Spectrum Health

ADVANCE CARE PLANNING (ACP) INTRODUCTION

Thank you for your interest in Advance Care Planning (ACP). This is an important step to having a say about your care.

THIS PACKET HAS THE FOLLOWING INFORMATION:

1. **What to Expect: Advance Care Planning (ACP)** (X26944)
   This is a guide to help you complete your documents.
2. **Designating/Accepting Durable Power of Attorney for Health Care (DPOAH)** (X24949)
   This is a legal document that gives permission for a specific person to speak for you when you cannot speak for yourself. Your decision maker is called a Patient Advocate.
3. **Treatment Preferences** (X24948)
   This document is a helpful tool for your Patient Advocate. In this document you say what matters most to you. You can also share any specific treatment preferences you may have, such as cardiopulmonary resuscitation (CPR) or ventilator support.
4. **Completion Checklist** (X27061)
   This will help you be sure these forms are completed correctly before sending them back to us.

INSTRUCTIONS TO RETURN:

- Return your document(s). Be sure all boxes are checked on your Completion Checklist. Call Advance Care Planning if you have questions or need help.
- RETURN YOUR DOCUMENT(S) IN ANY OF THE FOLLOWING WAYS:
  - Bring them to any Spectrum Health location.
  - Email a copy of your document(s) to: advancecareplanning@spectrumhealth.org
  - Fax 616.391.8965
  - Mail to: Advance Care Planning Department
    100 Michigan NE, MC 282
    Grand Rapids, MI 49503

IF YOU HAVE QUESTIONS OR NEED HELP:

We want to help you to complete your document(s).

Phone: 616.774.7615 Available Monday - Friday 8 a.m. to 5 p.m.
Email: advancecareplanning@spectrumhealth.org

What to Expect: Advance Care Planning (ACP)

Advance Care Planning is a process for you to reflect on your goals, values and make plans about your current and future health choices. The information below will help you understand different types of ACP forms and how to complete them. If you need assistance, the Spectum Health Advance Care Planning team is here to help.

p: 616.774.7615

e: AdvanceCarePlanning@spectrumhealth.org

Durable Power of Attorney for Health Care (DPOAH)

This form is used to designate a patient advocate, someone who can speak for you if you're unable. You will need two people to witness your signature on this form.

1. Choose your decision maker
2. Give end of life authority and express any additional wishes regarding your care
3. Sign in the presence of two witnesses
4. Capture witness signatures
5. (Optional) Patient advocate signatures

1. Choose your decision maker

You'll start by identifying the name of your preferred patient advocate and we recommend a designating a minimum of two patient advocates.

A patient advocate is a person who can, if enacted, speak for you if you are unable to. Their responsibilities may include:

- Honoring your preferences about care
- Reviewing and releasing medical records
- Arranging for medical care and treatment
- Making decisions about your living situation

Picking an appropriate patient advocate is important. This individual should:

- Be willing to take on this role and responsibility
- Have knowledge of what your preferences are
- Honor your preferences when making decisions for you, even if they disagree
- Be someone who can make medical decisions under stressful situations

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2. Give end of life authority and express any additional wishes regarding your care

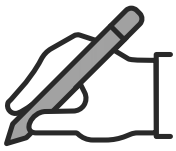
- You'll have the opportunity to give your patient advocate the authority to make medical decisions that could result in your death
- If this authority is not given, your patient advocate won't be able to remove you from ventilator support, for example
- On this page, you'll also be able to indicate any specific wishes concerning your care, including any religious beliefs that prevent an examination by a doctor, licensed psychologist or other medical professional

3. Wait to sign your document until you have your two witnesses with you

Your witnesses must:

- Be at least 18 years of age
- Not be the patient advocate or alternate patient advocate appointed by you signing this document
- Not be your spouse, parent, child, grandchild, sibling or presumptive heir, including relationships by marriage
- Not be listed to be a beneficiary of, or entitled to, any gift from your estate
- Not be directly financially responsible for the your health care
- Not be a health care provider treating you
- Not be an employee of a health care or insurance provider treating you

4. Capture witness signatures; both witnesses will share their contact information and sign



5. Patient advocate signatures (optional)

- The form is complete without patient advocate signatures, however, it's best to have them sign, if possible
- If your patient advocate is not with you, they can sign at a later date

Treatment preferences

This form is used to capture what's important to you and any specific treatment preferences.

Your signature of this form does not require witnesses.

1. Capture what's most important to you (your goals and values)
2. Make your treatment decisions
3. Identify your treatment preferences
4. Sign

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1. Capture what's most important to you (your goals and values)

- It's important for us to know your goals and values
- This helps us know you and what matters most

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2. Make your treatment decisions

There are four treatment decisions that you may share with your loved ones and health care team.

1. **If a circumstance arises where you are no longer able to recognize your family or friends and not expected to recover that ability.**
2. **If a situation arises where prolonged medical treatment is required with a low chance of survival (5 out of 100).**
3. **If your health worsens, and a decision needs to be made about using a ventilator.**
   - A medical ventilator is a machine that helps you breathe when you cannot breathe properly or when you cannot breathe on your own. A ventilator is sometimes called "life support." The ventilator moves oxygenated air in and out of your lungs through a tube in your mouth or neck to control your breathing.
   - A ventilator is most often used when you are sick, hurt or sedated during surgery. A ventilator may also be used if you have an infection, lung injury, low oxygen levels or weakened breathing muscles.
   - Ventilators are often used when having surgery as part of anesthesia. This use is usually for only a short time. It is used to do your breathing for you during surgery. If you have a chronic lung disease, your time on the ventilator may be longer when you have anesthesia. Ventilators do not treat a disease or condition; it is used to help you with breathing.
   - When using a ventilator:
     - You will not be able to talk, eat or move around while connected to the ventilator.
     - You may be given medicine to help you rest, sedatives and pain medicines. This helps you relax and be more comfortable.
     - You may have complications such as pneumonia, lung damage and confusion also known as delirium. Delirium is a change in mental abilities that results in confused thinking and reduced awareness of your environment.
     - The ventilator may damage the lungs and make your breathing muscles weak. If this happens, some people might permanently lose the ability to breathe on their own.
     - The healthier you are prior to being on the ventilator, the more likely it will be that you'll have good outcomes from the ventilator.
   - You are less likely to be helped by a ventilator if:
     - You are seriously ill from heart, lung, liver or kidney failure
     - You have a terminal illness, such as advanced cancer or advanced dementia
     - You are older, physically weak or very frail
   - If you choose not to use a ventilator, your care team will use other treatments and medications to keep you comfortable.

4. **If your heart or breathing stops, your preference for Cardiopulmonary Resuscitation (CPR).**
    - CPR stands for “cardiopulmonary resuscitation” and is performed when someone’s heart or breathing has stopped. When the heart stops beating, blood flow to the brain and other vital organs also stops. Brain damage or death can occur if this is not treated within minutes. CPR is an emergency procedure that squeezes the heart and moves blood and oxygen to the brain and lungs.
    - CPR can save lives and is most successful if you are healthy and the cause of your heart stopping can be fixed.
    - CPR is not as successful if the cause of your heart stopping is from chronic health conditions, if you are critically ill or if you are at the end of a terminal disease.
    - CPR includes:
        - Chest compressions
        - Airway support, which may include a ventilator
        - Medications
        - Electrical Shock(s) (Automated External Defibrillator (AED))
    - CPR works best and may prolong life if you are healthy and young. CPR also works best when it is started quickly, within minutes of your heart stopping. If CPR gets your heart beating again:
        - You will be admitted to the hospital
        - You will be on a ventilator in the Intensive Care Unit (ICU)
        - You may have damage or fractures to your ribs
        - You may have brain damage
        - Most who survive CPR do not return to their previous health
    - If you choose not to have CPR, a natural death will occur.

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3. Identify your end of life treatment preferences

There are four treatment preferences that you may share with your loved ones and health care team.

1. **Hospice**
    - What is hospice care?
        - Hospice is comforting care and nurturing support for patients and families who are coping with life-limiting illness
        - Goals for hospice care are complete physical, emotional and spiritual comfort for the patient, education and support for the caregivers, and enhanced qualify of life for all involved
        - The goal is that each day, the patient feels as well as possible to enjoy what really matters to him or her and that each caregiver feels equipped and prepared to provide the best care possible
    - What qualifies a person for hospice care?
        - A diagnosis of a life-limiting illness for which cure is no longer the focus
        - Certification by a physician as being appropriate for hospice care
        - Patient’s condition fits the Medicare requirements for the identified hospice diagnosis
        - Patient chooses a course of treatment that is now focused on comfort, rather than cure
        - Patient can give consent for hospice or have a representative who will give that consent on their behalf
    - What are some signs that a person may be ready for hospice?
        - A life-limiting illness is present and curative treatment is no longer being sought
        - Increase in pain, nausea, breathing distress or other symptoms that are decreasing quality of life
        - Physician efforts and treatments appear to be not making a difference or leading to more discomfort
        - The individual is tired of the frequent hospitalizations and trips to the ER and wants to remain home and be comfortable
        - He or she is emotionally withdrawn, sleeping more and less alert
        - His or her physical activity has significantly decreased

- What are some signs that a family could benefit from hospice care?
  - Family is physically and emotionally worn out from providing care
  - There is a prevalent feeling that more help is needed in the home
  - Feelings of uncertainty exist regarding how to best care for the patient and concern about what lies ahead
  - There are decisions regarding the patients care that may be made and there is confusion or conflict within the family regarding these decisions

2. **Funeral/Burial**
   People who care deeply about their impact on the environment can choose a green burial.
   - Green (or natural) burials emphasize simplicity while offering you the opportunity to be buried in a meaningful way where your body decomposes naturally
   - Examples of green burial practices include, but are not limited to, the use of non-toxic embalming chemicals, biodegradable coffins, caskets and shrouds and natural grave markers, such as trees, shrubs, perennial flowers or rocks
3. **Organ donation**
4. **Spiritual/Religious**

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4. Sign: Your signature for this form does not require witnesses

Reminder

Sharing your ACP information with your loved ones and your health care team is important. Making copies of your documents to share is acceptable.

You may share a copy of your documents with Spectrum Health in any of the following ways:

- Bring a copy to any Spectrum Health location
- Email advancecareplanning@spectrumhealth.org
- Fax 616.391.8965
- Mail to:
  Advance Care Planning Department
  MC282
  100 Michigan Street NE
  Grand Rapids, MI 49503

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ADVANCE DIRECTIVE: DESIGNATING/ACCEPTING DURABLE POWER OF ATTORNEY FOR HEALTH CARE (DPOAH)

NOTE:
- **This document was developed to meet the State of Michigan requirements for designating a Patient Advocate . It is not designed to replace the counsel of your attorney.**
- **"Individual" will mean Person designating DPOAH.**
- **On the fillable form, a signature must be signed by hand.**

DESIGNATING/ASSIGNING AUTHORITIES TO MY PATIENT ADVOCATE(S):

Individual designating this DPOAH (print) _____

Date of birth _____

DESIGNATING MY PATIENT ADVOCATE(S):

FIRST CHOICE FOR PATIENT ADVOCATE:

I designate as my Patient Advocate:

Name of first choice Patient Advocate _____

Address _____

Phone (_____) _____

ALTERNATE PATIENT ADVOCATE(S):

Second choice for Patient Advocate:

If the first individual is unable, unwilling or unavailable to serve as my Patient Advocate, then I designate as my Patient Advocate:

Name of second choice Patient Advocate _____

Address _____

Phone (_____) _____

Third choice for Patient Advocate:

If both the first and second individual is unable, unwilling or unavailable to serve as my Patient Advocate, then I designate as my Patient Advocate:

Name of third choice Patient Advocate _____

Address _____

Phone (_____) _____

PATIENT ADVOCATE ROLE AS DPOAH:

- This DPOAH is only in effect if I become unable to participate in treatment decisions.
- Medicines/treatment intended to provide comfort or pain relief will not be withheld or withdrawn.
- Exercise power in my name and for my benefit.
- Authority that includes, but is not limited to, making decisions regarding my care, custody or medical treatment.
- To help me achieve my goals of care. This may include beginning, not starting, or stopping treatment(s). I understand that such decisions could or would allow my death.

COMMUNICATION WITH MY PATIENT ADVOCATE:

- I have talked to my Patient Advocate(s) and shared my wishes.
- I have instructed my Patient Advocate(s) concerning my wishes and goals in the use of life sustaining treatment such as, but not limited to:
  - Ventilator (breathing machine)
  - Nutritional tube feedings
  - Kidney dialysis
  - Cardiopulmonary resuscitation (CPR)
  - Intravenous hydration
  - Medicines for blood pressure or antibiotics

CONTINUED ON PAGE 2 ➔

DESIGNATING/ASSIGNING AUTHORITIES TO MY PATIENT ADVOCATE(S): *(CONTINUED)*

COMMUNICATION WITH MY PATIENT ADVOCATE(S): *(CONTINUED)*

- These are my preferences/wishes for my care (e.g., including any religious beliefs that prevent an examination by a doctor, licensed psychologist, or other medical professional).
  Note: *You do not have to complete this area*

_____

_____

_____

_____

☐ **I have shared my wishes with my Patient Advocate(s) and am giving them authority to make decisions that might allow me to die. This includes having the authority to not start or stop life support or CPR.**

I UNDERSTAND:

- I do not intend for others (i.e., my family, the medical facility, doctors, nurses, other medical personnel involved in my care) to be liable for implementing the decisions of my Patient Advocate or honoring wishes expressed in this authorization.
- After it is signed and witnessed, photostatic copies of this document will have the same legal force as the original document.
- This document is to be treated as a DPOAH. It will survive my disability or incapacity.
- This Advance Directive includes Patient Advocate Acceptance and may also include Treatment Preferences.

I AGREE:

- I intend this authorization to be applied to the fullest extent possible wherever I may be.
- I am providing this designation of my own free will. I have not been told I am required to give a designation in order to receive care or to have care withheld/withdrawn.
- I am at least eighteen (18) years old.
- I am of sound mind.

SIGNATURE OF INDIVIDUAL DESIGNATING DPOAH:

DATE _____

Individual designating this DPOAH signature _____

Phone (_____) _____

WITNESSES TO INDIVIDUAL DESIGNATING DPOAH SIGNATURE:

Note: **There must be two (2) witnesses for this designation to be valid.**

AS A WITNESS, I CERTIFY THAT I AM:

- At least eighteen (18) years of age.
- Not designated as a Patient Advocate for the above Individual.
- Not the above Individual's spouse, parent, child, grandchild, sibling or presumptive heir.
- Not listed to be a beneficiary of, or entitled to, any gift from the above Individual's estate.
- Not directly financially responsible for the above Individual's health care.
- Not a health care provider treating the above Individual.
- Not an employee of a healthcare/insurance provider treating the above Individual.

CONTINUED ON PAGE 3 ➔

DESIGNATING/ASSIGNING AUTHORITIES TO MY PATIENT ADVOCATE(S): *(CONTINUED)*

WITNESSES TO INDIVIDUAL DESIGNATING DPOAH SIGNATURE: *(CONTINUED)*

Note: **There must be two (2) witnesses for this designation to be valid.**

I AM WITNESSING:

- The above Individual designating their Power of Attorney to their Patient Advocate(s).
- The above Individual is signing voluntarily and without duress, fraud, or undue influence.
- The above Individual is at least eighteen (18) years of age.
- I understand the above Individual to be of sound mind.

Witness One:

Witness One signature _____

Witness One (print) _____

Address _____

Witness Two:

Witness Two signature _____

Witness Two (print) _____

Address _____

INTERPRETATION SERVICES

I certify that I have interpreted, to the best of my ability, into and from the participant's stated primary language, _____, all oral presentations made by all of those present during the informed consent discussion.

TIME _____ ☐ AM ☐ PM **DATE** _____ Interpreter signature _____

Interpreter name (print) _____

CONTINUED ON PAGE 4 FOR "RECORD ADVANCE DIRECTIVE: ACCEPTING ROLE OF PATIENT ADVOCATE DESIGNATED IN DURABLE POWER OF ATTORNEY FOR HEALTHCARE (DPOAH)" ➔

ACCEPTING ROLE OF DPOAH:

NOTE: • **"Individual" will mean Person designating DPOAH.**
• **On the fillable form, a signature must be signed by hand.**

Individual designating this DPOAH (print) _____
Date of birth _____

I UNDERSTAND AND AGREE THAT, ACCORDING TO MICHIGAN LAW:

- This DPOAH is only in effect if the Individual becomes unable to participate in medical or mental health treatment decisions.
- I will not exercise powers concerning the Individual's care, custody or medical/mental health treatment that Individual (if he/she were able to participate in the decision) could not have exercised on his/her own behalf.
- If the Individual is pregnant, I cannot make a medical treatment decision to withhold or withdraw treatment if that would result in the Individual's death, even if these were the Individual's wishes.
- I can make a decision to withhold or withdraw treatment which would allow the Individual to die. I can do this only if the Individual has expressed clearly that I am permitted to make such a decision, and if I understand that such a decision could or would allow his or her death.
- I may not receive payment for serving as Patient Advocate, but I can be reimbursed for actual and necessary expenses which I incur in fulfilling my responsibilities.
- A fiduciary acts on behalf of the Individual. They put the Individual's best interests ahead of their own and have a duty to preserve good faith and trust. I will act as the Individual's fiduciary. The Individual may have expressed his/her treatment preferences or shown in past decisions (while he/she was able to participate in medical or mental health treatment decisions). These are presumed to be in the Individual's best interests.
- The Individual may revoke (take back) his/her designation of me as Patient Advocate at any time and in any manner sufficient to communicate an intent to revoke.
- For mental health treatment decisions, the Individual may waive (give up) the right to revoke his/her designation of me as Patient Advocate. If such waiver is made, the Individual's ability to revoke (for mental health treatment decisions) will be delayed for 30 days after he/she communicates his/her intent to revoke.
- I may revoke my acceptance of my role as Patient Advocate any time and in any manner sufficient to communicate an intent to revoke.
- If an Individual is admitted to a health facility or agency, he/she has the rights enumerated in Section 20201 of the Michigan Public Health Code, Exercise of Rights by Individual's Representative 1978 PA 368, MCL 333.20201.

CONTINUED ON PAGE 5 ➔

ACCEPTING ROLE OF DPOAH:

Note: Refer to DURABLE POWER OF ATTORNEY FOR HEALTH CARE (DPOAH) for the order Patient Advocate(s) are designated.

FIRST CHOICE FOR PATIENT ADVOCATE:

- I am at least 18 years of age.
- I accept the role of Patient Advocate designated by the Individual.
- I understand and agree to take reasonable steps to follow the desires and instructions of the Individual as indicated within their Advance Directives. Advance Directives may come in the form of his/her written or spoken instructions.
- If I am unable or unavailable to act after reasonable efforts to contact me, I delegate my Patient Advocate authority to the person designated as the Second Choice Patient Advocate. The following Patient Advocate(s) is/are authorized (in the order listed) to act until I become available to act.

DATE _____ First Choice Patient Advocate signature _____

First Choice Patient Advocate (print) _____

ALTERNATE PATIENT ADVOCATE(S):

SECOND CHOICE FOR PATIENT ADVOCATE

- I am at least 18 years of age.
- I accept the role of Patient Advocate designated by the Individual.
- I understand and agree to take reasonable steps to follow the desires and instructions of the Individual as indicated within their Advance Directives. Advance Directives may come in the form of his/her written or spoken instructions.
- If I am unable or unavailable to act after reasonable efforts to contact me, I delegate my Patient Advocate authority to the person designated as the Second Choice Patient Advocate. The following Patient Advocate(s) is/are authorized (in the order listed) to act until I become available to act.

DATE _____ Second Choice Patient Advocate signature _____

Second Choice Patient Advocate (print) _____

THIRD CHOICE FOR PATIENT ADVOCATE:

- I am at least 18 years of age.
- I accept the role of Patient Advocate designated by the Individual.
- I understand and agree to take reasonable steps to follow the desires and instructions of the Individual as indicated within their Advance Directives. Advance Directives may come in the form of his/her written or spoken instructions.

DATE _____ Third Choice Patient Advocate signature _____

Third Choice Patient Advocate (print) _____

INTERPRETATION SERVICES

I certify that I have interpreted, to the best of my ability, into and from the participant's stated primary language, _____, all oral presentations made by all of those present during the informed consent discussion.

TIME _____ ☐ AM ☐ PM **DATE** _____ Interpreter signature _____

Interpreter name (print) _____

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ADVANCE DIRECTIVE: TREATMENT PREFERENCES

NOTE: • **This is a supplement to my "Advance Directive: Durable Power of Attorney for Health Care (DPOAH)".**
• **On the fillable form, a signature must be signed by hand.**

This Advance Directive document represents
the Treatment Preferences for me (print name) _____
Date of birth _____

The following are my specific preferences and values concerning my health care. They are hopes for my health.

TODAY, IN MY CURRENT HEALTH:

Put an X along this line to show how you feel today, in your **current** health.

My main goal is to live as long as possible, no matter what.	**Equally important**	**My main goal of focus is on quality of life and being comfortable.**

AT THE END OF MY LIFE:

Put an X along this line to show how you feel if you were so sick **that you may die soon**.

My main goal is to live as long as possible, no matter what.	**Equally important**	**My main goal of focus is on quality of life and being comfortable.**

UNACCEPTABLE SITUATIONS (OUTCOMES):

- ☐ Unable to wake up or talk to my family and friends
- ☐ Unable to live without being hooked up to machines
- ☐ Unable to think for myself, such as dementia
- ☐ Unable to feed, bathe, or take care of myself
- ☐ Unable to live on my own
- ☐ Having constant, severe pain or discomfort
- ☐ Unable to walk or move on my own
- ☐ Something else _____

VALUES AND EXPERIENCES THAT ARE IMPORTANT TO ME:

- ☐ Communicate with my family and friends
- ☐ Activities with my family and friends
- ☐ Remain independent for as long as possible
- ☐ _____
- ☐ _____
- ☐ _____

CONTINUED ON PAGE 2 ➔

TREATMENT TO PROLONG MY LIFE:

If a circumstance arises where I am no longer able to recognize my family or friends and I am not expected to recover that ability:

- ☐ I want all possible efforts to prolong my life. Living as long as possible is more important than how I live.
- ☐ I want to receive treatment and care to keep me comfortable. How I live is more important than how long I live.
- ☐ I am undecided at this time.

If a situation arises where prolonged medical treatment is required with a low chance of survival (5 out of 100):

- ☐ I want all possible efforts to be done to prolong my life. Living as long as possible is more important than how I live, even if there is little hope of getting better.
- ☐ I want all possible efforts to prolong my life to be tried. If I do not improve, I would like my care to become comfort focused. I understand this may result in my death.
- ☐ I want to receive treatment and care to keep me comfortable. How I live is more important than how long I live.
- ☐ I am undecided at this time.

If my health worsens, and a decision needs to be made about using a ventilator:

- ☐ I want to receive ventilator therapies to help my breathing.
- ☐ I want to try the ventilator to help my breathing. If I do not improve, I would like care to become focused on my comfort. I understand this may result in my death.
- ☐ I do not want to receive ventilator therapies to help my breathing. I do want to receive treatment and care to keep me comfortable. How I live is more important than how long I live.
- ☐ I want these additional things to be considered _____

  _____
- ☐ I am undecided at this time.

If my heart or breathing stops, my preference for Cardiopulmonary Resuscitation (CPR) is:

- ☐ I want CPR.
- ☐ I do not want CPR. I want to have a natural death.
- ☐ I am undecided at this time.

NOTE: **This is NOT a Do Not Resuscitate (DNR) Order. A DNR is a separate legal document. Talk with your personal healthcare provider if you would like a DNR Order.**

AT THE END OF MY LIFE:

My funeral/burial preference is:

- ☐ I would like to be buried.
- ☐ I would like to be cremated.
- ☐ I would like a "green burial".
- ☐ I would like to be buried or cremated. I will let my next-of-kin decide.
- ☐ I would like _____

CONTINUED ON PAGE 3 ➔

AT THE END OF MY LIFE: *(CONTINUED)*

My organ donation decision is:

- ☐ I have a red heart on my driver's license.
- ☐ I want to donate my organs and tissue to help others.
- ☐ I will allow my Patient Advocate to make decisions about tissue and organ donation.
- ☐ I do not want my tissue or organs donated.

My decision about hospice is:

- ☐ I would like to receive hospice services.
- ☐ I do not want to receive hospice services.
- ☐ I will allow my Patient Advocate to make decisions about hospice services.

I want my health care providers to know about my religion/spirituality which is:

- My spiritual/religious belief(s) is/are _____
- I am connected with this faith group/congregation _____
- Try to notify my personal clergy or spiritual support person(s):
  Name _____ Phone (_____) _____
  Email _____
  Address _____
- I realize my religious beliefs and decisions may effect my physical, emotional or spiritual care. The information listed below is important to me (e.g., spiritual/religious rituals or sacraments, refusal of blood products, etc.) _____

DATE _____ My signature _____

INTERPRETATION SERVICES

I certify that I have interpreted, to the best of my ability, into and from the participant's stated primary language, _____, all oral presentations made by all of those present during the informed consent discussion.

TIME _____ ☐AM ☐PM **DATE** _____ Interpreter signature _____

Interpreter name (print) _____

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ADVANCE CARE PLANNING (ACP) COMPLETION CHECKLIST

All pages of the document(s) below must be included in order to meet the State of Michigan requirements. If any document does not meet State of Michigan requirements, it cannot be honored by your health care team. Document(s) that do not meet the requirements will **not** be uploaded to your Medical Record. You will only be notified (through MyChart or by mail) if your document(s) is/are **not** uploaded.

BEFORE RETURNING YOUR DOCUMENT, DOUBLE CHECK YOU HAVE DONE THE FOLLOWING:
NOTE: You must do all actions (for each check box) to meet State of Michigan requirements

- ON THE "DESIGNATING/ACCEPTING DURABLE POWER OF ATTORNEY FOR HEALTH CARE (DPOAH)" (X24949) DOCUMENT:

  In the "Designating/assigning authorities to my patient advocate(s)" section:

  - You should be the "Individual designating this DPOAH" and must:
    - ☐ Print your name (top of page 1)
    - ☐ Write your date of birth (top of page 1)
    - ☐ Sign your name (bottom of page 2)
    - ☐ Write the date above your signature (bottom of page 2)
  - Under "Witnesses to individual designating DPOAH signature", you must have two (2) people sign as witnesses to your designating a Patient Advocate.
    Note : Your witnesses cannot be family members (which includes family by marriage), health care workers or any individual you appointed to be your Patient Advocate.

    At top of page 3, check that both "Witness One" and "Witness Two":
    - ☐ Signed their names
    - ☐ Printed their names

  In the "Accepting role of DPOAH" section:

  - The acceptance signature(s) of your Patient Advocate(s) can be completed at a later date. Even if they are not available to sign now, your form is complete.

- ON THE "TREATMENT PREFERENCES" (X264948) DOCUMENT:

  You are the individual the Treatment Preferences are for and must:
  - ☐ Print your name (top of page 1)
  - ☐ Write your date of birth (top of page 1)
  - ☐ Sign your name (bottom of page 3)
  - ☐ Write the date above your signature (bottom of page 3)

MAKE A COPY OF YOUR COMPLETED DOCUMENT(S) FOR YOUR PERSONAL RECORD. SHARE IT/THEM WITH YOUR LOVED ONES AND HEALTH CARE TEAM.

