Advance Directive
including Durable Power of Attorney for Health Care

Overview

This legal document meets the requirements for Missouri. It lets you:

- Name another person to make your health care decisions if you cannot make them for yourself.
- Write down your goals and preferences for future medical care in specific situations.

The person you name is called your health care agent. You can also name alternate health care agents who can make decisions if the person you named first or second cannot or is not willing to make those decisions. This document gives your health care agent authority to make health care decisions on your behalf only after doctors have determined you are incapable of making health care decisions for yourself.

When selecting your health care agent, choose someone who knows you well. It should be someone you trust and who respects your views and values. This person should be able to make difficult decisions under stress. Often family members are good choices, but not always. Choose someone who will closely follow what you want and will be a good advocate for you. Take time to discuss this document and your views with the person(s) you choose to be your health care agent(s).

A health care agent must be at least 18 years old. Your health care agent may not be one of your health care providers, or an employee of your health care provider, unless he or she is a close relative.

This document **does not** give your health care agent authority to:

- Make financial or other business decisions.
- Make certain decisions about your mental health treatment.

Read this advance directive carefully before you complete and sign it. **You should discuss your goals, values, and this advance directive with your health care agent(s). Unless you talk with your health care agent(s), they may not know your goals and be able to follow your instructions.**

Recommendation: Make an appointment with an advance care planning facilitator for help. If this advance directive does not meet your needs, ask your health organization or attorney about other options.

To complete this advance directive

This advance directive is divided into four parts:
Part 1 – My health care agent
Part 2 – General authority of the health care agent
Part 3 – Statement of desires, care instructions or limits
Part 4 – Making the document legal
Follow the instructions in each of the four parts.

What to do after completing this advance directive

Take these steps:

- Talk to the person(s) you named as your health care agent(s) about your goals and preferences for future medical care, if you have not already. Make sure they feel able to do this important job for you in the future.
- Give your health care agent(s) a copy of this advance directive.
- Talk to the rest of your family and close friends who might be involved if you have a serious illness or injury. Make sure they know who your health care agent(s) is, and what your preferences are.
- Give a copy to your doctor and/or your health care facility. Make sure your preferences are understood.
- Keep a copy of this advance directive where it can be easily found.
- If you go to a hospital or nursing home, take a copy of this advance directive and ask that it be placed in your medical record.

- Review and update this advance directive whenever any of the "Five D's" occur:

  Decade – when you start each new decade of your life.
  Death (or Dispute) – when a loved one or a health care agent dies (or disagrees with your preferences).
  Divorce – when divorce (or annulment) happens. If your spouse or domestic partner is your health care agent, your advance directive is no longer valid. You must complete a new advance directive, even if you want your ex-spouse or ex-partner to remain your health care agent.
  Diagnosis – when you are diagnosed with a serious illness.
  Decline – when your health gets worse, especially when you are unable to live on your own.

- If your goals and preferences change:
  - Talk to your health care agent(s), your family, your doctor, and everyone who has copies of this advance directive.
  - Then, complete a new advance directive.

- Cut out the card below, fill it in, fold it and put it in your wallet.

Copies of this document have been given to:

Health Care Agent

Name_____

Alternate Health Care Agent

Name_____

2nd Alternate Health Care Agent

Name_____

Health Care Professional/Organization

Name _____ Telephone _____

Name _____ Telephone _____

Need Assistance? If you need assistance in completing this document, you may contact these offices from 8 a.m.-4:30 p.m.

- CoxHealth Center for Health Improvement 417-269-3903
- Mercy Pastoral Care 417-820-2735

Respecting Choices® of the Ozarks

This document is a project of Respecting Choices of the Ozarks, whose partners include CoxHealth, Mercy Springfield, Burrell Behavioral Health, Springfield-Greene County Health Department and Jordan Valley Community Health Center, with funding from the Hospice Foundation of the Ozarks.

✂----------Cut here----------

I HAVE AN ADVANCE DIRECTIVE

Name _____

Date of birth _____

Respecting Choices® of the Ozarks

My advance directive is filed at this health care facility

_____

City/State _____

Phone _____

My health care agent is

Name _____

Phone _____

✂----------Cut here----------

This Is an Advance Directive For:

Name _____ Date of Birth _____

Telephone
(Home)_____

(Work) _____ (Cell)_____

Address_____

City_____ State/ZIP_____

I intend for this document to be valid in any jurisdiction in which it is presented. The provisions of this document are separable, so that the invalidity of one or more provisions shall not affect any others. A copy of this document shall be as valid as the original.

Part 1: My Health Care Agent

If I can no longer make my own health care decisions, this document names the person I choose to make these choices for me. This person will be my health care agent. State law says he or she will make health care choices for me only after doctors have determined I am incapable of making health care decisions. My health care agent will make decisions about my medical care as I would if I was able. I understand that it is important for me to have ongoing talks with my agent(s) about my health care and health care choices.

This is a Durable Power of Attorney, and the authority of my health care 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.

My health care agent, acting under the powers of this document, will not become financially responsible for my expenses. If my agent(s) has reasonable expenses for carrying out my wishes, they can be reimbursed for them. Examples of such expenses are mileage, copies, etc. No person who relies on my health care agent(s) for carrying out my wishes will be liable to me or my estate for doing so.

The person I choose as my health care agent is:

Name_____ Relationship_____
Telephone (Home)_____
(Work) _____ (Cell)_____
Address_____City _____State/ZIP _____

If that person is unable or unwilling to make decisions for me, my next choice is: Second choice (alternate health care agent):

Name _____ Relationship _____
Telephone (Home)_____
(Work) _____ (Cell) _____
Address _____City _____State/ZIP _____

Initial_____

If this alternate health care agent is unable or unwilling to make these choices for me, **then my next choice for a health care agent is:**

Third choice (2nd alternate health care agent):

Name _____ Relationship _____
Telephone (Home)_____
(Work) _____ (Cell) _____
Address _____City _____State/ZIP _____

Initial the box before the statement you agree with:

☐ Initial here if you do NOT have an agent and wish for your providers to use this document.

IF I HAVE NOT DESIGNATED AN AGENT IN THE DURABLE POWER OF ATTORNEY, PART III OF THIS DOCUMENT IS MEANT TO BE IN FULL FORCE AND EFFECT AS MY HEALTH CARE DIRECTIVE.

☐ This document goes into effect when ONE physician decides that I can't make my health care decisions.

☐ This document goes into effect when TWO physicians decide that I can't make my health care decisions.

Part 2: General Authority of the Health Care Agent

I want my health care agent to be able to do the following:

*Draw a line through anything listed below that you do **not** want your health care agent to do. For example, it should look like this: ~~Decide on~~*

- Decide on tests, medicine, surgery and other medical care. If treatment has started, my agent can keep it going or stop it, based on my instructions or my best interests.
- Interpret my instructions based on what he or she knows of my preferences and values.
- Review and release my medical records and personal files as needed for my medical care.
- Decide whether organs or tissues (anatomical gifts) can be donated after my death according to my preferences and values.
- Make all necessary arrangements for my medical care, including hospital, psychiatric treatment facilities, hospice, nursing home, or any other health care organizations in Missouri or any other state as my health care agent feels necessary.
- Sign an out-of-hospital Do Not Resuscitate Order (which must also be signed by a physician).
- Determine which health care professionals and organizations provide my medical treatment.

Initial_____

Initial the box beside the statement you agree with:

Withholding or Withdrawal of Feeding Tube

☐ **Yes**, **my health care agent can make the decision** to have feeding tubes, including IV hydration, withheld or withdrawn from me.

☐ **No, my health care agent cannot make the decision** to have feeding tubes, including IV hydration, withheld or withdrawn from me.

Part 3: Statement of Desires, Special Provisions, or Limitations

My health care agent shall make decisions consistent with my stated desires and values. He or she is subject to any special instructions or limitations that I may list here.

If there are conflicts among my known values and goals, I want my health care agent to make the decision that would best represent my values and preferences. If I require treatment in a state that does not recognize this advance directive, or my health care agent cannot be contacted, I want the instructions to be followed based on my common law and constitutional right to direct my own health care.

If you choose **not** to provide any instructions, it is recommended that you draw a line and write "no instructions" across the section.

If you choose **not** to provide any instructions, your health care agent will make decisions based on your prior conversations or what is considered your best interest.

To complete this part:

Initial the box beside the one statement you agree with.
*You may add **other specific care instructions** on the next page.*

1. Treatments that may prolong life if I am in this situation.

With either choice below, I understand I will be kept clean and comfortable. I will continue to receive pain and comfort medicines, and food and fluids by mouth if I can swallow safely.

If I am sick or injured and my doctors believe there is little chance I will recover the ability to know who I am, who my family and friends are, or where I am, this is my choice:

☐ **I want to refuse or stop all life-prolonging treatments**. Some examples are a machine that breathes for me (respirator/ventilator), feeding tubes, blood products, antibiotics, or fluids given to me through an IV, treatments for chronic medical conditions, or other medications.

☐ **I want to receive all life-prolonging treatments,** unless my doctor determines the treatments would harm me more than help me.

Initial_____

2. Cardiopulmonary resuscitation (CPR).

Initial the box beside the one statement you agree with.

Based on my current health, this is my choice about CPR if my heart or breathing stops:

☐ I want CPR attempted ***unless*** my treating provider determines:

- I have a serious medical condition and no reasonable chance of survival with CPR, OR
- CPR would harm me more than help me.

☐ I do not want CPR. Let me die a natural death.

If you do not want emergency personnel to give you CPR, you will need to talk to your health care provider about other documents you need.

Other instructions or limitations I want my health care agent to follow:

Upon My Death

I authorize my health care agent to make choices about what happens to my body after death.

These are instructions for after my death. If I've chosen not to let my health care agent make these decisions (page 3), I ask that my next of kin and physician follow these requests if possible.

Donation of my Organs or Tissue (Anatomical Gifts) *Examples of organs are kidney, liver, heart, and lungs. Examples of tissue are eyes, skin, bones, and heart valves.*

Initial the box beside the one statement you agree with.

☐ A. I do not wish to donate any part of my body.

☐ B. After I die, I wish to donate any parts of my body that may help others.*

☐ C. After I die, I wish to donate **only** the following organs and tissue*:

_____

*If you checked B or C, register in your state at www.DonateLife.net.

Funeral or Final Arrangements *Initial the box beside your choice below.*

☐ I have made arrangements through the following funeral home:

_____

☐ I have not made any funeral or final arrangements but my wishes are as follows:

Initial_____

Part 4: Making the Document Legal

This document must be signed and dated **in front of two witnesses** who meet the qualifications listed below. **If naming a health care agent in Part 1, Missouri law requires a notary's signature, *so a notary must be present when you sign.***

My Signature
I am thinking clearly, I agree with everything that is written in this document, and I have completed this document willingly.

My signature _____ Date _____

Statement of Witnesses
By signing this document as a witness, I certify I am:

- At least 18 years old.
- Not related by blood, marriage, domestic partnership, or adoption to the person signing this document.
- Not a health care agent appointed by the person signing this document.

I know this to be the person identified in the document. I believe him or her to be of sound mind and at least 18 years old. I personally witnessed him or her sign this document, and I believe that he or she did so voluntarily.

Witness Number One:

Signature_____

Date_____

Print Name_____

Address_____

City_____

State/ZIP_____

Witness Number Two:

Signature_____

Date_____

Print Name_____

Address_____

City_____

State/ZIP_____

NOTARY ACKNOWLEDGEMENT

STATE OF MISSOURI)
) SS
COUNTY OF_____)

On this _____ day of _____ (month), _____ (year),

before me personally appeared _____,
to me known to be the person described in 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)

Initial_____