PATIENT ADVOCATE SIGNATURE: _____ **Date:**_____

ALTERNATE (SUCCESSOR) PATIENT ADVOCATE SIGNATURE (optional):

_____ **Date:**_____