The Rest Of Your Life www.theroyl.com

Advance Directive and Durable Power of Attorney

Durable Power Of Attorney for Health Care Choices & Health Care Choices Directive

State of Missouri

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).

DURABLE POWER OF ATTORNEY FOR HEALTH CARE CHOICES & HEALTH CARE CHOICES DIRECTIVE

6-PAGE FORM

Part I. Durable power of attorney for health care choices

I, EXAMPLE _____, _____,
Name Social Security number

appoint

_____, _____,
Name Phone

_____
Address

as my agent for health care choices when I am unable to make decisions or communicate my wishes. In the case the person above cannot serve as my agent, or if I am divorced from or legally separated from the agent above, I appoint the person below:

_____, _____,
Name Phone

_____
Address

This alternate agent may make health care decisions for me when I am unable to do so or to communicate my wishes.

This durable power of attorney becomes effective when **two** physicians certify that I am incapacitated and unable to make and communicate health care choices.

You may choose to have one physician, instead of two, determine whether you are incapacitated. If you want to exercise this option — allowing one physician to determine whether you are incapacitated — initial here.

By completing this durable power of attorney, I authorize my agent to make all decisions for me regarding my health care. This includes the power to withdraw any type of health care, treatment or procedure, even if I may die in the process. I expect my agent to follow my health care choices directive. My agent has 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.

My agent under this durable power of attorney will not incur any personal financial liability. The agent also should not be compensated for services performed for me. However, the agent shall be reimbursed for reasonable expenses that are part of my care.

THIS IS A DURABLE POWER OF ATTORNEY AND THE AUTHORITY OF MY ATTORNEY IN FACT, 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.

Part II. Health care choices directive

I want those involved in my health care to understand my wishes if I cannot communicate or make decisions on my own. I make this directive to provide clear and convincing proof of my wishes and instructions about my health care and treatment.
If my doctor believes medical treatment will lead to my recovery, I want to have the treatment. I also want to have care and treatment for pain or discomfort even if this treatment might shorten my life, affect my appetite, slow my breathing or be habit-forming.

If I have a terminal illness or condition and there is no reasonable hope I will recover, or if I am persistently unconscious, I direct all of the life-prolonging procedures I have initialed below to be withheld or withdrawn.

I direct the following treatments to be withheld or withdrawn:

- ☐ Surgery or other invasive procedures
- ☐ Cardiopulmonary resuscitation (CPR) to restart my heart or breathing
- ☐ Antibiotics
- ☐ Dialysis
- ☐ Mechanical ventilator (respirator)
- ☐ Artificially supplied nutrition and hydration (including tube feeding)
- ☐ Chemotherapy
- ☐ Radiation therapy
- ☐ All other "life-prolonging" medical treatments or surgeries that are merely intended to keep me alive without reasonable hope of making me better or curing my illness or injury.
- ☐ I consent to the donation of my organs or tissues. I realize my body may need to be maintained artificially after my death until my organs can be removed.
- ☐ I refuse to make anatomical gifts of part or all of my body. I prohibit my agent from consenting to such gifts before or after my death.

I also give the following directions regarding my health care:

_____

_____

_____

_____

_____

_____

Optional: Describe what you consider an acceptable quality of life. For example, being able to recognize my loved ones, make decisions, communicate or feed yourself.

_____

_____

_____

_____

_____

_____

Attach extra pages if necessary. Sign and date the attached pages.

Make sure to talk about this directive and your wishes with your agent, your doctors, family, friends and clergy. Give each of them a copy of the directive. Bring a copy with you when you go to a hospital or other health care facility. Keep the original with your important papers.

Part III. Relationship between health care choices directive and durable power of attorney for health care choices

As I have executed the health care choices directive and durable power of attorney for health care choices, I trust and encourage my agent to:

- First, follow my wishes as expressed in the directive or otherwise from knowledge about me or having had discussions with me about making choices regarding life-prolonging medical treatment.
- Second, if my agent does not know my wishes for a specific decision, but my agent has evidence of what I might want, my agent can try to figure out how I would decide. This is called substituted judgment and requires my agent imagining himself or herself in my position. My agent should consider my values, religious beliefs, past choices and past statements I have made. The aim is to choose as I probably would choose, even if it is not what my agent would choose for himself or herself.
- Third, if my agent has very little or no knowledge of what I would want, then my agent and the doctors will have to make a decision based on what a reasonable person in the same situation would decide. This is called making decisions in my best interest. I have confidence in my agent's ability to make decisions in my best interest if my agent does not have enough information to follow my preferences or use substituted judgment, and if this is the case, I authorize my agent to make decisions that might even be contrary to my directive in his or her best judgment.
- Finally, if the durable power of attorney for health care choices is determined to be ineffective, or if my agent is unable to serve, the health care choices directive is intended to be used on its own as firm instructions to my health care providers regarding life-prolonging procedures.

DURABLE POWER OF ATTORNEY FOR HEALTH CARE & HEALTH CARE DIRECTIVE

Sign this form before two witnesses who are not related to you or financially connected to your estate.

IN WITNESS THEREOF, I have executed this document on _____ (MONTH) ____ (DAY), _____ (YEAR).

Signature EXAMPLE _____

Print name _____ SS No._____

Address _____

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.

Signature _____ Signature _____

Print name _____ Print name _____

Address _____ Address _____

_____ _____

Notarization required

STATE OF MISSOURI)
) SS
COUNTY OF _____)

On this ____ day of _____, in the year of _____, personally appeared before me the person signing, known by me to be the person who completed this document and acknowledged it as his/her free act and deed.

IN WITNESS WHEREOF, I have set my hand and affixed my official seal in the County of _____, State of Missouri, the day and year first above written.

_____
Notary public's signature

A letter to my loved ones...

Dear Loved Ones,

I want the best quality of life possible during my last days. Therefore, I hereby request as follows...

☐	(a) I ask that medical treatment to alleviate pain, to provide comfort, and to mitigate suffering be provided so that I may be as free of pain and suffering as possible. Please consult with my doctor in this regard.
☐	(b) If my temperature is above normal, I want a cool moist cloth put on my head.
☐	(c) I want my mouth and lips kept moist.
☐	(d) I need to be kept fresh and clean at all times. I wish to have warm baths often or warm showers, if I am stable enough for a shower.
☐	(e) I desire to be massaged with or without warm oils as often as you think will help maintain my skin integrity and provide for my comfort.
☐	(f) I want my personal care such as nail clipping, hair combing, teeth brushing and shaving as long as they do not cause me pain.

I hope my family and friends would consider that...

- [ ] (a) I enjoy your company and want you with me when possible. I desire that one of you stay with me when it seems that my death may be imminent.
- [ ] (b) Please continue to talk to me about daily happenings and events, even if you think I don't understand, because I might be able to understand.
- [ ] (c) Please don't be afraid to hold my hand or hug me.
- [ ] (d) Please tell the members of my church or synagogue I am sick and ask them to pray for me and visit me.
- [ ] (e) Please maintain a cheerful atmosphere around me.
- [ ] (f) Please place pictures of my loved ones in my room, near my bed, or near the place I sit during the day.
- [ ] (g) My clothes and bed linens are to be kept clean, and they are to be changed as soon as possible, if they have been soiled.
- [ ] (h) If at all possible, allow me to die in my home.
- [ ] (i) Please arrange for me to watch television or listen to my favorite sports events.
- [ ] (j) Let me enjoy the outdoors as often as possible by letting me spend time in my yard, garden and other appropriate outdoor places, even if it causes slight discomfort to either you or me.
- [ ] (k) I want to have my favorite types of music played when possible.
- [ ] (l) I want to have religious readings read to me when I am near death.
- [ ] (m) I want to have my favorite poems read to me from time to time.

I want you to know the following about my thoughts and concerns, if I am disabled and cannot convey these thoughts to you verbally...

(1) I want you to know that I love you. ☐

(2) I would like to be forgiven for the times I have hurt you. ☐

(3) I forgive you for what you may have done to me in my life. ☐

(4) I want you to know that I do not fear death itself. ☐

(5) I want all of my family members to recommit their love for one another. ☐

(6) Please remember me the way I was before I had a terminal illness. ☐

(7) Please help me maintain meaning to my life during this process of dying by realizing that this is an opportunity for personal growth for all. ☐

(8) Don't be afraid to seek counseling, if you have trouble with my death. ☐

If friends want to know how I want to be remembered, tell them the following...

_____

_____

_____

_____

The following person(s) know my funeral plans...

_____

_____

_____

At any memorial service for me, I want to include the following music, songs, readings or other plans for such a service...

_____

_____

_____

_____

I also have the following requests...

_____

_____

_____

_____

These are requests of my family members, loved ones, and friends, and are not to be considered legal directives to my attorney-in-fact for health care, if any.

(If you wish to change your answer, you may do so by drawing an "X" through the answer you do not want, and circling the answer you prefer.)

Dated this ____ day of _____, 20_____.

Signature EXAMPLE _____

Print Name _____

Additional Pages:

Additional Pages: