MICHIGAN MENTAL HEALTH POWER OF ATTORNEY FORM

IMPORTANT INFORMATION

This power of attorney authorizes another person (your agent) to make decisions for you (the principal). Your agent will be able to make decisions and act on your behalf, whether or not you are able to act for yourself.

This power of attorney does not authorize the agent to make health care decisions for you. Such powers are governed by applicable laws for Advance Directives.

You should select someone you trust to serve as your agent. Unless you specify otherwise, generally the agent's authority will continue until you die or revoke the power of attorney or the agent resigns or is unable to act for you.

If your agent is unable or unwilling to act for you, your power of attorney will end unless you have named a successor agent. You may also name a second successor agent.

This power of attorney becomes effective immediately unless you state otherwise in the Special Instructions.

If you have questions about the power of attorney or the authority you are granting to your agent, you should seek legal advice before signing this form.

ADVANCE DIRECTIVE
FOR MENTAL HEALTH CARE

I, _____, am of sound mind and I
(Print or type your full name) voluntarily make this designation.

APPOINTMENT OF PATIENT ADVOCATE

I designate _____, my _____,
(Insert name of patient advocate) (Spouse, child, friend …)

living at _____,
(Address of patient advocate)
telephone number _____, as my patient advocate.

If my first choice cannot serve, I designate _____,
(Insert name of patient advocate)
my_____, living
at_____ (Spouse, child, friend …)
(Address of patient advocate)
_____, telephone number _____, as my patient advocate.

GENERAL POWERS

My patient advocate can only make decisions for me if a physician and a mental health professional determine I cannot give informed consent for mental health care.

My patient advocate must sign an acceptance before he or she can act. I have talked over this appointment with the individuals I have chosen as patient advocate.

In making decisions, my patient advocate shall try to follow my wishes, whether I have talked about them or written them in this document or any other document.

I give my patient advocate power to agree to or refuse treatment as set forth below, and to pay for such services with my funds.

SPECIFIC POWERS

Following is a list of types of treatment. I can choose one or more, by writing my initials on the line. By my initialing a line, I give my patient advocate power to consent to or refuse that type of treatment. On the following pages, I can indicate my specific wishes concerning each type of treatment I initial here.

_____ The individual I have chosen as my patient advocate shall have access to any of my medical and mental health records to which I have a right, immediately upon signing an Acceptance. To grant such access, I appoint this individual as my "personal representative" as defined in the privacy provisions of the Health Insurance Portability and Accountability Act, and as my "authorized representative" as defined in the Michigan Medical Records Access Act.

_____ 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 (psychiatric medicine)

_____ electro-convulsive therapy (ECT)

_____ placement in a group residence

_____ seclusion and restraints

STATEMENT OF PREFERENCES
(optional)

1. The doctor and mental health professional I want to make the decision if I am not able to give informed consent are:

_____

2. If I need outpatient therapy, I prefer it to be provided by _____, in the following setting:
   _____

3. If I need to be hospitalized for inpatient treatment, I prefer the following hospital:
_____.

4. If I need to be hospitalized, I prefer _____ to take me to the hospital.

5. If I need medication, I prefer to receive _____ at the following dose(s) _____. I **do not** want to receive the following medication or medications:
   _____, because
   _____

6. If I have given my patient advocate authority concerning ECT treatments, I want the maximum number of treatments to be _____.
   (Write " O" if you do not want ECT)

7. Additional wishes: _____

_____

_____

_____

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REVOCATION

(Initial one statement)

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

_____ 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.

LIABILITY

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.

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

SIGNATURE

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

Dated:

_____

Signed:

_____

(Your signature)

_____

(Address)

STATEMENT REGARDING WITNESSES

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

_____

(Print name) (Signature of witness)

_____

(Address)

_____ _____

(Print name) (Signature of witness)

_____

(Address)

ACCEPTANCE BY PATIENT ADVOCATE

(1)This designation shall not become effective unless the patient is unable to participate in decisions regarding the patient's mental health.

(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)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.

(4)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.

(5)The known desires of the patient expressed or evidenced while the patient is able to participate in medical or mental heath treatment decisions are presumed to be in the patient's best interests.

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

(7)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.

(8)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.

(9)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
(Name of patient advocate)
conditions and I accept the designation as patient advocate or successor patient advocate for _____, who signed an (Name of patient) advance directive for mental health care on the following date: _____.

Dated: _____

Signed: _____
(Signature of patient advocate or successor patient advocate)