COMBINED LIVING WILL AND ADVANCE HEALTHCARE DIRECTIVE

State of residence: MO **Place of paper signing:** MO **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 MO, as a directive to physicians, my healthcare agent, family members, and all other persons concerned with my care.

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 Healthcare Agent

I hereby appoint the following person as my Healthcare Agent (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):

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

When authority begins. My Agent's authority begins when a physician determines in writing that I lack the capacity to make or communicate my own healthcare decisions, and ends when I regain capacity.

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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.

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.

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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. **Missouri — declaration to withdraw or withhold treatment.** Under §459.025, a declaration to withdraw or withhold treatment has no effect during a pregnancy diagnosed by my attending physician. My decisions while I can decide supersede the declaration. This provision concerns the declaration; it does not itself cancel an agent appointment or decide every question of care.

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 this directive at any time and in any manner that communicates my intent to revoke, regardless of my mental or physical condition. Methods of revocation include: (a) a signed and dated written revocation; (b) physical destruction of this directive with intent to revoke; (c) an oral statement of revocation made to my Agent or to a healthcare provider; or (d) the execution of a subsequent directive that, in whole or in part, supersedes this one.

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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 MO, 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.

Signature of Declarant

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

Declarant

_____ PRINTED NAME

_____ SIGNATURE

_____ DATE

Paper signing location. MO. 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.

Statement of Witnesses

Each of the undersigned witnesses attests under penalty of perjury that:

1. The Declarant is personally known to me (or proved identity by satisfactory evidence) and signed or acknowledged this directive in my presence;
2. The Declarant appears to be of sound mind and under no duress, fraud, or undue influence;
3. I am at least eighteen (18) years of age;
4. I am not the person appointed as Agent by this directive;

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5. I am not the Declarant's attending physician, an employee of the attending physician, or an operator or employee of a healthcare facility where the Declarant is a patient or resident (unless related to the Declarant);
6. To the best of my knowledge, I am not entitled to any portion of the Declarant's estate upon death under any existing will or by operation of law.

Witness 1	**Witness 2**
_____	_____
PRINTED NAME	PRINTED NAME
_____	_____
SIGNATURE	SIGNATURE
_____	_____
DATE	DATE

Notary Acknowledgment

State of MO County of _____

On this _____ day of _____**, 20**, before me, the undersigned notary public, personally appeared **[DECLARANT NAME]**, proved to me on the basis of satisfactory evidence to be the person whose name is subscribed to this instrument, and acknowledged that the Declarant executed the same for the purposes therein contained, of sound mind and free from duress.

Notary Public: _____ My commission expires: _____ [Notary Seal]

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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