COMBINED LIVING WILL AND ADVANCE HEALTHCARE DIRECTIVE

State of residence: MI **Place of paper signing:** MI **Effective Date:** [DATE]

I, **[DECLARANT NAME]**, born [DATE], residing at [DECLARANT ADDRESS] (the "Declarant," "Principal," or "Patient"), being of sound mind and at least eighteen (18) years of age, voluntarily make this **Combined Advance Healthcare Directive** — comprising a **Living Will** (statement of treatment wishes) and a **Healthcare Power of Attorney** (appointment of a healthcare agent) — under the laws of the State of MI, as a directive to physicians, my healthcare agent, family members, and all other persons concerned with my care.

IMPORTANT — Michigan Notice. Michigan does not have a living-will statute. Instead, Michigan Compiled Laws §700.5506 et seq. recognizes a **Patient Advocate Designation**, under which my Patient Advocate may make medical and, if authorized, mental-health decisions on my behalf when I am unable to participate in those decisions. The treatment preferences below operate as written guidance to my Patient Advocate, who is bound by Michigan law to act consistently with my stated wishes.

1. Statement of Capacity and Voluntariness

I am competent to make this directive. I understand its contents and legal effect. I am not acting under duress, fraud, or undue influence. I make this directive freely and voluntarily, after reflection on the medical, personal, moral, and (where applicable) religious implications of the choices expressed herein.

2. Appointment of Patient Advocate

I hereby appoint the following person as my Patient Advocate (the "Agent") to make healthcare decisions for me if I lose the capacity to make them myself:

- **Name:** [PRIMARY AGENT FULL LEGAL NAME]
- **Relationship:** [RELATIONSHIP TO YOU]
- **Address:** [PRIMARY AGENT ADDRESS]
- **Phone:** [PRIMARY AGENT PHONE]

First Alternate Agent (serves if the primary Agent is unavailable, unwilling, or unable):

- **Name:** [ALTERNATE AGENT FULL LEGAL NAME RECOMMENDED]
- **Address:** [ALTERNATE AGENT ADDRESS]
- **Phone:** [ALTERNATE AGENT PHONE]

Second Alternate Agent (serves if both prior Agents are unavailable):

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- **Name:** [SECOND ALTERNATE AGENT FULL LEGAL NAME]
- **Phone:** [SECOND ALTERNATE AGENT PHONE]

Michigan patient advocate designation. My named adult agent is my patient advocate. I retain control while I can participate. Medical decision-making authority is exercisable only while I cannot participate in medical treatment decisions. My attending physician and another physician or licensed psychologist must examine me, determine this inability in writing, place their determination in my medical record, and review it at least annually. Authority is suspended whenever I regain the ability to participate.

Limits on every power granted here. My treatment instructions and my choice about delegating decisions are separate. I do not grant my patient advocate authority in this document to withhold or withdraw treatment that would allow me to die. No general grant in this document overrides this choice. If I expressly authorize my advocate to make an anatomical gift, that authority remains exercisable after my death. I confer no authority through a general medical power to consent to forced medication, nonvoluntary psychiatric hospitalization, or electroconvulsive therapy.

Scope of authority. My Agent has full authority to make all healthcare decisions I could make if I had capacity, including (without limitation): consenting to, refusing, or withdrawing any medical treatment, service, or procedure; selecting, hiring, and discharging physicians, nurses, therapists, and facilities; authorizing or refusing artificial nutrition, hydration, and life-sustaining treatment (consistent with any explicit instructions in this directive); obtaining medical information relevant to an authorized decision; making decisions about pain management, palliative sedation, hospice, and comfort care; admitting me to or discharging me from hospitals, nursing homes, assisted-living facilities, and hospice programs; authorizing an autopsy; directing disposition of my remains; and making an anatomical gift of my body or parts thereof consistent with any instruction below.

Agent obligation. My Agent shall make decisions consistent with my wishes as stated in this directive. Where my wishes are unknown or do not clearly address a specific circumstance, my Agent shall act in my best interest after consulting with my attending physician and weighing the burdens and benefits of treatment.

Ineligible persons. My Agent is not my attending physician, an employee of my attending physician, or an owner/operator/employee of a residential healthcare facility where I reside (unless related to me by blood, marriage, or adoption).

Nomination of guardian/conservator. If a court proceeding is ever initiated to appoint a guardian or conservator of my person, I nominate my Agent (and the alternates, in order) to serve in that capacity, to the maximum extent permitted by law.

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3. Statement of Treatment Wishes (Living Will)

Treatment choices. A blank or unselected item states no preference on that item. It is not consent, refusal or a medical order. Where a specific instruction applies, it takes priority over a general goal. A choice about ventilation does not choose CPR for me.

Overall philosophy. No specific instruction.

Conditions under which this directive applies. This directive takes effect if I am unable to make or communicate healthcare decisions and my attending physician (or, where required, two physicians) determines that I am in any of the following conditions:

Specific Treatment Instructions

Artificial Nutrition and Hydration (feeding tubes, IV fluids) — initial _____. No specific instruction.

Cardiopulmonary Resuscitation (CPR). No specific instruction.

Mechanical Ventilation. No specific instruction.

Dialysis. No specific instruction.

Antibiotics. No specific instruction.

Blood Transfusions. No specific instruction.

Emergency care and travel. These are personal instructions, not an emergency medical order. Review emergency orders with an authorized clinician for the setting where I receive care. When I travel or transfer, my care team should check the destination's requirements.

Pregnancy and the place of care

These instructions describe future decisions if I cannot decide for myself. They do not report a diagnosis. The place where care is provided may change which law applies. **Michigan care.** The Michigan Court of Claims enjoined enforcement of the pregnancy exclusions in MCL 700.5507(5), statement 3, 700.5509(1)(d), and 700.5512(1) in Koskenoja v Whitmer on April 16, 2026. Pregnancy alone does not suspend an otherwise authorized patient advocate's decision. My selections express my own wishes. If Michigan law governs an advocate's decision to withhold or withdraw treatment that would allow my death, MCL 700.5509(1)(e) requires clear and convincing expression that I authorize the advocate to make that decision and acknowledge that it could or would allow my death.

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5. Agent access to decision-related records

When my Agent has legal authority to make a healthcare decision for me, the Agent may obtain information relevant to that authority under 45 C.F.R. § 164.502(g), subject to applicable exceptions. Appointment alone is not blanket permission to disclose my records. Separate consent may be needed for specially protected records.

9. Preferred Setting for Care

I express no specific preference regarding care setting; my Agent and care team may decide based on the circumstances.

10. Personal Message to My Loved Ones and Caregivers

[PERSONAL MESSAGE TO LOVED ONES AND]

11. Revocation

I may revoke my patient advocate designation at any time and by any means that communicates my intent, even if I cannot participate in decisions. This document contains no waiver delaying revocation of mental-health authority.

12. Effect of Copy

A copy of this executed directive has the same force and effect as the signed original. I authorize my Agent, physicians, hospitals, and family members to rely on a photocopy, scan, facsimile, or electronic copy of this document.

13. Severability and Governing Law

If any provision of this directive is held invalid or unenforceable, the remaining provisions shall continue in full force and effect. This directive shall be governed by the laws of the State of MI, provided that it shall also be given effect in any other jurisdiction to the extent permitted by that jurisdiction's law.

Patient Self-Determination Act Notice

Under the federal Patient Self-Determination Act of 1990 (42 U.S.C. §§1395cc(f), 1396a(w)), hospitals, nursing homes, home health agencies, hospices, and HMOs participating in Medicare or Medicaid are required to ask adult patients whether they have an advance directive, to provide information about advance directives, and to not discriminate in care based on the existence or non-existence of a directive.

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Signature of Declarant

I sign this directive knowingly, voluntarily, and after careful consideration.

Declarant

_____ PRINTED NAME

_____ SIGNATURE

_____ DATE

Paper signing location. MI. If the place of signing and the place of care differ, check the rules for both. The residence entry does not establish where this document was signed.

Michigan paper patient advocate designation

The patient must be at least 18, of sound mind, and acting voluntarily. Choose an advocate and any successors who are at least 18. Sign and date the designation in the presence of both eligible witnesses. Both witnesses must sign. A notary alone does not complete this Michigan designation. Before implementation, make the designation part of the patient's applicable medical or mental-health record and give a copy to the proposed advocate. A successor must receive a copy and sign the acceptance before acting.

Declaration by each witness. The patient voluntarily signed the designation in my presence and appears of sound mind and free of duress, fraud or undue influence. I am neither the patient's spouse, parent, child, grandchild, sibling, presumptive heir, known devisee at witnessing, physician, nor a named patient advocate. I am not employed by a life or health insurer for the patient, a health facility treating the patient, a home for the aged where the patient resides, or a community mental health services program or hospital providing mental-health services to the patient.

Michigan witness 1

_____ PRINTED NAME

_____ SIGNATURE

_____ DATE

Michigan witness 2

_____ PRINTED NAME

_____ SIGNATURE

_____ DATE

Required acceptance before a patient advocate acts

By signing, each named advocate accepts the designation and these conditions:

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1. I can act only when the patient cannot participate in the applicable medical or mental-health decisions. If the designation authorizes anatomical gifts, that authority remains exercisable after death.
2. I cannot exercise a power concerning care, custody or treatment that the patient could not exercise personally.
3. I can withhold or withdraw treatment that would allow death only if the patient clearly and convincingly authorized me to make that decision and acknowledged that it could or would allow death.
4. I cannot be paid for acting as advocate. I may be reimbursed for actual, necessary expenses.
5. I must meet fiduciary standards of care and act consistently with the patient's best interests. The patient's known wishes expressed or evidenced while able to participate are presumed to be in the patient's best interests.
6. The patient may revoke this designation at any time by any means sufficient to communicate that intent.
7. Michigan allows an express waiver to delay revocation of certain mental-health authority for up to 30 days after intent to revoke is communicated. This designation contains no such waiver.
8. I may revoke my acceptance at any time by any means sufficient to communicate that intent.
9. A patient admitted to a health facility or agency retains the rights listed in MCL 333.20201.

Primary patient advocate: **[PRIMARY AGENT FULL LEGAL NAME]**

Primary advocate acceptance

_____ PRINTED NAME

_____ SIGNATURE

_____ DATE

Successor patient advocate: **[ALTERNATE AGENT FULL LEGAL NAME RECOMMENDED]**

Successor advocate acceptance

_____ PRINTED NAME

_____ SIGNATURE

_____ DATE

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Successor patient advocate: **[SECOND ALTERNATE AGENT FULL LEGAL NAME]**

Successor advocate acceptance

_____ PRINTED NAME

_____ SIGNATURE

_____ DATE

Distribution

This directive shall be distributed to, at minimum: (a) my primary-care physician; (b) my healthcare Agent and any alternate Agents; (c) the hospital or healthcare facility where I typically receive care; (d) close family members; and (e) if applicable, my state's advance-directive registry.

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