St. Clair County Community Mental Health

Advance Directive for Mental Health Care

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

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. OPTIONAL: I can choose the physician and mental health professional by filling in the two names and telephone numbers here:

_____

_____

My patient advocate must sign an acceptance before he or she can act for me the first time. 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.

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. 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.

SPECIFIC POWERS AND PREFERENCES

Following is a list of types of treatment. I can choose one or more. By writing **YES** next to a number, I give my patient advocate power to consent to that type of treatment. By writing **NO** next to a number, my patient advocate cannot consent to that treatment.

If I want, I can write my preferences for each power I give my patient advocate.

1. _____ Outpatient therapy. If I need outpatient therapy, I prefer it to be provided by:
2. _____ 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. If I need to be hospitalized, I prefer the following hospital: _____
3. _____ My admission to a hospital to receive inpatient mental health services. If I need to be hospitalized, I pre the following hospital: _____
4. _____ If I need to be hospitalized, I prefer_____ to take me to the hospital.
5. _____ psychotropic medication (psychiatric medicine). I prefer to receive the following medication(s) _____
6. _____ electro-convulsive therapy (ECT). I want the maximum number of treatments to be _____.
7. _____ placement in a group residence.
8. _____ seclusion and restraints
9. Additional wishes : (optional)
   _____
   _____
   _____

_____
_____
_____
_____
_____
_____

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 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, parent, 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 conditions, and I accept the designation
(Name of patient advocate) as a patient advocate or successor patient advocate for

_____, who signed an advance directive for mental health
(Name of patient) care on the following date: _____

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