

**DURABLE POWER OF ATTORNEY FOR  
HEALTH CARE  
AND  
HEALTH CARE DIRECTIVE**

**Question and Answers, Instructions  
and Sample Form**

**Distributed as a public service  
by**



**The Missouri Bar**

**Durable Power of Attorney for  
Health Care  
and  
Health Care Directive**

**Published by The Missouri Bar**

Read the Questions and Answers and Instructions which accompany this form carefully before attempting to complete the Durable Power of Attorney for Health Care and Health Care Directive. This form is not the only way to express your desires regarding future health care. This form is distributed with the understanding that The Missouri Bar, its committees, authors and speakers do not thereby render legal advice. If you do not understand this form, or if you feel the form does not meet your needs, you should consult a lawyer.

**This form belongs to:**

Name: \_\_\_\_\_

Address: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Telephone: \_\_\_\_\_

Social Security Number: \_\_\_\_\_

Medicare Number: \_\_\_\_\_

# QUESTIONS AND ANSWERS CONCERNING THE DURABLE POWER OF ATTORNEY FOR HEALTH CARE AND HEALTH CARE DIRECTIVE

## INTRODUCTION

Many Missouri citizens are concerned about the health care they may receive if they cannot express their desires. The Missouri Bar is providing this form to you as a public service. This form is not the only way to express your desires regarding future health care. If you have special needs, you may want to consult a lawyer. This form allows you to appoint an agent to make health care decisions if you are unable to do so. The form also allows you to furnish clear and convincing proof of your intentions regarding your future health care.

## QUESTIONS AND ANSWERS

The following questions and answers may help you understand the form:

### **Do I need a lawyer to complete this form?**

A. No. However, if you do not feel this form meets your needs, you may want to consult a lawyer.

### **Why does this form have three parts?**

A. Part I is your Durable Power of Attorney for Health Care. It allows you to appoint someone to make decisions for you if you are unable to act concerning your health care.

Part II is your Health Care Directive. It allows you to express your intention regarding your future health care.

Part III provides for notarization. If you intend to use the Durable Power of Attorney For Health Care in Part I, this document **must** be notarized.

### **What is a Durable Power of Attorney for Health Care (Part I)?**

A. It is a document that allows you to appoint someone to make all kinds of health care decisions for you, but only if you are not able to do so. These decisions may include, but are not limited to, decisions to withhold or withdraw life-prolonging procedures.

### **What is a Health Care Directive (Part II)?**

A. It is like a living will; it is a document that allows you to state in advance your wishes regarding the use of life-prolonging procedures. It may be relied upon when you are unable to communicate your decisions.

### **Do I need both?**

A. If you decide that you want someone to speak for you concerning your future health care you will need to fill out the Durable Power of Attorney for Health Care (Part I). Please consider doing this if there is someone you would like to appoint. If you decide that you want to express your desires about life-prolonging procedures you will need to fill out the Health Care Directive (Part II). The Directive will provide doctors and others with evidence concerning your wishes. The Health Care Directive (Part II) may also serve as a guide for your agent.

### **Does the person I appoint as my agent have to be a lawyer?**

A. No. You may appoint a person 18 years of age or older. An agent is usually a close relative or someone you trust with your life. It cannot be your doctor, an employee of your doctor, or an owner/operator or employee of a health care facility in which you are a resident, unless you are related.

### **Can an agent withhold or withdraw artificially supplied nutrition and hydration?**

A. Yes, if you specifically authorize your agent to do so. The Durable Power of Attorney for Health Care (Part I) requires that you indicate whether or not you want your agent to have authority to withdraw this type of medical treatment. The Health Care Directive (Part II) also requires that you indicate whether or not you want artificially supplied nutrition and hydration to be withheld or withdrawn under certain circumstances.

### **When can my agent act?**

A. The Durable Power of Attorney for Health Care (Part I) only become effective when you are incapacitated and unable to make health care decisions. Unless you state otherwise, Missouri law requires two doctors to make the incapacity decision. The form allows you to choose whether you would like one or two doctors to make the incapacity decision.

### **If I already have a Durable Power of Attorney, should I sign a Durable Power of Attorney for Health Care (Part I)?**

A. Possibly. Your existing Durable Power of Attorney may not cover health care or comply with Missouri Durable Power of Attorney for Health Care Act.

### **If I already have a Living Will, should I sign a Health Care Directive (Part II)?**

A. Possibly. Many Living Will forms currently in use only apply when you are expected to die within a short period of time and do not allow for the withdrawal or withholding of artificial nutrition and hydration. They do not cover a condition such as the persistent vegetative state which occurred in the well known case of *Cruzan v. Director*, 110 S.Ct. 2841 (1990).

**DURABLE POWER OF ATTORNEY FOR  
HEALTH CARE  
AND  
HEALTH CARE DIRECTIVE**

This form allows you to express your desires concerning your health care.

The Durable Power of Attorney for Health Care (Part I) allows you to appoint an agent to make health care decisions if you are unable to do so.

The Health Care Directive (Part II) allows you to furnish clear and convincing proof of your intentions regarding withholding or withdrawal of life-prolonging procedures, and may be relied upon by your physician even if you are unable to communicate your decisions.

The General Provisions (Part III) apply to both the Directive and the Power of Attorney. You may complete the Power of Attorney (Part I) or the Directive (Part II) or both.

**IF THERE IS A STATEMENT WITH WHICH YOU DO NOT AGREE, YOU MAY CHANGE IT AND ADD YOUR INITIALS.**

Read the Questions and Answers and Instructions which accompany this form carefully before attempting to complete the Durable Power of Attorney for Health Care and Health Care Directive. This form is not the only way to express your desires regarding future health care. This form is distributed with the understanding that The Missouri Bar, its committees, authors, and speakers do not thereby render legal advice. If you do not understand this form, or if you feel the form does not meet your needs, you should consult a lawyer.

**GENERAL INSTRUCTIONS FOR COMPLETING THE  
DURABLE POWER OF ATTORNEY FOR HEALTH CARE  
AND HEALTH CARE DIRECTIVE**

Read the entire form before signing or initialing any part.

Discuss this form with your family and close friends. Include anyone who may be asked to make decisions concerning your future health care if you are unable to do so.

**Give a copy of this form to your family, close friends, doctor, lawyer, minister or anyone that may be asked to make decisions concerning your health care if you are unable to do so.** Do not place the original of this form in your safe deposit box. It will not be usable unless your agent or alternate agents have access to your safe deposit box without your presence through a signature card from the bank where the safe deposit box is located.

Decide whether you want to complete the Durable Power of Attorney for Health Care (Part I) and the Health Care Directive (Part II). You may choose to complete only one or both.

# Instructions for Completing Part I.

## Durable Power of Attorney for Health Care

If you decide not to complete the Durable Power of Attorney for Health Care (Part I), write your initials above the line that says “initials” in the shaded box which appears below the words “**Part I. Durable Power of Attorney for Health Care**”.

If you decide to complete the Durable Power of Attorney for Health Care (Part I), please follow the instructions below.

DO NOT initial the shaded box below the words “**Part I. Durable Power of Attorney for Health Care**”.

Complete **Section 1 Selection of Agent** with the name, address, and telephone number of the person you choose as your agent.

If you wish to complete **Section 2 Alternate Agents** write the names, addresses, and telephone numbers of persons you would like to be your agent if the person you named in Section 1 is not available.

# Part I. Durable Power of Attorney for Health Care

- If you do *NOT* wish to name an agent to make health care decisions for you, write your initials in the box to the right and go to Part II.

_____ Initials
-------------------

This form has been prepared to comply with the “Durable Power of Attorney for Health Care Act” of Missouri.

**1. Selection of Agent.** I appoint:

Name: \_\_\_\_\_

Address: \_\_\_\_\_

\_\_\_\_\_

Telephone: \_\_\_\_\_

**It is suggested that only one Agent be named. However, if more than one Agent is named, any one may act individually unless you specify otherwise.**

as my Agent.

**2. Alternate Agents.** Only an Agent named by me may act under this Durable Power of Attorney. If my Agent resigns or is not able or available to make health care decisions for me, of if an Agent named by me is divorced from me or is my spouse and legally separated from me, I appoint the person(s) named below (in the order named if more than one):

**First Alternate Agent**

Name: \_\_\_\_\_

Address: \_\_\_\_\_

\_\_\_\_\_

Telephone: \_\_\_\_\_

**Second Alternate Agent**

Name: \_\_\_\_\_

Address: \_\_\_\_\_

\_\_\_\_\_

Telephone: \_\_\_\_\_

**THIS IS A DURABLE POWER OF ATTORNEY, AND THE AUTHORITY OF MY AGENT, 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.**



## Instructions for Completing Part I. (Continued)

In **Section 3 Effective Date and Durability** the form lets you choose whether one or two doctors need to certify that you are incapacitated. Incapacitated means that you are no longer able to make decisions for yourself and it is time for your agent to act.

Choose whether you want one or two physicians to decide whether you are incapacitated.

If you want two doctors to decide that you are incapacitated, do *not* write anything in this section.

If you want one doctor to decide that you are incapacitated, write your initials in the shaded box above the line that says “initials” to the right of the statement “If you want one physician instead of two to decide whether you are incapacitated, write your initials in the box to the right.” that is found in Section 3.

In **Section 4 Agent’s Powers** you decide whether or not your agent can make decisions concerning withholding or withdrawing artificially supplied nutrition and hydration. Please indicate your decision in the space provided.

If you complete this Part I, you **must** sign it before a notary for it to be effective. Please look at the instructions on page 14.

# Part I. Durable Power of Attorney for Health Care (Continued)

**3. Effective Date and Durability.** Except for such earlier dates as may be set forth in Section 4, below, this Durable Power of Attorney is effective when **two** physicians decide and certify that I am incapacitated and unable to make and communicate a health care decision.

- **If you want ONE physician, instead of TWO, to decide whether you are incapacitated, write your initials in the box to the right.**

_____ Initials
-------------------

**4. Agent's Powers.** I grant to my Agent full authority to:

A. Give consent to, prohibit or withdraw any type of health care, medical care, treatment or procedure, even if my death may result.

- **If you wish to AUTHORIZE your Agent to direct a health care provider to withhold or withdraw artificially supplied nutrition and hydration (including tube feeding of food and water), write your initials in the box to the right.**

_____ Initials
-------------------

- **If you DO NOT WISH TO AUTHORIZE your Agent to direct a health care provider to withhold or withdraw artificially supplied nutrition and hydration, (including tube feeding of food and water), write your initials in the box to the right.**

_____ Initials
-------------------

B. Make all necessary arrangements for health care services on my behalf, and to hire and fire medical personnel responsible for my care;

C. Move me into or out of any health care facility (even if against medical advice) to obtain compliance with the decisions of my Agent; and

D. Take any other action necessary to do what I authorize here, including (but not limited to) granting any waiver or release from liability required by any health care provider, and taking any legal action at the expense of my estate to enforce this Durable Power of Attorney.

E. Act, effective immediately, as my "personal representative" as defined in 45 C.F.R. § 164.502(g), the regulations enacted pursuant to the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), and as hereafter amended, for the purpose of authorizing the release of my complete health record as may be necessary in order to obtain for my benefit medical treatment or consultation.

**5. Agent's Financial Liability and Compensation.** My Agent acting under this Durable Power of Attorney will incur no personal financial liability. My Agent shall not be entitled to compensation for services performed under this Durable Power of Attorney, but my Agent shall be entitled to reimbursement for all reasonable expenses incurred as a result of carrying out any provision hereof.

## **Instruction for Completing Part II. Health Care Directive**

If you decide not to complete the Health Care Directive (Part II), write your initials above the line that says “initials” in the shaded box which appears below the words **“Part II. Health Care Directive”**.

If you decide to complete the Health Care Directive (Part II), please follow the instructions below:

DO NOT initial the shaded box below the words **“Part II. Health Care Directive”**.

Read the Directive Carefully.

Review the list of life-prolonging procedures and decide which, if any, of these procedures you would like to have withheld or withdrawn. Write your initials next to each procedure you want to be withheld or withdrawn if you are persistently unconscious or there is no reasonable expectation of your recovery from a seriously incapacitating or terminal illness or condition.

## Part II. Health Care Directive

- If you ***DO NOT WISH*** to make a health care directive, write your initials in the box to the right, and go to Part III.

<hr style="width: 80%; margin: auto;"/> Initials
--

I make this HEALTH CARE DIRECTIVE (“Directive”) to exercise my right to determine the course of my health care and to provide clear and convincing proof of my wishes and instructions about my treatment.

If I am persistently unconscious or there is no reasonable expectation of my recovery from a seriously incapacitating or terminal illness or condition, I direct that all of the life-prolonging procedures that I have initialled below be withheld or withdrawn.

**I want the following life-prolonging procedures to be withheld or withdrawn:**

- **artificially supplied nutrition and hydration (including tube feeding of food and water)** .....
- **surgery or other invasive procedures** .....
- **heart-lung resuscitation (CPR)** .....
- **antibiotic** .....
- **dialysis** .....
- **mechanical ventilator (respirator)** .....
- **chemotherapy** .....
- **radiation therapy** .....
- **all other “life-prolonging” medical or surgical procedures that are merely intended to keep me alive without reasonable hope of improving my condition or curing my illness or injury** .....

Initials
Initials
Initials
Initials
Initials
Initials
Initials
Initials
Initials
Initials

However, if my physician believes that any life-prolonging procedure may lead to a significant recovery, I direct my physician to try the treatment for a reasonable period of time. If it does not improve my condition, I direct the treatment be withdrawn even if it shortens my life. I also direct that I be given medical treatment to relieve pain or to provide comfort, even if such treatment might shorten my life, suppress my appetite or my breathing, or be habit-forming.

I want to donate my organs or tissues and realize it may be necessary to maintain my body artificially after my death on a breathing machine until my organs can be removed.

- Yes                     
  No                             
  I do not want to address this question now

**IF I HAVE NOT DESIGNATED AN AGENT IN THE DURABLE POWER OF ATTORNEY, THIS DOCUMENT IS MEANT TO BE IN FULL FORCE AND EFFECT AS MY HEALTH CARE DIRECTIVE.**

## **Instructions for Completing Part III.**

### **General Provisions Included in the Directive and Durable Power of Attorney**

**Part III. must be completed for the Durable Power of Attorney for Health Care (Part I) and the Health Care Directive (Part II) to be effective. Please see the instructions on the back of the following page.**

## **Part III. General Provisions Included in the Directive and Durable Power of Attorney**

**1. Relationship Between Directive and Durable Power of Attorney.** If I have executed the Directive and the Durable Power of Attorney, I encourage my Agent to follow my wishes as expressed in the Directive in making decisions regarding life-prolonging procedures. However, I have confidence in my Agent's ability to make decisions in my best interest, and I authorize my Agent to make decisions that are contrary to my Directive in his or her best judgment. If the Durable Power of Attorney is somehow determined to be ineffective, or if my Agent is not able to serve, the Directive is intended to be used on its own as firm instructions to my health care providers regarding life-prolonging procedures.

**2. Protection of Third Parties Who Rely on My Agent.** No person who relies in good faith upon any representations by my Agent or Alternate Agent shall be liable to me, my estate, my heirs or assigns, for recognizing the Agent's authority.

**3. Revocation of Prior Directive or Durable Power of Attorney.** I revoke any prior LIVING WILL, Declaration or Health Care Directive executed by me. If I have appointed an Agent in a prior durable power of attorney, I revoke any health care terms contained in that durable power of attorney.

**4. Validity.** This document is intended to be valid in any jurisdiction in which it is presented. The provisions of this document are separable, so that the invalidity of one or more provisions shall not affect any others. A copy of this document shall be as valid as the original.

## Instructions for Completing Part III. (Continued)

Part III must be completed for the Durable Power of Attorney for Health Care (Part I) and the Health Care Directive (Part II) to be effective. Please follow the instructions below:

Sign and date in the space provided. **Please print your name and address under the signature line.**



Have two witnesses sign and write in their addresses on the lines provided.



If you have completed the **Durable Power of Attorney for Health Care (Part I)**, you will need to sign the form in the presence of a notary public who will then complete the notary block. You will also need to have two witnesses sign the form.







## **Ordering Information**

Additional copies of this form are available at courthouses, libraries, and University of Missouri Extension Centers across Missouri at no charge. The form may be photocopied for use by additional persons. The form may also be ordered directly from The Missouri Bar. Copies of the form are available from The Missouri Bar at no charge.

Please send a written request for the number of copies you desire to:

Health Care Proxy Form  
The Missouri Bar  
P.O. Box 119  
Jefferson City, MO 65102-0119

# **. . . . . From The Missouri Bar To You**

This health care decisions form has been developed as a project of The Missouri Bar, the statewide association for all lawyers. Working for the public good, The Missouri Bar strives to improve the law and the administration of justice.