Introduction to Your Missouri Durable Power of Attorney and Living Will

This packet contains a legal document, a Missouri Durable Power of Attorney and Living Will, that protects your right to refuse medical treatment you do not want, or to request treatment you do want, in the event you lose the ability to make decisions yourself. You may complete Part I, Part II, or both, depending on your advance-planning needs. You must complete Part III.

Part I, Durable Power of Attorney, lets you name someone, your agent, to make decisions about your health care - including decisions about life-sustaining treatment – if you can no longer speak for yourself. The Durable Power of Attorney is especially useful because it appoints someone to speak for you any time you are unable to make your own health-care decisions, not only at the end of life.

Part I goes into effect when your doctor determines that you are no longer able to make or communicate your health care decisions.

Part II, Living Will, lets you state your wishes about health care in the event that you can no longer speak for yourself. If you also complete Part I, your living will is an important source of guidance for your agent.

Part II goes into effect when your doctor determines that you are no longer able to make or communicate your health care decisions.

Part III contains the signature and witnessing provisions so that your document will be effective.

This form does not expressly address mental illness. If you would like to make advance care plans regarding mental illness, you should talk to your physician and an attorney about a document tailored to your needs.

Note: This document will be legally binding only if the person completing them is competent adult who is 18 years of age or older or has been married or is a parent.

Instructions for Completing Your Missouri Durable Power of Attorney and Living Will

How do I make my Missouri Durable Power of Attorney and Living Will Legal?

If you complete Part I, the Durable Power of Attorney, you (or another person at your direction, if you are unable) must sign and date this document in the presence of two adult witnesses.·The person you name as your agent or alternate agent cannot act as a witness.

If you only complete Part II, the living will, there are no special witnessing requirements. However, because your living will may be used as evidence of your wishes, it is best that you sign and date this document in the presence of witnesses just as if you had completed Part I.

Whom should I appoint as my agent?

Your agent is the person you appoint to make decisions about your health care if you become unable to make those decisions yourself. Your agent may be a family member or a close friend whom you trust to make serious decisions. The person you name as your agent should clearly understand your wishes and be willing to accept the responsibility of making health care decisions for you.

You can appoint a second person as your alternate agent. The alternate will step in if the first person you name as an agent is unable, unwilling, or unavailable to act for you.

You may not appoint the operator, administrator, or employee of a hospital where you are a patient or a resident or where you have applied for admission, unless the person is related to you by blood, marriage, or adoption. Your agent cannot also act as your attending physician. You cannot appoint, as your agent, someone who is already an agent for ten or more people, unless the agent is your spouse, child, parent, sibling, or a grandparent.

Should I add personal instructions to my Missouri Durable Power of Attorney and Living Will?

One of the strongest reasons for naming an agent is to have someone who can respond flexibly as your health care situation changes and deal with situations that one did not foresee. If you add instructions to this document it may help your agent carry out your wishes, but be careful that you do not unintentionally restrict your agent's power to act in your best interest. In any event, be sure to talk with your agent about your future medical care and describe what you consider to be an acceptable "quality of life."

What if I change my mind?

You may revoke your advance directive by notifying your agent or health care provider orally or in writing, or by any other act that clearly shows your intent to revoke the document. Such acts might include tearing up your advance directive, signing a written revocation, or executing a new advance directive with different terms.

Go to Complete FAQs & Instructions | Reset or Clear Form | READ BEFORE PRINTING | Print Form

DURABLE POWER OF ATTORNEY FOR HEALTH CARE AND/OR HEALTH CARE DIRECTIVE OF

(Print full name here) _____

(Address, City, State, Zip) _____

PART I. DURABLE POWER OF ATTORNEY FOR HEALTH CARE

(If you *DO NOT WISH* to name someone to serve as your decision-making Agent, mark an "X" through Part I on pages 1 & 2 and continue on to Part II.)

1. **Selection of Agent**. I, _____, currently a resident of Select County County, Missouri, appoint the following person as my true and lawful attorney-in-fact ("Agent"):

Name: _____

Address: _____

_____

Phone(s): 1st _____ 2nd _____

2. **Alternate Agent**. If my Agent resigns or is not able or available to make health care decisions for me, or if an Agent named by me is divorced from me or is my spouse and legally separated from me, I appoint the following persons in the order named below to serve as my alternate Agent and to have the same powers as my Agent:

First Alternate Agent:

Name: _____

Address: _____

_____

Phone(s): 1st _____

2nd _____

Second Alternate Agent:

Name: _____

Address: _____

_____

Phone(s): 1st _____

2nd _____

3. **Durability**. This is a Durable Power of Attorney, and the authority of my 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.

4. **Effective Date as to Health Care Decision Making**. This Durable Power of Attorney is effective as to health care decision making when I am incapacitated and unable to make and communicate a health care decision as certified by ***(check one of the following boxes):*** ☐ one physician **OR** ☐ two physicians.

5. **Agent's Powers**. I grant to my Agent full authority as to health care decision making to:

A. Give consent to, prohibit, or withdraw any type of health care, long-term care, hospice or palliative care, medical care, treatment, or procedure, either in my residence or a facility outside of my residence, even if my death may result, including, but not limited to, an out of hospital do-not-resuscitate order, with the following specific authorization ***(initial one of the following boxes to indicate your choice):***

_____ **Initials** I wish to AUTHORIZE my Agent to direct a health care provider to withhold or withdraw artificially supplied nutrition and hydration (including tube feeding of food and water);

_____ **Initials** OR I DO NOT AUTHORIZE my Agent to direct a health care provider to withhold or withdraw artificially supplied nutrition and hydration (including tube feeding of food and water);

B. Make all necessary arrangements for health care services on my behalf and to hire and fire medical personnel responsible for my care;

C. Move me into, or out of, any health care or assisted living/residential care facility or my home (even if against medical advice) to obtain compliance with the decisions of my Agent;

D. Take any other action necessary to do what I authorize here, including, but not limited to, granting any waiver or release from liability required by any health care provider and taking any legal action at the expense of my estate to enforce this Durable Power of Attorney for Health Care;

E. Receive information regarding my health care, obtain copies of and review my medical records, consent to the disclosure of my medical records, and act as my "personal representative" as defined in the regulations [45 C.F.R. 164.502(g)] enacted pursuant to the Health Insurance Portability and Accountability Act of 1996 ("HIPAA");

6. **Effective Date as to Other Authority.** In addition to the powers set forth above, I authorize effective upon my signature and without the need for a physician's certification of incapacity that my Agent be authorized to have one or more of the following powers ***(initial your desired choices):***

_____ **Initials** Determine what happens to my body after my death (authority for right of sepulcher);

_____ **Initials** Give consent after my death to an autopsy or postmortem examination of my remains;

_____ **Initials** Delegate health care decision-making power to another person ("Delegee") as selected by my Agent, and the Delegee shall be identified in writing by my Agent;

With respect to anatomical gifts of my body or any part (i.e., organs or tissues), please initial your desired choice below:

_____ **Initials** **AUTHORIZATION OF ANATOMICAL GIFTS**. I wish to AUTHORIZE my Agent to make an anatomical gift of my body or part (organ or tissue).

My donations are for the following purposes: (check one)	GIFT SPECIFICATIONS: (check one) I would like to donate
☐ Transplantation ☐ Therapy ☐ Research ☐ Education ☐ All the above	☐ Any needed organs and tissues, as allowed by law. ☐ Any needed organs and tissues as allowed by law, with the following restrictions:

_____ **Initials** **PROHIBITION OF ANATOMICAL GIFTS**. I DO NOT AUTHORIZE my Agent to make an anatomical gift of my body or any part (organ or tissue).

7. **Agent's Financial Liability and Compensation**. My Agent, acting under this Durable Power of Attorney for Health Care, will incur no personal financial liability. My Agent shall not be entitled to compensation for services performed under this Durable Power of Attorney for Health Care, but my Agent shall be entitled to reimbursement for all reasonable expenses incurred as a result of carrying out any provisions hereof.

PART II. HEALTH CARE DIRECTIVE

(If you *DO NOT WISH* to make a health care directive but only wish to have an Agent make your decisions without the directive, be sure that you have completed Part I on pages 1 & 2, mark an "X" through Part II on pages 2 & 3 and continue to Part III.)

1. I make this HEALTH CARE DIRECTIVE ("Directive") to exercise my right to determine the course of my health care and to provide clear and convincing proof of my choices and instructions about my treatment.

2. If I am persistently unconscious or there is no reasonable expectation of my recovery from a seriously incapacitating or terminal illness or condition, I direct that all of the life-prolonging procedures that I have initialed below be withheld or withdrawn.

_____ Initials **artificially supplied nutrition and hydration (including tube feeding of food and water)**

_____ Initials **surgery or other invasive procedures**

_____ Initials **heart-lung resuscitation (CPR)**

_____ Initials **antibiotics**

_____ Initials **dialysis**

_____ Initials **mechanical ventilator (respirator)**

_____ Initials **chemotherapy**

_____ Initials **radiation therapy**

_____ Initials **other procedures specified by me (insert) _____**

_____ Initials **all other "life-prolonging" medical or surgical procedures that are merely intended to keep me alive without reasonable hope of improving my condition or curing my illness or injury**

3. However, if my physician believes that any life-prolonging procedure may lead to a recovery significant to me as communicated by me or my Agent to my physician, then I direct my physician to try the treatment for a reasonable period of time. If it does not cause my condition to improve, I direct the treatment to be withdrawn even if it shortens my life. I also direct that I be given medical treatment to relieve pain or to provide comfort, even if such treatment might shorten my life, suppress my appetite or my breathing, or be habit-forming.

4. If I have already consented to be on the Missouri organ and tissue donor registry or my Agent has authorized the donation of my organs or tissues, I realize it may be necessary to maintain my body artificially after my death until my organs or tissues can be removed.

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

PART III. GENERAL PROVISIONS INCLUDED IN THE DURABLE POWER OF ATTORNEY FOR HEALTH CARE AND HEALTH CARE DIRECTIVE

1. Relationship Between Durable Power of Attorney for Health Care and Health Care Directive . If I have executed both the Durable Power of Attorney for Health Care and Health Care Directive, I encourage my Agent to:

A. First, follow my choices as expressed in the above Directive or otherwise from knowing me or having had various discussions with me about making decisions regarding life-prolonging procedures.

B. Second, if my Agent does not know my choices for the specific decision at hand, but my Agent has evidence of my preferences, my Agent can determine how I would decide. My Agent should consider my values, religious beliefs, past decisions, and past statements. The aim is to choose as I would choose, *even if it is not what my Agent would choose for himself or herself.*

C. Third, if my Agent has little or no knowledge of choices I would make, then my Agent and the physicians will have to make a decision based on what a reasonable person in the same situation would decide. 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.

D. Finally, if the Durable Power of Attorney for Health Care is determined to be ineffective, or if my Agent is not able to serve, the Health Care Directive is intended to be used on its own as firm instructions to my health care providers regarding life-prolonging procedures.

2. Protection of Third Parties Who Rely on My Agent. No person who relies in good faith upon any representations by my Agent or Alternate Agent shall be liable to me, my estate, my heirs or assigns, for recognizing the Agent's authority.

3. Revocation of Prior Durable Power of Attorney for Health Care or Health Care Directive. I revoke any prior living will, declaration or health care directive executed by me. If I have appointed an Agent in a prior durable power of attorney, I revoke any prior health care durable power of attorney or any health care terms contained in that other durable power of attorney and intend that this Durable Power for Attorney for Health Care (if completed) and this Health Care Directive (if completed) replace or supplant earlier documents or provisions of earlier documents.

4. Validity. This document is intended 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.

IF YOU HAVE COMPLETED THE ENTIRE DOCUMENT OR ONLY THE DIRECTIVE (PART II), YOU MUST SIGN THIS DOCUMENT IN THE PRESENCE OF TWO WITNESSES.

IN WITNESS WHEREOF, I signed this document on _____(month, date),_____(year).

_____
Signature
Printed Name: _____

WITNESSES: 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 eighteen years of age.

Signature	_____	Signature	_____
Print Name	_____	Print Name	_____
Address	_____	Address	_____
	_____		_____

NOTARY ACKNOWLEDGMENT
(Only required if Part I or entire document completed.)

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)