Initials

Michigan Department of Health and Human Services

PATIENT ADVOCATE DESIGNATION

Instructions for Completing DCH-3916

For questions and/or problems, or help to translate, call the Beneficiary Help Line at 1-800-642-3195 or TTY 1-866-501-5656.

Spanish: Si necesita ayuda para traducir o entender este texto, por favor llame al telefono, 1-800-642-3195 or TTY 1-866-501-5656

Arabic: TTY 1-866-501-5656

إذا كان لديكم أيّ سؤال، يرجى الإتصال بخط المساعدة على الرقم المجاني ٣١٩٥-٦٤٢-٠٠٨٠-١

Important Information about a Patient Advocate Designation

You have the right to name a person to make treatment decisions for you if you become so seriously ill or injured that you cannot make these decisions for yourself. This person is called your "patient advocate." You can select someone to be your patient advocate by using this "Patient Advocate Designation" form.

This is an important legal document. It can affect decisions about your health care. A separate document, titled "Frequently Asked Questions about a Patient Advocate Designation," is also available. This document explains what a patient advocate designation is, why it is important and how to complete the Patient Advocate Designation form (DCH-3916). A copy of this document can also be found here:

www.michigan.gov/advancedirective

Make sure that you have read this document and ask for help if you have questions. If you do not want a patient advocate, you do not have to complete this form. However, you may want to keep this page for your records.

☐ I decline to complete this form.

If you choose not to complete this form, you do not have to do anything further. This means that if you do not want to choose a patient advocate using this form, you do not have to share this form with the Peace of Mind Registry (either by mail or online).

If you do choose to complete the form, here are a few things to keep in mind:

Witnesses are required.

- Do not sign the form until you have picked out two witnesses. You must have two witnesses with you when you sign this form.
- There are restrictions on who can be a witness. The "Frequently Asked Questions about a Patient Advocate Designation" document explains who can be a witness.

You have choices.

- It is a good idea to select a second person, or a "successor patient advocate" in case the first person you choose is unable to serve for any reason.
- You can write down any wishes you have in this form. Your patient advocate must follow any wishes you write in this form or that you share with them in another way.
- There are some optional sections on life-support treatment, mental health treatment and organ donation. You can complete these sections or leave them blank.

You have responsibilities.

- Your patient advocate must also sign an acceptance as part of this form. If you select a "successor patient advocate" they must also accept by signing this form.
- You, your doctor, and your patient advocate should have a copy of a complete and signed form. You may also send a copy to the Peace of Mind Registry, or upload it to the Registry's website. The “Frequently Asked Questions about a Patient Advocate Designation” document explains how to do this.

You have rights.

- You have the right to decide your own health care as long as you are able to do so. Completing this form does not change that.
- Your patient advocate will only be able to make decisions for you when a doctor and another provider determine that you cannot participate in your care anymore.

Initials

Michigan Department of Health and Human Services

PATIENT ADVOCATE DESIGNATION

(Print or type your full name)

Street Address, City, State, and Zip Code

Date of Birth

Last 4 digits of Social Security Number

I, _____ (Print or type your full name), am of sound mind and I voluntarily make this designation. The person I choose as my patient advocate is:

Name

Telephone Number

Street Address, City, State, and Zip Code

If my first choice cannot serve, I have chosen another person as my second choice or my "successor patient advocate." The person I choose as my successor patient advocate is:

Name

Telephone Number

Street Address, City, State, and Zip Code

My patient advocate or successor patient advocate must sign this form before he or she can act. I have talked with the individuals I have chosen as patient advocate and successor patient advocate.

GENERAL POWERS

My patient advocate or successor patient advocate shall have power to make care, custody and medical treatment decisions for me only if my attending physician and another physician determine I am unable to participate in medical treatment decisions. For mental health decisions, the second health care professional may be a licensed psychologist.

☐ My religious beliefs prohibit me from having an examination by a doctor, licensed psychologist or other medical professional. A determination of my inability to make decisions or provide informed consent for mental health treatment will be made by: _____

In making decisions, my patient advocate shall try to follow my previously expressed wishes, whether those wishes were spoken, written down in another document, or are in this designation.

In making decisions, my patient advocate has authority to consent to or refuse treatment on my behalf, arrange medical and personal services for me, and pay for such services with my funds.

In making decisions, my patient advocate shall have access to any of my medical records to which I have a right, as well as my birth certificate and other legal documents needed to apply for Medicare, Medicaid or other government programs.

I may change my mind at any time by communicating in any manner that this designation does not reflect my wishes.

It is my intent that no one involved in my care shall be liable for honoring my wishes as expressed in this designation, or for following the directions of my patient advocate.

Initials

Photocopies of this document can be relied upon as though they were originals.

STATEMENT OF WISHES

My patient advocate has the power to make a wide variety of treatment decisions. In this document, I can write down my general wishes for the care I would like to receive, like wanting to stay in my home or be treated by a certain doctor or hospital. I can also list specific treatments that I do or do not want for certain serious illnesses, injuries or disabilities. I can also state no wishes at all. If I choose not to write down any wishes, this choice shall not be interpreted as limiting the power of my patient advocate.

☐ I choose not to write any wishes in this document;

OR

☐ My wishes are as follows (you may attach more sheets of paper):

_____

_____

_____

_____

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 death. My patient advocate can sign a do-not-resuscitate declaration for me. My patient advocate can refuse food and water administered to me through tubes.

_____ _____

(Sign your name if you wish to give your patient advocate this authority) Date

POWER REGARDING ORGAN DONATION

(OPTIONAL)

I expressly authorize my patient advocate to make a gift of the following: *(check any that reflect your wishes)*

☐ any needed organs or body parts for the purposes of transplantation, therapy, medical research or education
☐ only the following listed organs or body parts for the purposes of transplantation, therapy, medical research or education: _____
☐ my entire body for anatomical study
☐ I wish my gift to go to: _____

The gift is effective upon my death. Unlike other powers I give to my patient advocate, this power remains after my death.

_____ _____

(Sign your name if you wish to give your patient advocate this authority) Date

Initials

POWER REGARDING MENTAL HEALTH TREATMENT

(OPTIONAL)

I expressly authorize my patient advocate to make decisions concerning the following treatments if a physician and a mental health professional determine I cannot give informed consent for mental health care: (*check one or more consistent with your wishes)*

- ☐ outpatient therapy
- ☐ my admission as a formal voluntary patient to a hospital to receive inpatient mental health services. I have the right to give three days' notice of my intent to leave the hospital
- ☐ my admission to a hospital to receive inpatient mental health services
- ☐ psychotropic medication
- ☐ electro-convulsive therapy (ECT)
- ☐ I give up my right to have a revocation effective immediately. If I revoke my designation, the revocation is effective 30 days from the date I communicate my intent to revoke. Even if I choose this option, I still have the right to give three days' notice of my intent to leave a hospital if I am a formal voluntary patient.

I have specific wishes about mental health treatment, such as a preferred mental health professional, hospital or medication. My wishes are as follows (you may attach more sheets of paper):

_____

_____

_____

_____ _____

(Sign your name if you wish to give your patient advocate this authority) Date

SIGN THIS DOCUMENT ON THE FOLLOWING PAGE, ALONG WITH YOUR WITNESSES.

Initials

SIGNATURE

I sign this document voluntarily, and I understand its purpose.

Date | Your Signature

Your Telephone | Your address (Street Address, City, State and Zip Code)

STATEMENT REGARDING WITNESSES

I have chosen two adult witnesses who are not named in my will; who are not my spouse, parent, child, grandchild, brother, sister or presumptive heir; who are not my physician or my patient advocate; who are not an employee of my life or health insurance company; who are not an employee of a home for the aged where I reside; who are not an employee of community mental health program providing me services; and who are not an employee of the health care facility where I am now.

STATEMENT AND SIGNATURE 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, without duress, fraud or undue influence.

Date | Print Name

Signature of Witness

Witness address (Street Address, City, State and Zip Code)

Date | Print Name

Signature of Witness

Witness address (Street Address, City, State and Zip Code)

FOR YOUR PATIENT ADVOCATE:

The role of the patient advocate is defined in Michigan law. As an advocate, it is important that you understand the authority, limitations, rights and responsibilities that apply when you accept this role.

The following list describes some of these rights and responsibilities as described by law. By signing this form, you are accepting these responsibilities. If you have any questions about your duties, refer to the "Frequently Asked Questions about a Patient Advocate Designation" document or ask a lawyer to help you.

Initials

ACCEPTANCE BY PATIENT ADVOCATE

(1) This designation shall not become 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 in 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 which 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 or 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 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.

I, _____ , understand the above conditions and I
(Name of patient advocate)

accept the designation as patient advocate for

_____ , who signed a patient advocate designation for health care on the
(Name of patient)

following date: _____

Signed:

_____ _____
Signature of patient advocate Date

Initials

I, _____, understand the above conditions and I
(Name of successor patient advocate)
accept the designation as successor patient advocate for
_____, who signed a patient advocate designation for health care on the
(Name of patient)
following date: _____

Signed:

_____ _____
Signature of successor patient advocate Date

Authority: The MCL 400.105(d)(1)(g) Completion: Is optional for Healthy Michigan Plan members.	Michigan Department of Health and Human Services is an equal opportunity employer.