# Mississippi Advance Directive
# Durable Power of Attorney for Health Care and Living Will

This advance directive form is an official document where you can write down your wishes for your healthcare. If you can't make health care decisions for yourself, this advance directive can help guide the people who will make decisions for you.

You can use this form to:

- Name specific people to make health care decisions for you
- Describe your preferences for how you want to be treated
- Describe your preferences for medical care, long-term care, or other types of healthcare

**If you do not choose a healthcare decision maker** and are too sick to make your own decisions, your care team will turn to your family to make decisions for you according to Mississippi law in the following order: (1) spouse; (2) adult children (all are equal, majority rules); (3) parents; (4) adult brothers and sisters (all are equal, majority rules); (5) any next closest relative; (6) any competent adult who has been known to care for you. A conservator or guardian by court order overrides any of the above.

## PART 1: YOUR PERSONAL INFORMATION

| | | |
|---|---|---|
| YOUR NAME *(Last, First, Middle)*: | | |
| YOUR STREET ADDRESS, CITY, STATE, ZIP: | | |
| HOME PHONE: | WORK PHONE: | CELL PHONE: |

### Primary Care Providers

| | | |
|---|---|---|
| NAME | CLINIC | OFFICE PHONE NUMBER |
| STREET ADDRESS, CITY, STATE, ZIP | | |

If the person named above can't or doesn't want to make decisions for me, or is not reasonably available, I appoint the person named below as my primary care provider:

| | | |
|---|---|---|
| NAME | CLINIC | OFFICE PHONE NUMBER |
| STREET ADDRESS, CITY, STATE, ZIP | | |

## PART 2: DURABLE POWER OF ATTORNEY FOR HEALTH CARE

This section of the advance directive form is called a Durable Power of Attorney for Health Care. It lets you appoint a specific person to make health care decisions for you if you are too sick to make decisions for yourself. This person will be called your Health Care Agent.

Your Health Care Agent

- Should be someone who you trust, who knows you well, and is familiar with your values and beliefs.
- **CANNOT** be someone who works at a hospital, nursing home or similar facility where you are being treated unless you are related.

| **HEALTH CARE AGENT** | | |
|---|---|---|
| Place your initials in the box next to your choice. | | |
| Initials | I designate the following individual as my agent to make healthcare decisions for me if I am unable to decide for myself. | |
| NAME *(Last, First, Middle)*: | | Relationship to me: |
| STREET ADDRESS: | CITY, STATE, ZIP: | |
| HOME PHONE: | WORK PHONE: | CELL PHONE: |

| **ALTERNATE HEALTH CARE AGENT** | | |
|---|---|---|
| Fill out this section if you want to appoint a second person to make health care decisions for you, in case the first person isn't willing or able to speak for you when the time comes. | | |
| Initials | If I revoke my agent's authority, or if the person named above can't or doesn't want to make decisions for me, or is not reasonably available, I appoint the person named below as my Health Care Agent. | |
| NAME *(Last, First, Middle)*: | | Relationship to me: |
| STREET ADDRESS: | CITY, STATE, ZIP: | |
| HOME PHONE: | WORK PHONE: | CELL PHONE: |

**My Healthcare Decision Maker's Authority:** My healthcare decision maker can make any healthcare decisions for me, but **must** follow my wishes as expressed in Part 3, even if he/she disagrees or thinks this isn't in my best interest. My healthcare decision maker can access my personal health information and medical records, and talk with my care providers about my health. If my medical choices are not clear, he or she must make those decisions in my best interest and based on what is known of my wishes. I can revoke or limit my Agent's authority at any time.

**Effective Date:** My healthcare decision maker can make healthcare decisions for me **(CHOOSE ONE):**

☐ when my primary care provider or treating physician determines I cannot make my own decisions or

☐ immediately after signing this form until revoked

## PART 3: LIVING WILL

This section of the advance directive form is called a Living Will. This section lets you write down how you want to be treated, in case you aren't able to decide for yourself anymore and helps others choose the care you would want.

### LIFE SUPPORT MEASURES

If I am so sick that I might die soon (CHOOSE ONE):

☐ ***I do not want to receive life support treatments***. I want to focus on being comfortable.

☐ ***Try all life support treatments that my doctors think might help***.

If the treatments do not work and there is little hope of getting better (CHOOSE ONE):

☐ I want to stop life support treatments if they are not working.
☐ I want to stay on life support treatments *unless* it looks like I am suffering.
☐ I want to stay on life support treatments *even* if I look like I am suffering.

☐ Other (use additional sheets if needed):

_____
_____
_____
_____
_____

### COMFORT AND PAIN RELIEF

In this section, you can indicate your preferences for comfort and pain relief. Place your initials in the box next to the statements that reflect your wishes for comfort and pain relief. **Initial all that apply.**

| | |
|---|---|
| Initials | I want to receive maximum pain relief even if it may unintentionally cause me to die sooner. |
| Initials | I want to receive maximum pain relief medication even if it may result in temporary dependence if I survive, recover or rebound from my current conditions and/or hospital stay. |
| Initials | I want a voluntary non-opioid directive. I am refusing, at my own insistence, the offer or administration of any opioid medications including in an emergency situation where I am unable to speak for myself. |

### CONSENT TO DONATE

☐ I want to give away as many of my organs, eyes, and tissues as possible for the purpose of donation.

☐ I only want to give away the following organs, eyes, and/or tissues for the purpose of donation:

_____

☐ I do not want to give away my organs, eyes, or tissues.

Complete this sentence if it is true. *I am already a body donor and have filled out the required consent forms with the following facility*: _____

## SPECIFIC PREFERENCES ABOUT END-OF-LIFE TREATMENTS (OPTIONAL)

| CPR (Cardiopulmonary Resuscitation) | |
|---|---|
| CPR is a group of procedures used when the heart stops or breathing stops as a result of a serious illness or injury. | ☐ **Yes.** I would want CPR attempted at the end of life, even if the burden may outweigh the benefits.<br>☐ **No.** I do not want CPR attempted |

| Kidney Dialysis | |
|---|---|
| Kidney dialysis uses machines to remove waste products and excess fluid from the body when the kidneys are not working well enough for a person to survive. | ☐ **Yes.** I would want kidney dialysis at the end of life, even if the burden may outweigh the benefits.<br>☐ **No.** I do not want my life prolonged with dialysis machines. |

## SPECIFIC PREFERENCES ABOUT LIFE-SUPPORT TREATMENTS (OPTIONAL)

In this section, you can indicate your preferences for life support treatments in certain situations. Think about each situation described on the left and ask yourself, "In that situation, would I want to have life-support treatments?" Place your initials in the box that best describes your treatment preference. **You may complete some, all, or none of this section. Choose only one box for each statement.**

| | **Yes.** I would want life-support treatments | **No.** I would not want life-support treatments. |
|---|---|---|
| If I need to use a breathing machine to survive for the rest of my life. | Initials | Initials |
| If I cannot eat or drink by mouth and depend on artificial feeding/hydration through a tube or IV. | Initials | Initials |
| If I am unconscious, in a coma, or in a vegetative state, and there is little or no chance of recovery. | Initials | Initials |
| If I have permanent, severe, brain damage that makes me unable to recognize my family or friends (for example, severe dementia). | Initials | Initials |
| If I have a permanent condition where other people must help me with my daily needs (for example, eating, bathing, toileting). | Initials | Initials |
| OTHER: | Initials | Initials |

## ADDITIONAL PREFERENCES

This section is optional. In this space you can write other important preferences for your health care that aren't described somewhere else in this document. If you need more space, you may attach extra pages and use this space to refer to the attached pages. **Be sure to initial and date every page you attach.**

_____

_____

_____

_____

_____

_____

_____

## PART 4: SIGNATURES

### YOUR SIGNATURE

| ***By my signature below, I certify that this form accurately describes my preferences.*** | |
|---|---|
| SIGNATURE: | DATE: |
| NAME *(Printed or Typed)*: | |

### WITNESSES SIGNATURES

**WITNESS #1**

| I declare under penalty of perjury that I personally witnessed the person signing this advance directive, that the person is known to me, and that the person appears to be of sound mind and under no duress, fraud, or undue influence. I am not appointed as Health Care Agent in this advance directive or an employee at this hospital. I am not financially responsible for the care of the person making this advance directive. To the best of my knowledge, I am not named in the person's will. | |
|---|---|
| SIGNATURE: | DATE: |
| NAME *(Printed or Typed)*: | |
| STREET ADDRESS: | CITY, STATE, ZIP: |

**WITNESS #2**

| I personally witnessed the signing of this advance directive. I am not appointed as Health Care Agent in this advance directive. I am not financially responsible for the care of the person making this advance directive. To the best of my knowledge, I am not named in the person's will. I am not related to the person by blood, marriage, or adoption. | |
|---|---|
| SIGNATURE: | DATE: |
| NAME *(Printed or Typed)*: | |
| STREET ADDRESS: | CITY, STATE, ZIP: |

## PART 5: SIGNATURE AND SEAL OF NOTARY PUBLIC *(OPTIONAL)*

This Advance Directive form is valid in NMHS facilities without being notarized. However, you may need to have it notarized to be legally binding outside the NMHS health care setting. Space for a Notary's signature and seal is included below.

**STATE OF _____**

**COUNTY OF _____**

On this date, _____, the Declarant, _____, personally appeared before me and having provided verifiable identification to be the Declarant whose name is subscribed to this instrument and acknowledged to me that s/he executed the same in his/her capacity, and that by his/her signature on the instrument, executed the instrument.

I declare that s/he appears to be of sound mind and not under or subject to duress, fraud or undue influence, that s/he acknowledges the execution the same to be his/her voluntary act and deed, and that I am not the advocate, attorney-in-fact, proxy, surrogate, or a successor of any such, as designated within this document, nor do I hold any interest in his/her estate through a Will or by any other means or process of law.

***WITNESS*** my hand and seal.

_____
(Notary Signature)

My Commission Expires: _____
(Date)