The Rest Of Your Life www.theroyl.com

Advance Directive and Durable Power of Attorney

Living Will and Durable Power of Attorney for Health Care

State of Michigan

The Rest of Your Life recommends that you review completed documents with an attorney, especially if there are mitigating circumstances surrounding your Advance Directive or Durable Power of Attorney.

Advance Directives Electronic Forms

The ROYL is a leader in offering electronic Advance Directive documents for digital signatures. Electronic Advance Directive Forms are secure and accessible anytime from any device that allows for Internet access.

Why do an Advance Directive?

Anyone 18 years of age or older should have an Advance Directive. This document allows for the care you have designated to be respected and followed through in the event you cannot speak for yourself. It allows for you to name someone to speak on your behalf, but most importantly it removes the stress, anxiety and guilt from decisions that your loved ones would otherwise have to make on your behalf.

An Advance Directive is not just for aging people. The cases of Teri Shivo and Karen Ann Quinlan serve as examples of how any adult, regardless of age, can benefit from having one. Both young adults, Shivo and Quinlan were kept alive by machines for years because they did not tell or write down what they wanted in the event of a tragic accident. The court battles that ensued took not only an emotional toll, but required government involvement because of disagreements between spouses and family members.

Description:

An Advance Directive, sometimes referred to as a Living Will or an Advance Health Care Directive, allows you to make your wishes known if you are unable to speak for yourself. An Advance Directive provides you and your loved ones with peace of mind that your care is compatible with your wishes. This is truly a gift to those you love as it helps them clearly know what to do in this stressful situation.

Advance Directive requirements vary from state to state. You can download the appropriate state form here at no cost prior to completing the form online so that you have the required information prepared in advance.

Security:

Your documents are processed using DocuSign, the leader in global electronic signature and document security.

When you complete your Advance Directive with The ROYL, you can download it as a PDF file to your computer's hard drive. DocuSign will email a final copy to the designees in your Advance Directive. We recommend you print a hard copy and send it via email or mail to others you want to have copies.

Contact us if you have questions in preparing the forms selected.

NOTICE: You must have the required information available prior to initiating the document (designees, contact information, wishes for care).

Michigan

LIVING WILL

I, EXAMPLE, am of sound mind, and I voluntarily make this declaration.

If I become terminally ill or permanently unconscious as determined by my doctor and at least one other doctor, and if I am unable to participate in decisions regarding my medical care, I intend this declaration to be honored as the expression of my legal right to consent to or refuse medical treatment.

My desires concerning medical treatment are _____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

My family, the medical facility, and any doctors, nurses and other medical personnel involved in my care shall have no civil or criminal liability for following my wishes as expressed in this declaration.

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

Photostatic copies of this document, after it is signed and witnessed, shall have the same legal force as the original document.

I sign this document after careful consideration. I understand its meaning and I accept its consequences.

Signed: _____ Dated: _____

Address: _____

_____

This declaration was signed in our presence. The declarant appears to be of sound mind, and to be making this declaration voluntarily without duress, fraud or undue influence.

Signed by witness: _____

Address: _____

_____

Signed by witness: _____

Address: _____

_____

DURABLE POWER OF ATTORNEY
FOR HEALTH CARE

(also available in printable PDF format from the State Bar of Michigan)

DURABLE POWER OF ATTORNEY
FOR HEALTH CARE

I, EXAMPLE _____,

(Print or type your full name)

am of sound mind, and I voluntarily make this designation.

I designate_____, (insert name of patient advocate)

my
_____ , (Spouse, child, friend ...)

living at _____
(Address of patient advocate)

as my patient advocate to make care, custody and medical treatment decisions for me in the event I become unable to participate in medical treatment decisions. If my first choice cannot serve, I designate _____ (Name of successor)

living at_____(Address of successor)

to serve as patient advocate.

The determination of when I am unable to participate in medical treatment decisions shall be made by my attending physician and another physician or licensed psychologist.

In making decisions for me, my patient advocate shall follow my wishes of which he or she is aware, whether expressed orally, in a living will, or in this designation.

My patient advocate has authority to consent to or refuse treatment on my behalf, to arrange medical services for me, including admission to a hospital or nursing care facility, and to pay for such services with my funds. My patient advocate shall have access to any of my medical records to which I have a right.

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.

_____

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

My specific wishes concerning health care are the following: (if none, write "none")

_____

_____

_____

_____

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 my family, the medical facility, and any doctors, nurses and other medical personnel involved in my care shall have no civil or criminal liability for honoring my wishes as expressed in this designation or for implementing the decisions of my patient advocate.

Photostatic copies of this document, after it is signed and witnessed, shall have the same legal force as the original document.

I sign this document after careful consideration. I understand its meaning and I accept its consequences.

Signed: EXAMPLE Date: _____

Address: _____

_____

NOTICE REGARDING WITNESSES

You must have two adult witnesses who will not receive your assets when you die (whether you die with or without a will), and who are not your spouse, child, grandchild, brother or sister, an employee of a company through which you have life or health insurance, or an employee at the health care facility where you are a patient.

STATEMENT 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.

Signed by witness: _____

_____
(Print or type full name)

Address: _____

_____

Signed by witness: _____

_____
(Print or type full name)

Address: _____

_____

ACCEPTANCE BY PATIENT ADVOCATE

(A) This designation shall not become effective unless the patient is unable to participate in treatment decisions.

(B) A patient advocate shall not exercise powers concerning the patient's care, custody and medical treatment that the patient, if the patient were able to participate in the decision, could not have exercised in his or her own behalf.

(C) 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.

(D) 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.

(E) 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.

(F) 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 treatment decisions are presumed to be in the patient's best interests.

(G) A patient may revoke his or her designation at any time or in any manner sufficient to communicate an intent to revoke.

(H) 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.

(I) 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 accept the designation as patient advocate for EXAMPLE _____

Dated:_____Signed: _____

Additional Page: