MISSISSIPPI
Advance Directive
Planning for Important Healthcare Decisions

CaringInfo
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CaringInfo, a program of the National Hospice and Palliative Care Organization (NHPCO), is a national consumer engagement initiative to improve care at the end of life.

It's About How You LIVE

It's About How You LIVE is a national community engagement campaign encouraging individuals to make informed decisions about end-of-life care and services. The campaign encourages people to:

Learn about options for end-of-life services and care
Implement plans to ensure wishes are honored
Voice decisions to family, friends and healthcare providers
Engage in personal or community efforts to improve end-of-life care

Note: The following is not a substitute for legal advice. While CaringInfo updates the following information and form to keep them up-to-date, changes in the underlying law can affect how the form will operate in the event you lose the ability to make decisions for yourself. If you have any questions about how the form will help ensure your wishes are carried out, or if your wishes do not seem to fit with the form, you may wish to talk to your health-care provider or an attorney with experience in drafting advance directives.

Using these Materials

BEFORE YOU BEGIN

1. Check to be sure that you have the materials for each state in which you may receive healthcare

2. These materials include:
    - Instructions for preparing your advance directive, please read all the instructions.
    - Your state-specific advance directive forms, which are the pages with the gray instruction bar on the left side.

ACTION STEPS

1. You may want to photocopy or print a second set of these forms before you start so you will have a clean copy if you need to start over.

2. When you begin to fill out the forms, refer to the gray instruction bars — they will guide you through the process.

3. Talk with your family, friends, and physicians about your advance directive. Be sure the person you appoint to make decisions on your behalf understands your wishes.

4. Once the form is completed and signed, photocopy the form and give it to the person you have appointed to make decisions on your behalf, your family, friends, health-care providers and/or faith leaders so that the form is available in the event of an emergency.

5. You may also want to save a copy of your form in an online personal health records application, program, or service that allows you to share your medical documents with your physicians, family, and others who you want to take an active role in your advance care planning.

INTRODUCTION TO YOUR MISSISSIPPI ADVANCE HEALTH-CARE DIRECTIVE

This packet contains a legal document, a **Mississippi Advance Health-Care Directive,** that protects your right to refuse medical treatment you do not want, or to request treatment you do want, in the event you lose the ability to make decisions yourself. You may complete any or all of the first four parts, depending on your advance planning needs. You must complete part 5.

Part 1 is a **Power of Attorney for Health Care**. This part lets you name someone (an agent) to make decisions about your health care in the event that you can no longer speak for yourself. The power of attorney for health care becomes effective when your doctor determines that you can no longer make or communicate your health-care decisions, unless you elect for it to be effective immediately.

Part 2 includes your **Individual Instructions**. This is your state's living will. It lets you state your wishes about health care in the event that you can no longer speak for yourself and

- are terminally ill,
- are permanently unconscious, or
- the likely risks and burdens of the proposed treatment would outweigh the expected benefits.

Your individual instructions go into effect when your physician determines that you can no longer communicate your wishes and one of the conditions listed above exists.

Part 3 allows you to express your wishes regarding organ donation.

Part 4 of this form lets you designate a physician to have primary responsibility for your health care.

Part 5 contains the signature and witnessing provisions so that your document will be effective.

This form does not expressly address mental illness. If you would like to make advance care plans regarding mental illness, you should talk to your physician and an attorney about an advance directive tailored to your needs.

Note: These documents will be legally binding only if the person completing them is a competent adult who is 18 years of age or older or an emancipated minor.

Instructions for Completing Your Mississippi Advance Health-Care Directive

How do I make my Advance Health-Care Directive legal?

In order to make your Advance Health-Care Directive legally binding you have two options:

1. Sign your document in the presence of two witnesses. Your witnesses must be at least 18 years of age. Neither of your witnesses can be:
    - the person you appointed as your agent,
    - a health-care provider, or
    - an employee of a health-care provider or facility.

In addition, one of your witnesses **cannot** be:

- related to you by blood or marriage or adoption,
- entitled to any part of your estate either under your last will and testament or by operation of law.

OR

2. Sign your document in the presence of a notary public.

Who should I appoint as my agent?

Your agent is the person you appoint to make decisions about your health care if you become unable to make those decisions yourself. Your agent may be a family member or a close friend whom you trust to make serious decisions. The person you name as your agent should clearly understand your wishes and be willing to accept the responsibility of making health-care decisions for you.

You can appoint a second person as your alternate agent. The alternate will step in if the first person you name as an agent is unable, unwilling, or unavailable to act for you.

Unless related by blood, marriage, or adoption, your agent cannot be an owner, operator, or employee of a residential long-term health-care institution at which you are receiving care.

Should I add personal instructions to my Advance Health-Care Directive?

One of the strongest reasons for naming an agent is to have someone who can respond flexibly as your health-care situation changes and deal with situations that you did not foresee. If you add instructions to this document it may help your agent carry out your wishes, but be careful that you do not unintentionally restrict your agent's power to act in your best interest. In any event, be sure to talk with your agent about your future medical care and describe what you consider to be an acceptable "quality of life."

What if I change my mind?

To revoke the designation of an agent in Part 1 of your Mississippi Advance Health-Care Directive, you must do so in a signed writing or by personally informing your primary physician or the provider who has undertaken primary responsibility for your healthcare.

Unless you provide otherwise, a decree of annulment, divorce, dissolution of marriage, or legal separation automatically revokes a previous designation of your spouse as your agent.

You make revoke all or part of your advance health-care directive, other than the designation of an agent, at any time and in any manner that communicates an intent to revoke by, for example, destroying the advance health-care directive.

A later advance directive that conflicts with an earlier advance directive will revoke the earlier advance directive to the extent of the conflict.

EXPLANATION

Explanation

You have the right to give instructions about your own health care. You also have the right to name someone else to make health-care decisions for you. This form lets you do either or both of these things. It also lets you express your wishes regarding the designation of your primary physician. If you use this form, you may complete or modify all or any part of it. You are free to use a different form.

Part 1 of this form is a power of attorney for health care. Part 1 lets you name another individual as agent to make health-care decisions for you if you become incapable of making your own decisions or if you want someone else to make those decisions for you now even though you are still capable. You may name an alternate agent to act for you if your first choice is not willing, able, or reasonably available to make decisions for you. Unless related to you, your agent may not be an owner, operator, or employee of a residential long-term health-care institution at which you are receiving care.

Unless the form you sign limits the authority of your agent, your agent may make all health-care decisions for you. This form has a place for you to limit the authority of your agent. You need not limit the authority of your agent if you wish to rely on your agent for all health-care decisions that may have to be made. If you choose not to limit the authority of your agent, your agent will have the right to:

(a) Consent or refuse consent to any care, treatment, service, or procedure to maintain, diagnose, or otherwise affect a physical or mental condition;
(b) Select or discharge health-care providers and institutions;
(c) Approve or disapprove diagnostic tests, surgical procedures, programs of medication, and orders not to resuscitate; and
(d) Direct the provision, withholding, or withdrawal of artificial nutrition and hydration and all other forms of health care.

Part 2 of this form lets you give specific instructions about any aspect of your health care. Choices are provided for you to express your wishes regarding the provision, withholding, or withdrawal of treatment to keep you alive, including the provision of artificial nutrition and hydration, as well as the provision of pain relief. Space is provided for you to add to the choices you have made or for you to write out any additional wishes.

Part 3 of this form lets you designate a physician to have primary responsibility for your health care.

EXPLANATION CONTINUED

Part 4 of this form lets you authorize your agent to make an anatomical gift on your behalf in accordance with your wishes if you have not done so yourself.

After completing this form, sign and date the form at the end in **Part 5** and have the form witnessed by one of the two alternative methods listed below. Give a copy of the signed and completed form to your physician, to any other health-care providers you may have, to any health-care institution at which you are receiving care, and to any health-care agents you have named. You should talk to the person you have named as agent to make sure that he or she understands your wishes and is willing to take the responsibility.

You have the right to revoke this Advance Health-Care Directive or replace this form at any time.

PART 1
POWER OF ATTORNEY FOR HEALTH CARE

(1) **DESIGNATION OF AGENT**:

PRINT YOUR NAME

I, _____, designate the
(your name)
following individual as my agent to make health-care decisions for me:

PRINT THE NAME, HOME ADDRESS AND HOME AND WORK TELEPHONE NUMBERS OF YOUR PRIMARY AGENT

_____
(Name of individual you choose as agent)

_____
(address) (city) (state) (zip code)

_____
(home phone) (work phone)

OPTIONAL: If I revoke my agent's authority or if my agent is not willing, able, or reasonably available to make a health-care decision for me, I designate as my first alternate agent:

PRINT THE NAME, HOME ADDRESS AND HOME AND WORK TELEPHONE NUMBERS OF YOUR FIRST ALTERNATE AGENT

_____
(Name of individual you choose as first alternate agent)

_____
(address) (city) (state) (zip code)

_____
(home phone) (work phone)

OPTIONAL: If I revoke the authority of my agent and first alternate agent or if neither is willing, able, or reasonably available to make a health-care decision for me, I designate as my second alternate agent:

PRINT THE NAME, HOME ADDRESS AND HOME AND WORK TELEPHONE NUMBERS OF YOUR SECOND ALTERNATE AGENT

_____
(Name of individual you choose as second alternate agent)

_____
(address) (city) (state) (zip code)

_____
(home phone) (work phone)

ADD PERSONAL INSTRUCTIONS ONLY IF YOU WANT TO LIMIT THE POWER OF YOUR AGENT

2) **AGENT'S AUTHORITY**: My agent is authorized to make all health-care decisions for me, including decisions to provide, withhold, or withdraw artificial nutrition and hydration, and all other forms of health care to keep me alive, except as I state here:

_____

_____

_____

_____

_____

(Add additional sheets if needed.)

INITIAL THE BOX ONLY IF YOU WISH YOUR AGENT'S AUTHORITY TO BECOME EFFECTIVE IMMEDIATELY

(3) **WHEN AGENT'S AUTHORITY BECOMES EFFECTIVE**: My agent's authority becomes effective when my primary physician determines that I am unable to make my own health-care decisions unless I mark the following box. If I mark this box [ ], my agent's authority to make health-care decisions for me takes effect immediately.

CROSS OUT AND INITIAL ANY STATEMENTS IN PARAGRAPHS 3, 4 OR 5 THAT DO NOT REFLECT YOUR WISHES

(4) **AGENT'S OBLIGATION**: My agent shall make health-care decisions for me in accordance with this power of attorney for health care, any instructions I give in Part 2 of this form, and my other wishes to the extent known to my agent. To the extent my wishes are unknown, my agent shall make health-care decisions for me in accordance with what my agent determines to be in my best interest. In determining my best interest, my agent shall consider my personal values to the extent known to my agent.

(5) **NOMINATION OF GUARDIAN**: If a guardian of my person needs to be appointed for me by a court, I nominate the agent designated in this form. If that agent is not willing, able, or reasonably available to act as guardian, I nominate the alternate agents whom I have named, in the order designated.

PART 2
INSTRUCTIONS FOR HEALTH CARE

If you are satisfied to allow your agent to determine what is best for you in making end-of-life decisions, you need not fill out this part of the form. If you do fill out this part of the form, you may strike any wording you do not want.

(6) **END-OF-LIFE DECISIONS**: I direct that my health-care providers and others involved in my care provide, withhold or withdraw treatment in accordance with the choice I have marked below:

INITIAL THE PARAGRAPH THAT BEST REFLECTS YOUR WISHES REGARDING LIFE-SUPPORT MEASURES

INITIAL ONLY ONE BOX

[ ] (a) **Choice NOT To Prolong Life**
I do not want my life to be prolonged if (i) I have an incurable and irreversible condition that will result in my death within a relatively short time, (ii) I become unconscious and, to a reasonable degree of medical certainty, I will not regain consciousness, or (iii) the likely risks and burdens of treatment would outweigh the expected benefits, or

[ ] (b) **Choice To Prolong Life**
I want my life to be prolonged as long as possible within the limits of generally accepted health-care standards.

INITIAL THE BOX ONLY IF YOU WANT ARTIFICIAL NUTRITION AND HYDRATION REGARDLESS OF YOUR MEDICAL CONDITION

(7) **ARTIFICIAL NUTRITION AND HYDRATION**: Artificial nutrition and hydration must be provided, withheld or withdrawn in accordance with the choice I have made in paragraph (6) unless I mark the following box.
If I mark this box [ ], artificial nutrition and hydration must be provided regardless of my condition and regardless of the choice I have made in paragraph (6).

ADD PERSONAL INSTRUCTIONS ONLY IF YOU WANT TO LIMIT COMFORT TREATMENT

(8) **RELIEF FROM PAIN**: Except as I state in the following space, I direct that treatment for alleviation of pain or discomfort be provided at all times, even if it hastens my death:

_____

_____

_____

_____

(Add additional sheets if needed.)

ADD OTHER INSTRUCTIONS, IF ANY, REGARDING YOUR ADVANCE CARE PLANS

THESE INSTRUCTIONS CAN FURTHER ADDRESS YOUR HEALTH-CARE PLANS, SUCH AS YOUR WISHES REGARDING HOSPICE TREATMENT, BUT CAN ALSO ADDRESS OTHER ADVANCE PLANNING ISSUES, SUCH AS YOUR BURIAL WISHES

ATTACH ADDITIONAL PAGES IF NEEDED

(9) **OTHER WISHES**: (If you do not agree with any of the optional choices above and wish to write your own, or if you wish to add to the instructions you have given above, you may do so here.) I direct that:

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

(Add additional sheets if needed.)

(10) **EFFECT OF COPY**: A copy of this form has the same effect as the original.

PART 3
PRIMARY PHYSICIAN
(OPTIONAL)

PRINT THE NAME, ADDRESS AND TELEPHONE NUMBER OF YOUR PRIMARY PHYSICIAN

(11) I designate the following physician as my primary physician:

_____
(name of physician)

_____
(address) (city) (state) (zip code)

_____
(phone)

PRINT THE NAME, ADDRESS AND TELEPHONE NUMBER OF YOUR ALTERNATE PRIMARY PHYSICIAN

If the physician I have designated above is not willing, able, or reasonably available to act as my primary physician, I designate the following physician as my primary physician:

_____
(name of physician)

_____
(address) (city) (state) (zip code)

_____
(phone)

PART 4
AUTHORIZATION FOR ORGAN DONATION
(OPTIONAL)

CROSS OUT AND INITIAL THIS STATEMENT IF YOU DO NOT AUTHORIZE YOUR AGENT TO MAKE AN ANATOMICAL GIFT OF YOUR ORGANS OR PHYSICAL PARTS

OTHERWISE, INITIAL YOUR ORGAN DONATION WISHES

ADD INSTRUCTIONS HERE ONLY IF YOU WANT TO LIMIT YOUR ANATOMICAL GIFT

(12) I authorize my agent to make this anatomical gift, if medically acceptable, to take effect upon my death. The words and marks below indicate my desires.

Upon my death, I wish to donate:
_____ My body for anatomical study if needed.
_____ Any needed organs, tissues, or eyes.
_____ Only the following organs, tissues, or eyes:

_____
_____
_____

I authorize the use of my organs, tissues, or eyes:
_____ For transplantation
_____ For therapy
_____ For research
_____ For medical education
_____ For any purpose authorized by law.

This authority granted to my patient advocate to make an anatomical gift is limited as follows *(here list limitations or special wishes, if any):*

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

(Add additional sheets if needed.)

PART 5: EXECUTION

This advance directive will not be valid unless it is EITHER:

IF YOU CHOOSE TO SIGN WITH WITNESSES, USE ALTERNATIVE 1, BELOW (P. 15)

(A) Signed in the presence of two adult witnesses, at least 18 years of age, who must also sign the document to show that they personally know you and believe you to be of sound mind and under no duress, fraud, or undue influence.

Neither of your witnesses can be:

- the person you appointed as your agent,
- a health-care provider, or an employee of a health-care provider or facility.

In addition, one of your witnesses cannot be:

- related to you by blood or marriage or adoption,
- entitled to any part of your estate either under your last will and testament or by operation of law.

(If you choose to sign with witnesses, use alternative 1 below).

OR

IF YOU CHOOSE TO HAVE YOUR SIGNATURE NOTARIZED, USE ALTERNATIVE 2, BELOW (P. 16)

(B) Witnessed by a notary.

(If you choose to have your signature notarized, use alternative 2, below).

SIGN AND DATE YOUR ADVANCE DIRECTIVE

PRINT YOUR NAME AND ADDRESS

YOUR WITNESSES MUST SIGN, DATE, AND PRINT THEIR NAMES HERE

WITNESS NO. 1 MUST BE UNRELATED TO YOU AND NOT HAVE ANY INTEREST IN YOUR ESTATE

Alternative No. 1: Sign Before Witnesses

_____ _____
(signature) (date)

_____
(printed name)

_____
(address)

DECLARATION OF WITNESSES

Witness No. 1

I declare under penalty of perjury pursuant to Section 97-9-61, Mississippi Code of 1972, that the principal is personally known to me, that the principal signed or acknowledged this advance directive in my presence, that the principal appears to be of sound mind and under no duress, fraud or undue influence, that I am not the person appointed as agent by this document, and that I am not a health-care provider, nor an employee of a health-care provider or facility. I am not related to the principal by blood, marriage or adoption, and to the best of my knowledge, I am not entitled to any part of the estate of the principal upon the death of the principal under a will now existing or by operation of law.

_____ _____
(signature of witness) (date)

_____
(printed name of witness)

Witness No. 2

I declare under penalty of perjury pursuant to Section 97-9-61, Mississippi Code of 1972, that the principal is personally known to me, that the principal signed or acknowledged this advance directive in my presence, that the principal appears to be of sound mind and under no duress, fraud or undue influence, that I am not the person appointed as agent by this document, and that I am not a health-care provider, nor an employee of a health-care provider or facility.

_____ _____
(signature of witness) (date)

_____
(printed name of witness)

Alternative No. 2: Sign Before a Notary Public

SIGN AND DATE YOUR ADVANCE DIRECTIVE

_____ _____
(signature) (date)

PRINT YOUR NAME AND ADDRESS

_____
(printed name)

_____
(address)

Notary Public

A NOTARY PUBLIC SHOULD COMPLETE THIS SECTION OF YOUR DOCUMENT

State of _____

County of _____

On this _____ day of _____, in the year_____,

before me, _____ (insert name of notary public)

appeared _____, personally known to me (or proved to me on the basis of satisfactory evidence) to be the person whose name is subscribed to this instrument, and acknowledged that he or she executed it. I declare under the penalty of perjury that the person whose name is subscribed to this instrument appears to be of sound mind and under no duress, fraud or undue influence.

Notary Seal

_____
(Signature of Notary Public)

Courtesy of CaringInfo
1731 King St., Suite 100, Alexandria, VA 22314
www.caringinfo.org, 800/658-8898

You Have Filled Out Your Health-Care Directive, Now What?

1. Your Mississippi Advance Health-Care Directive is an important legal document. Keep the original signed document in a secure but accessible place. Do not put the original document in a safe deposit box or any other security box that would keep others from having access to it.

2. Give photocopies of the signed original to your agent and alternate agents, doctor(s), family, close friends, clergy, and anyone else who might become involved in your health-care. If you enter a nursing home or hospital, have photocopies of your document placed in your medical records.

3. Be sure to talk to your agent(s), doctor(s), clergy, family, and friends about your wishes concerning medical treatment. Discuss your wishes with them often, particularly if your medical condition changes.

4. You may also want to save a copy of your form in an online personal health records application, program, or service that allows you to share your medical documents with your physicians, family, and others who you want to take an active role in your advance care planning.

5. If you want to make changes to your documents after they have been signed and witnessed, you must complete a new document.

6. Remember, you can always revoke your Mississippi document.

7. Be aware that your Mississippi document will not be effective in the event of a medical emergency. Ambulance and hospital emergency department personnel are required to provide cardiopulmonary resuscitation (CPR) unless they are given a separate directive that states otherwise. These directives called “prehospital medical care directives” or “do not resuscitate orders” are designed for people whose poor health gives them little chance of benefiting from CPR. These directives instruct ambulance and hospital emergency personnel not to attempt CPR if your heart or breathing should stop.

   Currently not all states have laws authorizing these orders. We suggest you speak to your physician if you are interested in obtaining one. **CaringInfo does not distribute these forms.**

Congratulations!

You've downloaded **your free, state specific advance directive.**

You are taking important steps to make sure your wishes are known. Help us keep this free.

Your generous support of the National Hospice Foundation and CaringInfo allows us to continue to provide these FREE resources, tools, and information to educate and empower individuals to access advance care planning, caregiving, hospice and grief services, and information.

I hope you will show your support for our mission and make a tax-deductible gift today.

Since 1992, the National Hospice Foundation has been dedicated to creating FREE resources for individuals and families facing a life-limiting illness, raising awareness for the need for hospice care, and providing ongoing professional education and skills development to hospice professionals across the nation.

Your gift strengthens the Foundation's ability to provide FREE caregiver and family resources.

Support your National Hospice Foundation by returning a **generous tax-deductible gift of $23, $47, $64,** or the most generous amount you can send.

You can help us provide resources like this advanced directive FREE by sending in your gift to help others.

Please help to make this possible with your contribution! Cut along the dotted line and use the coupon below to return a check contribution of the most generous amount you can send. Thank you.

YES! I want to support the important work of the National Hospice Foundation.

- ☐ $23 helps us provide free advanced directives
- ☐ $47 helps us maintain our free HelpLine
- ☐ $64 helps us provide webinars to hospice professionals

Return to:
National Hospice Foundation
PO Box 824401
Philadelphia, PA 19182-4401

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OR donate online today: www.caringinfo.org/donate