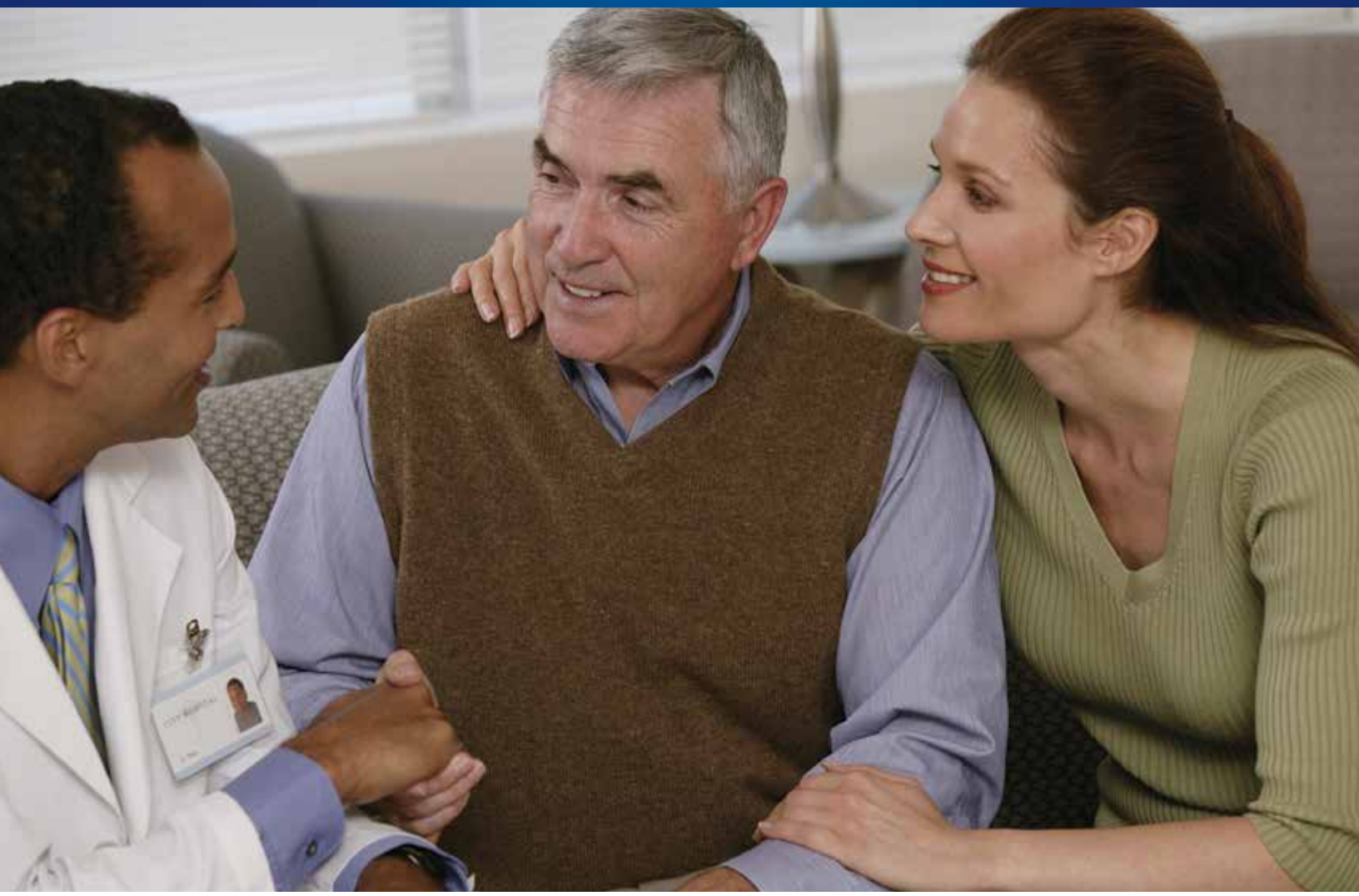

Advance Directive for Health Care

A document to help you choose your patient advocate
and express your health care wishes

ST JOHN PROVIDENCE

Believe in better

Blank back

Have a Say In Your Healthcare...
...When it Matters Most

Every day we plan for the smallest things—we plan what to wear, we plan what's for dinner, we plan what TV show we want to watch at night. However, we often neglect to plan for the big things in life like our own healthcare.

To begin planning for our own healthcare, we must first *reflect* on what's important to us: what are our most important values and beliefs? What past experiences have we had? Who do we want to help speak on our behalf? We must begin to plan in advance for what type of care we would want if we couldn't speak for ourselves.

Once we have successfully done that, this Advance Directive for Health Care form will help you document those plans and share them with your family members, friends, loved ones, and health-care providers.

This form is a **legal document** that has several parts. The parts will let you:

PART 1: First, understand – Frequently Asked Questions (FAQs)

PART 2: Start By Having Conversations

PART 3: Choose a Patient Advocate

PART 4: Create Guidelines for your Health Care

PART 5: Organ Donation

PART 6: Create Guidelines for your Mental Health Care *(Optional to Complete)*

PART 7: Make it Legal

PART 8: Continue Planning for the Future

FOR HEALTHCARE ASSOCIATES: Please check for completeness and ensure that the document owner has initialed pages 8-15 in the lower right corner. Please scan pages 8-15 into the Electronic Medical Record (EMR).

PART 1

First, Understand

Frequently Asked Questions (FAQs)

Here are some commonly asked questions and answers about Advance Directives:

What is an Advance Directive?

An Advance Directive is a form that is made in advance of a serious illness or accident that would keep you from being able to speak or make decisions for yourself. The Advance Directive lets you legally select someone to help make medical decisions in one of these situations and also lets you outline some of your choices and preferences for medical treatment. It is your legal right to complete an Advance Directive.

Who should complete an Advance Directive?

Everyone who is at least 18 years old or older and is of sound mind. Having an Advance Directive is a normal part of good healthcare and people who are healthy should especially have one.

Are Advance Directives just for people who are old or sick?

No. It is your legal right to have an Advance Directive. Having an Advance Directive is a normal part of good healthcare. Many healthcare providers ask every person that enters their office, hospital, or clinic if they have an Advance Directive.

When should I complete an Advance Directive?

You should complete an Advance Directive when you have reflected and feel confident about who your Patient Advocate is and what your values and beliefs are that will guide your medical care. It's best to do this before an emergency or serious illness happens, and it is good to start thinking about these topics as soon as you can.

Who should I give a copy of my Advance Directive to?

You should give a copy to your primary doctor, your Patient Advocate, and anyone else that you think should understand your preferences for health care. Even if you do not give a copy of your Advance Directive to all of your family members and loved ones, it is important to still communicate your plan with them so everyone understands what is important to you.

Does this Advance Directive expire?

No. There is no expiration date on this Advance Directive as long as it is your most current version.

Does the Advance Directive have any connection to my financial matters?

No. Although your Patient Advocate may also be called a "Durable Power of Attorney for Health Care" it is not the same as a "Durable Power of Attorney," which relates to decisions about your money and financial matters. This booklet does not address your finances or who will have the ability to make decisions related to your money.

Frequently Asked Questions (FAQs) continued

What is the difference between a "Durable Power of Attorney for Healthcare" and a "Patient Advocate?"

These two terms are used interchangeably. That is, by completing this Advance Directive and choosing a Patient Advocate, that person can also be considered your "Durable Power of Attorney for Healthcare". The State of Michigan uses the term "Patient Advocate" to describe the role of a "Durable Power of Attorney for Healthcare".

Do I need a lawyer to complete my Advance Directive?

No. Although some people select to complete their Advance Directive with a lawyer it is not necessary or even preferred. If possible, you should talk with your primary doctor, your Patient Advocate, and loved ones, though.

What if I change my mind after I have made my Advance Directive?

You can make a new Advance Directive at any time. Just like your thoughts, relationships and preferences change over time. It's likely that your Advance Directive will change over time, too. If you make a new Advance Directive be sure to destroy any old versions and give the new form to anyone who would have the outdated version. Be sure to give the new one to your primary doctor, your Patient Advocate and whoever else is important to you.

How do you decide what type of medical care you would wish to receive or not receive?

- Reflect on your values and beliefs, your lifetime goals, current health status, and the past experiences you have had.
- Have conversations with your primary doctor, family members, loved ones, Patient Advocate, and faith leader.
- Think about what questions you may have and ask your doctors, faith leaders, and other professionals to help you to understand these questions.

What is the difference between an Advance Directive and a Living Will?

The Living Will is just one section of the Advance Directive. By completing this Advance Directive, PART 4 is considered your Living Will or "Guidelines for your Health Care". The Living Will section helps to outline the type of medical care that you would wish to receive or not receive. It will help guide your doctors, nurses, and Patient Advocate make the best possible medical decisions for you if you were unable to communicate or make them for yourself.

Where can I get more information about Advance Directives?

Your primary doctor is a good person to ask for more information and guidance about Advance Directives. You can visit also St. John Providence's Advance Directive web page for a list of resources and additional information at www.stjohnprovidence.org/AdvanceDirective **OR** you can call 866-501- DOCS (3627) to see if there are any educational classes scheduled in your area.

PART 2

Start by Having Conversations

As you read through this booklet, reflect on what is important to you. Thinking about your values, beliefs, and past experiences can then help to guide the types of medical care you may – or may not – like to receive in different situations. Talk about it with your family, friends and physician(s).

As you reflect, here are some questions you, your loved ones, and your physician may consider or discuss:

- How do you define important terms like "Quality of Life" or "Terminal Illness"?
- What do you know about your health status?
- Have you been diagnosed with any serious illnesses already? What may those illnesses look like in one year from now? Five years from now?
- What is most important in your life right now?
- What makes you feel most comfortable or at-ease? Are they people? Are they feelings?
- Have you or your loved ones had any past experiences with serious illness or death? If you were in that situation again, what would you be most hopeful of? Most fearful of?
- What do you most hope to avoid?
- In your opinion, what would a "good death" look like?

Watch the educational video at www.stjohnprovidence.org/AdvanceDirective

Answering questions like the ones above may help reveal what your most important values, beliefs, and understandings are, and help to guide what type of medical care you would – or wouldn't – prefer to have.

Based upon your values, beliefs, and experiences, here are a few topics you may want to discuss with your faith or spiritual leader, physician, and Patient Advocate:

- Pain Management and Comfort
- Nutrition/Hydration
- Cardiopulmonary Resuscitation (CPR) Organ and Tissue Donation
- Mental Health

Take a look at the Resources tab at www.stjohnprovidence.org/AdvanceDirective for more tools to help guide you through reflecting and thinking about what's important to you.

PART 3

Choosing a Patient Advocate

Your Patient Advocate should be someone you trust. They should be someone who knows you, your values and your beliefs. He or she may have to make important health care and/or mental health decisions for you if you are not able to make them for yourself.

- Your Patient Advocate needs to be at least 18 years of age.
- He/she can be a family member, but does not need to be. It should be someone you trust to honor your wishes no matter how difficult the situation may be.
- Your Patient Advocate cannot be your physician, your medical or mental health professional, or any other professionals providing care to you.
- It is important to discuss your medical preferences with your Patient Advocate and your physician(s) so that they will know what you want.
- Your Patient Advocate cannot delegate his or her responsibility to someone else. But you can choose an "Alternate Patient Advocate" in case your first Patient Advocate is not able to fulfill his or her responsibilities.
- Your Patient Advocate and your Alternate Patient Advocate must be willing to accept the responsibility that comes with this role. The "Patient Advocate Acceptance Form" in this booklet needs to be signed by your Patient Advocate and the Alternate Patient Advocate.

STOP:

See page 17 for further instructions to complete this section.

Designation of Patient Advocate(s)

This form meets the legal requirements of the State of Michigan.

These instructions express my preferences about my medical care and/or mental health care if I am no longer able to make my own decisions as determined in writing by a treating physician and at least one other physician or licensed psychologist. (Michigan Compiled Laws "MCL" 700.5508). I want my family, caregivers, physicians, mental health professionals, and anyone else concerned with my health care needs to act in accordance with my wishes as stated in my Patient Advocate Designation Document and my Advance Directive.

By this instrument I intend to: (1) create a Durable Power of Attorney for Health Care under MCL Sections 700.5506-700-5512 of the Estates and Protected Individuals Code; (2) authorize my agent (patient advocate), at all times, to be able to request a copy of my medical records and obtain individually identifiable health information; and (3) authorize my agent to act as personal representative under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA").

My Patient Advocate or Successor Patient Advocate(s) may only act if I am unable to participate in making decisions regarding my medical or mental health treatment.

My Patient Advocate or Successor Patient Advocate(s) may delegate his/her responsibilities to the next successor Patient Advocate if he or she is unable to act, but cannot delegate his/her responsibilities to someone I have not designated.

Ⓐ I, _____ appoint and designate the following person(s)
(print your name)
as my Patient Advocate.

Ⓑ

Patient Advocate for Health Care:

Name _____

Address _____

Daytime phone #: _____ Cell phone #: _____

Alternate Patient Advocate(s)

I appoint the following person(s), in the order listed, as my Alternate Patient Advocate(s), if my Patient Advocate no longer accepts my appointment, is incapacitated, resigns, is removed, or is unavailable. My Alternate Patient Advocate is to have the same powers and rights as my Patient Advocate.

Ⓒ

First Alternate Patient Advocate

Name _____

Address _____

Daytime phone #: _____

Cell phone #: _____

Ⓓ **Second Alternate Patient Advocate**

Name _____

Address _____

Daytime phone #: _____

Cell phone #: _____

Patient Initials: _____

Healthcare Associate PLEASE SCAN THIS PAGE

PART 4

Guidelines for my Health Care

General Instructions

If I lose decision-making capacity, my Patient Advocate has the authority to consent or refuse the medical care (which could include but is not limited to testing, medication, surgery, procedure, hospitalization, and hospice care) prescribed by my physician consistent with law and regulation, including but not limited to the following:

- Interpret and communicate any instructions I have given in this document and in other discussions according to my previously stated wishes and values;
- Review and/or release my medical records, and personal files as needed for my medical care;
- If necessary for my medical care, arrange treatment, hospitalization, and my transfer in Michigan or any other state;
- Determine which health professionals and organizations may provide my medical treatment;
- Make choices about my mental health treatment, including the ability to consent to forced administration of medicines and inpatient hospitalization; or
- If I have included no specific instructions, act and make decisions that are in my best interest with considering my condition, treatment options, and stated values and beliefs.

Patient Initials: _____

Healthcare Associate PLEASE SCAN THIS PAGE

Specific Instructions

My Patient Advocate is to follow the specific instructions below, which may limit the authority described above in the General Instructions. I understand that I can choose one of the instructions regarding life-sustaining treatment listed below. If I choose one, I will sign my name below my choice. In all circumstances, I direct that all medically appropriate measures be taken to keep me comfortable and free from pain as much as possible.

Sign your name only once below one of the three following options.

1) I do not want my life to be prolonged if any of the following occur: (1) I have an incurable and irreversible condition that will result in my death within a relatively short time; (2) I become unconscious and, to a reasonable degree of medical certainty, I will not regain consciousness; and/or (3) the likely risks and burdens of treatment would outweigh the expected benefits.

My Patient Advocate has the authority to consent or request withdrawal of treatment. I understand that my decision may allow natural death to occur.

My signature: _____Date: _____

2) I want my life to be prolonged as long as possible with all medically appropriate interventions.

My signature: _____Date: _____

3) I want my Patient Advocate, my doctors and those providing care for me to make healthcare decisions in my best interests with consideration about my condition, treatment options, my stated values and beliefs, and potential use of time limited trial periods.

My Patient Advocate has the authority to consent or request withdrawal of treatment. I understand that my decision may allow natural death to occur.

My signature: _____Date: _____

Other thoughts about my medical care: _____

_____

_____

Patient Initials: _____

Healthcare Associate PLEASE SCAN THIS PAGE

Spiritual and/or Religious Needs

If I am nearing my death (initial all that apply):

_____ I would like my pastor/spiritual leader to be notified of my medical condition.

_____ I would like a representative of my place of worship with me as I am nearing my death.

I am of the _____ faith, and am a member of the _____ _____congregation or worship group.

Phone Number (if known): _____

PART 5

Organ Donation

At the time of my death, I want my Patient Advocate to respect the following request [initial one of the following]:

_____ I wish to donate any organs or tissue if possible.
(initials)

_____ I wish to donate only the following organs or tissue [specify]:
(initials)

_____

_____ I do not want to donate any organ or tissue.
(initials)

Patient Initials: _____

Healthcare Associate PLEASE SCAN THIS PAGE

PART 6

~ OPTIONAL ~

Guidelines for My Mental Health Care

Following is a list of types of treatment. I can choose none, one or more. By writing YES next to a choice, I give my Patient Advocate power to consent to that type of treatment. By writing NO next to a choice, my Patient Advocate CANNOT consent to that treatment.

_____ Outpatient therapy. If I need outpatient therapy, I prefer it to be provided by _____ .

_____ 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 _____ .

_____ My admission to a hospital to receive inpatient mental health services. If I need to be hospitalized, I prefer the following hospital _____ .

_____ If I need to be hospitalized, I prefer _____to take me to the hospital.

_____ Psychotropic medication (psychiatric medicine). I prefer to receive the following medication or medications: _____ .

I PREFER NOT to receive the following:

_____ Medication treatments: _____

_____

_____

_____ Electro-convulsive therapy (ECT).

_____ Placement in a group residence.

_____ Seclusion and restraints.

Because: _____

_____

What has worked in the past: _____

_____

Additional wishes:_____

Revocation Options For Mental Health

(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.

Patient Initials: _____

Healthcare Associate PLEASE SCAN THIS PAGE

PART 7

Signatures for Legal Documentation

The witnesses must be present when you sign this document!

Ⓔ I, _____, being of sound mind and at least 18 years
(print your name)
of age, have freely expressed these medical preferences and designated the above person(s) to serve as my Patient Advocate(s) when I am unable to participate in my medical and/or mental health decision-making.

_____ _____
(My signature) (Date)

Witnesses' Declaration:

I declare that the person who signed this document is known to me either personally or by presentation of valid identification (such as driver's license, passport, or other government issued photo ID card), and that the person signed it in my presence. The person who signed appears to be of sound mind and under no duress, fraud or undue influence, and is at least 18 years old. I am not the designator/signer's spouse, parent, child, grandchild, sibling, presumptive heir, known beneficiary of his/her will, devisee, physician, or Patient Advocate, nor am I an employee of a life or health insurance provider, or an employee of a health facility treating the person designating/signing this form. I further declare that I am at least 18 years old.

Ⓕ _____ _____
[Witness #1 Signature] [Witness #2 Signature]

_____ _____
[Print Name] [Print Name]

_____ _____
[Date] [Date]

Patient Initials: _____

Healthcare Associate PLEASE SCAN THIS PAGE

Patient Advocate Acceptance Form

Ⓖ I, _____, have discussed with _____
(Print Patient Advocate's Name) (Print Name of Patient)

his/her wishes, and I understand and accept the following:

1. This designation as Patient Advocate does not become effective unless the Patient is unable to participate in medical and/or mental health treatment decisions as determined in writing by a treating physician and at least one other physician or licensed psychologist.
2. The Patient has indicated his/her wishes regarding my authority to make an anatomical donation.
3. A Patient Advocate may not exercise powers concerning the Patient's care, custody, medical or mental health treatment that the Patient, when able to participate in the decision, could not have exercised on his/her own behalf.
4. This Patient Advocate designation cannot be used to make a treatment decision to withhold or withdraw treatment from a patient who is pregnant and that would result in the patient's death.
5. A Patient Advocate may make a decision to withhold (not to start) or withdraw treatment that would allow a Patient to die only if the Patient has expressed in a clear and convincing manner that the Patient Advocate is authorized to make such a decision, and that the Patient acknowledges that such a decision could or would allow the Patient's death.
6. A Patient Advocate shall not receive compensation for the performance of his/her authority, rights and responsibilities, but a Patient Advocate may be reimbursed for actual and necessary expenses incurred in the performance of his/her authority, rights, and responsibilities.
7. A Patient Advocate must act in accordance with the standards of care applicable to fiduciaries when acting for the Patient and must act consistent with the Patient's best interests. The known desires of the Patient expressed or evidenced while the Patient was able to participate in treatment decisions are presumed to be in the Patient's best interests.
8. A Patient may revoke his/her Patient Advocate designation at any time and in any manner sufficient to communicate intent to revoke. Mental health revocation can be waived for a 30 day period if that decision to waive that right is documented in this Advance Directive Document.
9. A Patient Advocate may revoke his/her acceptance of the designation at any time and in any manner sufficient to communicate an intent to revoke.
10. A Patient admitted to a health facility or agency has the rights enumerated in section 20201 of the public health code, 1978 PA 368, MCL 333.20201.

I accept the above responsibilities and my designation as Patient Advocate and agree to take reasonable steps to follow the desires and instructions of the Patient as indicated in this booklet, in other written instructions of the Patient, and as we have discussed verbally. If I am unavailable to act after reasonable effort to contact me, an alternate Patient Advocate, in the order determined by the Patient, shall act as a Patient Advocate until I become available.

Ⓗ _____ _____ _____
[Print Name of Patient Advocate] [Signature of Patient Advocate] [Date]

Ⓘ _____ _____ _____
[Print Name of 1st Alternate Patient Advocate] [Signature of 1st Alternate Patient Advocate] [Date]

Ⓙ _____ _____ _____
[Print Name of 2nd Alternate Patient Advocate] [Signature of 2nd Alternate Patient Advocate] [Date]

Patient Initials: _____

Healthcare Associate PLEASE SCAN THIS PAGE

PART 8

Next Steps

Now that you have completed your Advance Directive for Health Care, you should also take the following steps:

Communicate Your Plan:

- ✓ Review and discuss your values, beliefs, and health care wishes with the person you have asked to be your Patient Advocate, First Alternate Patient Advocate, and Second Patient Advocate.
- ✓ Talk to the rest of your family members and loved ones who might be involved if you have a serious illness or injury.
- ✓ Communicate your plan with your doctor and make sure that he or she understands who your Patient Advocate would be.

Give Copies:

- ✓ Give your Patient Advocate (and Alternate(s)) a copy of your Advance Directive for Health Care.
- ✓ Give a copy of your Advance Directive to your Primary Care Physician; discuss it with them to ensure your wishes and thoughts are understood.
- ✓ When you go to the hospital or nursing home, ask that it be placed in your medical record.
- ✓ Make a copy for yourself.

Review Regularly

- ✓ Review your Advance Directive annually and keep your Patient Advocate included to any further discussions.

Plan it Forward. **Tell others why you planned for your future health care affairs.**

Patient Initials: _____

Healthcare Associate PLEASE SCAN THIS PAGE

Review Your Plan

There is no expiration date with this legal document. However, it is recommended to review it every year at your wellness check or at any of the "5 D's" The 5 D's are:

1. *Diagnosis* of a chronic illness
2. *Decline* in functional status
3. *Death* of a loved one
4. Each *decade* of life
5. *Divorce*

If you do not want to change anything to the current document, you can reaffirm it by signing and dating below. If you need to make changes, complete another document and destroy this version.

My signature _____ Date _____

My signature _____ Date _____

My signature _____ Date _____

My signature _____ Date _____

My signature _____ Date _____

Notes

Patient Initials: _____

Healthcare Associate PLEASE SCAN THIS PAGE

Instructions for Completing PART 3 and PART 7 of this Advance Directive

Items Ⓐ -Ⓙ must be filled in before your Advance Directive can become legal. Please read each item's instruction carefully to make sure your Advance Directive can be a legal document in the State of Michigan.

Ⓐ Read the above text and print your name in the space provided (page 8).

Ⓑ Print the name, address, and phone numbers of the person you want to be your Patient Advocate in the space provided (page 8).

Ⓒ Print the name, address, and phone numbers of the person you want to be your Alternate Patient Advocate in the space provided (this person may also be referred to as your Successor or Back-up Patient Advocate) (page 8).

Ⓓ Print the name, address, and phone numbers of the person you want to be your Second Alternate Patient Advocate in the space provided (this person may also be referred to as your Second Successor or Second Back-up Patient Advocate) (page 8).

Ⓔ Print your name and sign your name to prove that you are making this Advance Directive being of sound mind and at least 18 years of age. This will be the same information as found in item **A** (page 13).

Ⓕ Have your two witnesses sign, print, and date their names on these two lines to prove that they are of sound mind, at least 18 years of age, and under no duress or undue influence. The witnesses will watch your Patient Advocate and (up to) two Alternate Patient Advocates sign the acceptance form on Page 14). The witnesses may not be: a family member, spouse, beneficiary to your will, an employee of the health system where you are receiving care, or the Patient Advocate themselves (page 13).

Ⓖ In the first space provided, print the Patient Advocate's name (found in item **B**); in the second space provided, print your name (also found in item **A**) (page 14).

Ⓗ Have the person you have selected as your Patient Advocate (as identified in item **B**) print, sign, and date their name (page 14).

Ⓘ Have the person you selected as your Alternate Patient Advocate (as identified in item **C**) print, sign, and date their name (page 14).

Ⓙ Have the person you selected as your Second Alternate Patient Advocate (as identified in item **D**) print, sign, and date their name (page 14).

Important Terms

Allow Natural Death (AND) – This is a choice you can make about how you'd like to spend your final days and hours. If you choose to Allow Natural Death, physicians and health care providers will attend to your spiritual, social, and physical needs by providing quality comfort care (excluding aggressive and invasive measures that do not provide comfort) and by encouraging the presence of family, friends, and loved ones.

Brain Death – The patient is pronounced dead when the doctor determines that all brain functions that maintain vital life organs have stopped.

Cardiopulmonary resuscitation (CPR) – An emergency procedure used to attempt to restore heartbeat when the heart and/or breathing has stopped. While this is important in an emergency, there are some situations that could make it ineffective or even undesirable. It is important that you discuss this with your doctor.

Code – An emergency response by a medical team to attempt to revive a patient whose heart or breathing has stopped.

Comfort Care – This is a means of minimizing pain and other symptoms. It includes support of family and loved ones as well as attention to your spiritual, social, emotional, and physical well-being. It usually excludes the aggressive and invasive measures that can cause a person more suffering without any real benefit.

Do Not Resuscitate (DNR) Order – Also known as "Do Not Attempt Resuscitation," this is an order that must be written by a doctor. It means that CPR would not be attempted to restore respiration and heartbeat. It is important to discuss this with your doctor. Your doctor can tell you if CPR would or would not be of benefit to you.

Electro-convulsive therapy (ECT) – This treatment is often known as electro shock therapy. It is most often used for the treatment of major depression when other treatments have not worked. Electrodes are placed on the patient's head to deliver electrical stimulus to the brain.

Hospice Care – Care that addresses the physical, emotional, educational, social, and spiritual needs of terminally ill patients, their caregivers, and families. It provides a compassionate approach to healthcare when curative measures are no longer an option. Hospice services can be provided by a team of professionals and volunteers in a private home, a nursing home, or a hospital.

Palliative Care – Specialized medical care for people with a serious illness. Palliative care is focused on providing people with relief from the symptoms, pain and stress of an illness with equal attention to emotional and spiritual well-being. Palliative care is delivered by a team of doctors, nurses and other specialists who work with a person's primary doctor to provide an extra layer of support. This type of care can be provided at the same time as treatment that is meant to cure a person.

Persistent Vegetative State (PVS) – a rare incurable condition in which the person is unable to speak, think, or move purposefully but breathing and heartbeat continue with periods of apparent wakefulness and sleep.

Terminal condition – a condition caused by an incurable illness or injury in which death may be expected within days or months. Life-sustaining procedures may sometimes be considered as only prolonging the dying process.

Wallet Cards

You should complete these wallet cards, cut them out and keep them in your wallet or purse. You may want to laminate them.

IN CASE OF EMERGENCY

My Patient Advocate Information:

_____

[Print Name of Patient Advocate]

_____

[Phone # of Patient Advocate]

_____

[Other Phone # of Patient Advocate]

has been appointed by me
as my Patient Advocate.

_____

[My Signature]

IN CASE OF EMERGENCY

My Patient Advocate Information:

_____

[Print Name of Patient Advocate]

_____

[Phone # of Patient Advocate]

_____

[Other Phone # of Patient Advocate]

has been appointed by me
as my Patient Advocate.

_____

[My Signature]

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