

MISSOURI

Advance Directive

Planning for Important Healthcare Decisions

Caring Connections

1731 King St., Suite 100, Alexandria, VA 22314

www.caringinfo.org

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Caring Connections, a program of the National Hospice and Palliative Care Organization (NHPCO), is a national consumer engagement initiative to improve care at the end of life.

It's About How You LIVE

It's About How You LIVE is a national community engagement campaign encouraging individuals to make informed decisions about end-of-life care and services. The campaign encourages people to:

- L**earn about options for end-of-life services and care
- I**mplement plans to ensure wishes are honored
- V**oice decisions to family, friends and healthcare providers
- E**ngage in personal or community efforts to improve end-of-life care

Note: The following is not a substitute for legal advice. While Caring Connections updates the following information and form to keep them up-to-date, changes in the underlying law can affect how the form will operate in the event you lose the ability to make decisions for yourself. If you have any questions about how the form will help ensure your wishes are carried out, or if your wishes do not seem to fit with the form, you may wish to talk to your health care provider or an attorney with experience in drafting advance directives.

Using these Materials

BEFORE YOU BEGIN

1. Check to be sure that you have the materials for each state in which you may receive healthcare.
2. These materials include:
 - 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.

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 the form and give it to the person you have appointed to make decisions on your behalf, your family, friends, health care providers and/or faith leaders so that the form is available in the event of an emergency.
5. You may also want to save a copy of your form in Google Health, or another online medical records management 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. You can read more about Google Health at <http://www.caringinfo.org/googlehealth>.

INTRODUCTION TO YOUR MISSOURI ADVANCE 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. You may fill out Part I, Part II, or both depending on your advance-planning needs. You must fill out Part IV.

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. This part becomes effective either immediately, or when your doctor determines that you can no longer make or communicate your health care decisions, depending on how you fill out the form.

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 II allows you to choose specific treatments that you wish to be withheld or withdrawn in the event you have a terminal illness or are persistently unconscious. Part II also allows you to make choices regarding organ donation, and includes space for you to add additional instructions and describe your feelings regarding what constitutes an acceptable quality of life. Part II becomes effective when you can no longer make or communicate your health care decisions.

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.

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 durable power of attorney tailored to your needs.

Note: These documents will be legally binding only if the person completing them is a competent adult (at least 18 years old).

COMPLETING YOUR MISSOURI ADVANCE DIRECTIVE

How do I make my Missouri Advance Directive Legal?

In order for Part I to be effective, you must have your signature notarized.

In order for Part II to be effective, you must sign 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.

Who should I pick 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.

Should I add other instructions to my Missouri Advance Directive?

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 you 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 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 treating healthcare provider. In any event, it is a good idea to tell your agent and your physician or other treating health care provider about your decision to revoke.

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

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.

What other important facts should I know?

Your agent can refuse 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.

What other important facts should I know?

Any directions you give to withhold or withdraw treatments will not be given effect in the event you are pregnant.

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. _____

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:

- 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.

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

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

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)

- _____ 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.

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.

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

INITIAL YOUR
ORGAN DONATION
PREFERENCE

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MISSOURI ADVANCE DIRECTIVE – PAGE 4 OF 6

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

OPTIONAL
DESCRIBE YOUR
IDEA OF AN
ACCEPTABLE
QUALITY OF LIFE

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I also give the following directions regarding my health care:

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

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

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.

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

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Part IV. Execution

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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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

*Courtesy of Caring Connections
1731 King St., Suite 100, Alexandria, VA 22314
www.caringinfo.org, 800/658-8898*

You Have Filled Out Your Health Care Directive, Now What?

1. Your Missouri Advance Directive is an important legal document. Keep the original signed document in a secure but accessible place. Do not put the original document in a safe deposit box or any other security box that would keep others from having access to it.
2. Give photocopies of the signed original to your agent and alternate agent, doctor(s), family, close friends, clergy, and anyone else who might become involved in your healthcare. If you enter a nursing home or hospital, have photocopies of your document placed in your medical records.
3. Be sure to talk to your agent(s), doctor(s), clergy, family, and friends about your wishes concerning medical treatment. Discuss your wishes with them often, particularly if your medical condition changes.
4. You may also want to save a copy of your form in Google Health, or another online medical records management 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. You can read more about Google Health at <http://www.caringinfo.org/googlehealth>.
5. If you want to make changes to your documents after they have been signed and witnessed, you must complete a new document.
6. Remember, you can always revoke your Missouri document.
7. Be aware that your Missouri document will not be effective in the event of a medical emergency. Ambulance and hospital emergency department personnel are required to provide cardiopulmonary resuscitation (CPR) unless they are given a separate directive that states otherwise. These directives called "prehospital medical care directives" or "do not resuscitate orders" are designed for people whose poor health gives them little chance of benefiting from CPR. These directives instruct ambulance and hospital emergency personnel not to attempt CPR if your heart or breathing should stop.

Currently not all states have laws authorizing these orders. We suggest you speak to your physician if you are interested in obtaining one. **Caring Connections does not distribute these forms.**