MISSOURI
Advance Directive
Planning for Important Healthcare Decisions

Courtesy of CaringInfo
www.caringinfo.org
800-658-8898

CaringInfo, a program of the National Hospice and Palliative Care Organization (NHPCO), is a national consumer engagement initiative to improve care and the experience of caregiving during serious illness and at the end of life. As part of that effort, CaringInfo provides detailed guidance for completing advance directive forms in all 50 states, the District of Columbia, and Puerto Rico.

This package includes:

- Instructions for preparing your advance directive. Please read all the instructions.
- Your state-specific advance directive forms, which are the pages with the gray instruction bar on the left side.

BEFORE YOU BEGIN

Check to be sure that you have the materials for each state in which you may receive healthcare. Because documents are state-specific, having a state-specific document for each state where you may spend significant time can be beneficial. A new advance directive is not necessary for ordinary travel into other states. The advance directives in this package will be legally binding only if the person completing them is a competent adult who is 18 years of age or older, or an emancipated minor.

ACTION STEPS

1. You may want to photocopy or print a second set of these forms before you start so you will have a clean copy if you need to start over.

2. When you begin to fill out the forms, refer to the gray instruction bars — they will guide you through the process.

3. Talk with your family, friends, and physicians about your advance directive. Be sure the person you appoint to make decisions on your behalf understands your wishes.

4. Once the form is completed and signed, photocopy, scan, or take a photo of the form and give it to the person you have appointed to make decisions on your behalf, your family, friends, healthcare providers, and/or faith leaders so that the form is available in the event of an emergency.

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5. You may also want to save a copy of your form in your electronic healthcare record, or an online personal health records application, program, or service that allows you to share your medical documents with your physicians, family, and others who you want to take an active role in your advance care planning.

INTRODUCTION TO YOUR MISSOURI ADVANCE HEALTH CARE DIRECTIVE

This packet contains a legal document, a **Missouri Advance Directive**, 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.

Part I, Durable Power of Attorney for Health Care Choices, lets you name someone (an :agent", sometimes called an "attorney in fact") to make decisions about your health care.

Part II is a **Health Care Choices Directive**. This is similar to a living will, although this form—which is based on the form created by the Missouri Attorney General—allows you to make a broader range of decisions than allowed by Missouri's statutory living will. Part II lets you state your wishes about health care in the event that you can no longer speak for yourself.

Part III describes the relationship between Part I and Part II.

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

You may fill out Part I, Part II, or both depending on your advance-planning needs. **You must fill out Part IV.**

How do I make my Missouri Advance Health Care Directive legal?

In order for Part I, **Durable Power of Attorney for Health Care Choices,** to be effective, you must have your signature notarized.

In order for Part II, **Health Care Choices Directive**, to be effective, you must sign and date your Missouri Advance Directive in the presence of two witnesses who are 18 years or older, neither of whom can be a person signing on your behalf if you are physically unable to sign for yourself.

If you fill out both Part I and Part II, you will need to have your signature both witnessed and notarized.

Whom should I appoint as my agent?

Your agent is the person you appoint to make decisions about your healthcare 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 healthcare decisions for you.

Your agent may not be your physician or an employee of your physician, or an owner, operator, or employee of the health care facility in which you reside, unless the person is your spouse, parent, child, grandparent, sibling, or grandchild.

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.

Should I add personal instructions to my advance directive?

Yes! One of the most important reasons to execute an advance directive is to have your voice heard. When you name an agent and clearly communicate to them what you want and don't want, they are in the strongest position to advocate for you. Because the future is unpredictable, be careful that you do not unintentionally restrict your agent's power to act in your best interest. Be especially careful with the words "always" and "never." In any event, be sure to talk with your agent and others about your future healthcare and describe what you consider to be an acceptable "quality of life."

When does my agent's authority become effective?

Depending on how you fill out Part I, **Durable Power of Attorney for Health Care Choices**, this part becomes effective either immediately or when your doctor and one other doctor certify that you are unable by reason of any physical or mental condition to receive and evaluate health care treatment information or to communicate health care decisions. You may choose to have one physician, instead of two, determine whether you are incapacitated (unable to make health care decisions) by initialing the statement in Part I.

Part II, **Health Care Choices Directive**, becomes effective when you can no longer make or communicate your health care decisions.

You retain the primary authority for your healthcare decisions as long as you are able to make your wishes known.

Agent Limitations

Your agent can refuse or withdraw artificial nutrition and hydration on your behalf only if you specifically grant such authority. In order to grant this authority, you must initial the line next to this treatment in Part II.

Before your agent may authorize withdrawal of artificial nutrition or hydration, your physician must:

- Attempt to explain the intent to withdraw artificial nutrition or hydration and the consequences of withdrawal to you and give you an opportunity to refuse withdrawal; or
- Certify that you are comatose or consistently in a condition which makes it impossible for you to understand the intent to withdraw artificial nutrition and hydration and the consequences of withdrawal.

Any directions you give to withhold or withdraw treatments will not be given effect in the event you are pregnant. Your agent will be bound by the current laws of Missouri as they regard pregnancy and termination of pregnancies.

What if I change my mind?

You may revoke your Missouri Advance Directive at any time and in any manner that reflects your intent to revoke. Examples of revocation include tearing your document, orally stating your intent to revoke, or executing a written revocation.

Part II is revoked automatically when you revoke, but revocation of your agent's powers (Part I) becomes effective only once you notify your agent or your physician or other treating health care provider about your decision to revoke.

Executing a new advance directive that appoints a new agent will automatically revoke your previous agent's authority.

Unless your Missouri Advance Directive expressly provides otherwise, if you have appointed your spouse as your agent, filing of any action for divorce or dissolution of your marriage automatically terminates your spouse's authority as your agent.

Mental Health Issues

These forms do not *expressly* address mental illness, although you can state your wishes and grant authority to your agent regarding mental health issues. The National Resource Center on Psychiatric Advance Directives maintains a website (https://nrc-pad.org/) with links to each state's psychiatric advance directive forms. If you would like to make more detailed advance care plans regarding mental illness, you could talk to your physician and an attorney about a durable power of attorney tailored to your needs.

What other important facts should I know?

Be aware that your advance directive will not be effective in the event of a medical emergency, except to identify your agent. Ambulance and hospital emergency department personnel are required to provide cardiopulmonary resuscitation (CPR) unless you have a separate physician's order, which are typically called "prehospital medical care directives" or "do not resuscitate orders." DNR forms may be obtained from your state health department or department of aging (https://www.hhs.gov/aging/state-resources/index.html). Another form of orders regarding CPR and other treatments are state-specific POLST (portable orders for life sustaining treatment) (https://polst.org/form-patients/). Both a POLST and a DNR form MUST be signed by a healthcare provider and MUST be presented to the emergency responders when they arrive. These directives instruct ambulance and hospital emergency personnel not to attempt CPR (or to stop it if it has begun) if your heart or breathing should stop.

Part I. Durable Power of Attorney for Health Care Choices

PRINT YOUR NAME

I, ____, appoint

PRINT YOUR AGENT'S NAME AND ADDRESS

Name: ____

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:

PRINT YOUR ALTERNATE AGENT'S NAME AND ADDRESS

Name: ____ 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.

INITIAL HERE IF YOU WANT TO ALLOW ONLY ONE PHYSICIAN TO DETERMINE WHETHER YOU ARE INCAPACITATED

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. _____

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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:

IF YOU DON'T WANT YOUR AGENT TO HAVE ANY OF THESE POWERS DRAW A LINE THROUGH THE PROVISION AND INITIAL NEXT TO IT

- 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.

YOUR AGENT MAY HAVE A CLAIM AGAINST YOUR ESTATE FOR REASONABLE EXPENSES THAT ARE PART OF YOUR CARE

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.

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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: (initial all that apply)

INITIAL ALL TREATMENTS THAT YOU WANT TO BE WITHHELD OR WITHDRAWN IN THE EVENT YOU ARE TERMINALLY ILL OR PERMANENTLY UNCONSCIOUS

_____ 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.

INITIAL YOUR ORGAN DONATION PREFERENCE

Organ Donation Choices (initial only one)

_____ 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.

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ADD OTHER INSTRUCTIONS, IF ANY, REGARDING YOUR ADVANCE CARE PLANS

THESE INSTRUCTIONS CAN FURTHER ADDRESS YOUR HEALTH CARE PLANS, SUCH AS YOUR WISHES REGARDING HOSPICE TREATMENT, BUT CAN ALSO ADDRESS OTHER ADVANCE PLANNING ISSUES, SUCH AS YOUR BURIAL WISHES

ATTACH ADDITIONAL PAGES IF NEEDED

I also give the following directions regarding my health care:

____

____

____

____

____

____

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

OPTIONAL DESCRIBE YOUR IDEA OF AN ACCEPTABLE QUALITY OF LIFE

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.

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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.

THIS PART DESCRIBES THE RELATIONSHIP BETWEEN PARTS I AND II IN THE EVENT YOU FILL OUT BOTH PARTS

IF YOU DISAGREE WITH THIS RELATIONSHIP, YOU MAY WANT TO ONLY FILL OUT ONE PART OR TALK TO AN ATTORNEY ABOUT AN ADVANCE DIRECTIVE TAILORED TO YOUR NEEDS

Part III. Relationship Between Health Care Choices Directive and Durable Power of Attorney for Health Care Choices

This Part is effective only if I have completed Part I and Part II.

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.

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DATE YOUR DOCUMENT

SIGN HERE AND PRINT YOUR NAME AND ADDRESS

IF YOU FILLED OUT PART II, YOUR WITNESSES MUST SIGN AND PRINT THEIR NAMES AND ADDRESSES HERE

A NOTARY MUST FILL OUT THIS SECTION IF YOU FILLED OUT PART I

NOTE: YOU MUST HAVE YOUR DOCUMENT BOTH NOTARIZED AND SIGNED BY TWO WITNESSES IF YOU FILLED OUT PARTS I AND II

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Part IV. Execution

IN WITNESS THEREOF, I have executed this document on this ____day of ____________________, in the year of ________.

Signature: ____

Print name: ____

Address: ____

If you filled out Part II, you must have your signature witnessed by two people who are at least 18 years of age.

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.

Witness #1
Signature: ____

Print name: ____

Address: ____

Witness #2
Signature: ____

Print name: ____

Address: ____

If you filled out Part I, you must have your advance directive notarized.

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   Notary seal