

# **MISSISSIPPI**

## **Advance Directive**

### **Planning for Important Healthcare Decisions**

Courtesy of CaringInfo

[www.caringinfo.org](http://www.caringinfo.org)

800-658-8898

CaringInfo, a program of the National Hospice and Palliative Care Organization (NHPCO), is a national consumer engagement initiative to improve care and the experience of caregiving during serious illness and at the end of life. As part of that effort, CaringInfo provides detailed guidance for completing advance directive forms in all 50 states, the District of Columbia, and Puerto Rico.

This package includes:

- 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.

#### **BEFORE YOU BEGIN**

Check to be sure that you have the materials for each state in which you may receive healthcare. Because documents are state-specific, having a state-specific document for each state where you may spend significant time can be beneficial. A new advance directive is not necessary for ordinary travel into other states. The advance directives in this package 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.

#### **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, scan, or take a photo of the form and give it to the person you have appointed to make decisions on your behalf, your family, friends, healthcare 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 your electronic healthcare record, or 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.

**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.

**Part 2** includes your **Individual Instructions**. This is your state's living will. It lets you state your wishes about healthcare 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.

**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 healthcare.

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

You may complete any or all of the first four parts, depending on your advance planning needs. **You must complete part 5.**

### **How do I make my Mississippi Advance Health Care Directive legal?**

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

Option one: 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**

Option two: Sign your document in the presence of a notary public.

## **Whom should I appoint as my agent?**

Your agent is the person you appoint to make decisions about your healthcare 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 healthcare decisions for you.

You can appoint a second person as your alternate agent. An alternate agent will step in if the person you name as 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 healthcare institution at which you are receiving care.

## **Should I add personal instructions to my advance directive?**

Yes! One of the most important reasons to execute an advance directive is to have your voice heard. When you name an agent and clearly communicate to them what you want and don't want, they are in the strongest position to advocate for you. Because the future is unpredictable, be careful that you do not unintentionally restrict your agent's power to act in your best interest. Be especially careful with the words "always" and "never." In any event, be sure to talk with your agent and others about your future healthcare and describe what you consider to be an acceptable "quality of life."

## **When does my agent's authority become effective?**

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.

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.

You retain the primary authority for your healthcare decisions as long as you are able to make your wishes known.

## **Agent Limitations**

Your agent will be bound by the current laws of Mississippi as they regard pregnancy and termination of pregnancies.

## **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 may revoke all or part of your advance healthcare 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 healthcare directive.

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

## **Mental Health Issues**

These forms do not *expressly* address mental illness, although you can state your wishes and grant authority to your agent regarding mental health issues. The National Resource Center on Psychiatric Advance Directives maintains a website (<https://nrc-pad.org/>) with links to each state's psychiatric advance directive forms. If you would like to make more detailed advance care plans regarding mental illness, you could talk to your physician and an attorney about a durable power of attorney tailored to your needs.

## **What other important facts should I know?**

Be aware that your advance directive will not be effective in the event of a medical emergency, except to identify your agent. Ambulance and hospital emergency department personnel are required to provide cardiopulmonary resuscitation (CPR) unless you have a separate physician's order, which are typically called "prehospital medical care directives" or "do not resuscitate orders." DNR forms may be obtained from your state health department or department of aging (<https://www.hhs.gov/aging/state-resources/index.html>). Another form of orders regarding CPR and other treatments are state-specific POLST (portable orders for life sustaining treatment) (<https://polst.org/form-patients/>). Both a POLST and a DNR form **MUST** be signed by a healthcare provider and **MUST** be presented to the emergency responders when they arrive. These directives instruct ambulance and hospital emergency personnel not to attempt CPR (or to stop it if it has begun) if your heart or breathing should stop.

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.

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**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.

EXPLANATION  
CONTINUED

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**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)

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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:

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(Add additional sheets if needed.)

(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.

(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.

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

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

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



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**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:

[  ] (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.

(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).

(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:

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(Add additional sheets if needed.)

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

INITIAL ONLY ONE  
BOX

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

ADD PERSONAL  
INSTRUCTIONS  
ONLY IF YOU WANT  
TO LIMIT COMFORT  
TREATMENT

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Palliative Care  
Organization  
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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:

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(Add additional sheets if needed.)

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

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**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:

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(name of physician)

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(address)

(city)

(state)

(zip code)

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(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:

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(name of physician)

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(address)

(city)

(state)

(zip code)

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(phone)

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**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.)

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**PART 5: EXECUTION**

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

(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**

(B) Witnessed by a notary.

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

IF YOU CHOOSE TO SIGN WITH WITNESSES, USE ALTERNATIVE 1, BELOW (P. 10)

IF YOU CHOOSE TO HAVE YOUR SIGNATURE NOTARIZED, USE ALTERNATIVE 2, BELOW (P. 11)

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**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)

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

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**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

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)

A NOTARY PUBLIC  
SHOULD  
COMPLETE THIS  
SECTION OF YOUR  
DOCUMENT