



The Arc[®]

The Arc Michigan
Guide to the Use of
Medical Powers of
Attorney

October 2015

Introduction

Many adults with intellectual or developmental disabilities use the assistance of others to help them make decisions about the services and supports they receive from the community mental health system and other public agencies. One way that a person can appoint another individual to make decisions on his or her behalf is by signing a Power of Attorney.

There has been much confusion in the field about the various types of Powers of Attorney available as well as their applicability and use by people with intellectual and developmental disabilities. This Field Guide was developed to give guidance about the types of documents that are appropriate and not appropriate for this purpose. By providing guidance on powers of attorney, we are ensuring that people can obtain the support they need in a manner that promotes their independence and autonomy.

Presumption of Competence

All individuals, regardless of disability, are presumed competent at the age of 18. Only a probate judge acting on a petition for guardianship or conservatorship can make a legal determination that a person is incapacitated or incompetent. For people with serious mental illness, guardianship (medical, education, living arrangements) and/or conservatorship (financial) is obtained under the Estates and Protected Individuals Code (EPIC). Guardianship of the person (medical, education and living arrangements) and/or estate (financial) for people with intellectual and developmental disabilities is obtained under the Michigan Mental Health Code (MMHC).

Like people without disabilities, many people with disabilities need support, but not the judicial involvement and oversight that guardianships and conservatorships require. Use of Powers of Attorney offers an important way for people to obtain the support they need. Presumption of competence requires that third parties not question an individual's capacity to execute a document that they present for this purpose. Questions of capacity, which must be presumed, must be separated from concerns about exploitation, which individuals working in the mental health system and other professionals may address through appropriate avenues.

Presuming competence means treating people with disabilities like people without disabilities and not requiring a higher level of knowledge than is required of the general population. The nature of community mental health services and supports, and other community-based services and supports, especially for people with intellectual and developmental disabilities, along with the use of the person-centered planning process, ensures against medically unnecessary, exploitative or experimental services that the concept of informed consent was designed to address.

Guardianship is a legal concept that removes a person's rights and autonomy, rather than supporting his or her freedom and authority. As such, guardianship directly conflicts with the foundation of the community mental health system including recipient rights, person-centered planning and self-determination.

History of Powers of Attorney

Throughout history, individuals have been able to appoint another person to handle a matter for them. These documents are called Powers of Attorney and have been recognized by courts since before the United States was founded. The person making the designation is called a Principal and the person appointed is called the Agent. The Principal gives to the Agent the power to perform acts on behalf of, in the place of, and instead of the Principal. Powers of Attorney terminate when the principal dies. Under common law, Powers of Attorney also terminate when the principal becomes incapacitated or unable to handle his or her affairs. The Michigan Supreme Court has stated that a person can appoint an Agent to handle any decision or matter that he or she could do themselves. Because, these Powers of Attorney evolved under common law, rather than statute, they are called common law Powers of Attorney.

While Powers of Attorney can be very specific (a single real estate transaction) or broad (all financial matters), like guardianship and conservatorship, financial and medical issues are handled in separate documents: Financial Powers of Attorney or Medical Powers of Attorney.

For the purposes of community mental health services, the documents that are useful or appropriate are Medical Powers of Attorney and Patient Advocate Designation (see below) because they deal with medical issues, service and support needs and where someone lives. Financial Powers of Attorney, while they may be very useful for other purposes, should not be accepted or used by Prepaid Inpatient Health Plans (PIHPs), Community Mental Health Service Programs (CMHSPs), their subcontracted agencies or other public agencies serving people with intellectual and developmental disabilities.

Statutory Powers of Attorney

To meet very specific needs, the Michigan Legislature has developed two specific types of Powers of Attorney to address concerns that arose from the use of common law Powers of Attorney. These documents do not invalidate or replace common law Powers of Attorney; they merely offer options not available under common law. These two powers of attorney were developed under the Estates and Protected Individual Code. These documents were not developed with people with intellectual and developmental disabilities in mind and not intended for use by people with intellectual and developmental disabilities.

Durable Power of Attorney for Finances

The Durable Power of Attorney is a financial power of attorney that either becomes effective when a person becomes incapacitated (springing) or is effective upon signing of the document and lasts through a person's incapacity. In both cases, the statutory wording that the document lasts through incapacity must be included. Typically, a Durable Power of Attorney would be executed by a person without disability to provide direction on how to handle his or her affairs should the person lose capacity through an illness or injury. This type of Power of Attorney is described in EPIC and must follow the statutory requirements including a statutory acknowledgement of responsibilities by the agent.

Patient Advocate Designation

Similarly, a Patient Advocate Designation is a statutory Power of Attorney to appoint a surrogate decision maker (Patient Advocate) to make decisions about health care. This statute was

passed in response to the national right to die cases in the early 1990s as well as a Michigan case. The Patient Advocate Designation can include a person's intentions or preferences for life-sustaining treatment if he or she experiences a terminal illness or injury (these preferences are often called Advance Directives). The form for a Patient Advocate Designation has very specific statutory requirements including limitations on who can witness the document. The Patient Advocate must sign an acknowledgement of responsibilities.

The biggest drawback to the Patient Advocate Designation (and the biggest barrier to its use to access services in the community mental health system) is that appointment of a Patient Advocate, by statutory definition, is a springing power that cannot be activated or used until the individual signing the document can no longer participate in medical treatment decisions. Like the springing Durable Power of Attorney for Finances, the legislature designed the document for people without disabilities whose Patient Advocate would only be needed when the person who executed the document experienced some change in their condition through illness, accident or injury. For more information on Patient Advocate Designation, please see [https://www.michigan.gov/documents/mdch/Advance Directive Supplement FAQs 474087 7.pdf](https://www.michigan.gov/documents/mdch/Advance_Directive_Supplement_FAQs_474087_7.pdf)

Patient Advocate Designation for Mental Health Treatment

The Michigan legislature has also provided by statute that a person who experiences mental health issues can put their preferences for mental health treatment (also called Psychiatric Advanced Directives) in writing. The Patient Advocate Designation for Mental Health Treatment has a very unique provision that states that Psychiatric Advanced Directives cannot be revoked for 30 days if a person is experiencing a mental health crisis.

For more information on Psychiatric Advanced Directives, please see:
http://www.michigan.gov/mdch/0,4612,7-132-2941_4868_41752---,00.html

To review a sample Patient Advocate Designation form that includes optional advance directives on life-sustaining treatment and psychiatric care, please see:
[https://www.michigan.gov/documents/mdch/DCH-3916 - Patient Advocate Designation-Final 474084 7.pdf](https://www.michigan.gov/documents/mdch/DCH-3916_-_Patient_Advocate_Designation-Final_474084_7.pdf)

Medical Powers of Attorney

As described above, Patient Advocate Designations are not usable or appropriate for many people with developmental disabilities and/or serious mental illness who want to appoint a loved one to be a surrogate decision maker NOW to help them make decisions about medical treatment and/or supports and services from the community mental health system. They may not understand or desire to express preferences regarding life-sustaining treatment so Patient Advocate Designations are neither desirable nor appropriate documents for them.

These individuals need and can use a very simple common law medical power of attorney that appoints an Agent to make decisions regarding medical treatment and/or services and supports from the community mental health system. These documents are written in very simple language and encompass simple concepts such as "If I am sick, I want my mom to take me to the doctor and make decisions for me." A Medical Power of Attorney should be labelled as such and should not be titled "Patient Advocate Designation" or use the language attached to that document through the statutory requirements. In executing a Medical Power of Attorney, a

person does not have to understand all of the risks and benefits of a medical treatment (that has general acceptance) in order to have the capacity to appoint a loved one to make decisions about such treatment on his or her behalf. Sample Medical Powers of Attorney are included below.

Authorized Representatives

The State of Michigan Department of Health and Human Services recognizes that a person can appoint an Authorized Representative to apply for assistance or otherwise act on his or her behalf. The Authorized Representative assumes all responsibilities of the person. The Authorized Representative must give his or her name, address and title or relationship to the person.

Application for Medicaid may be made on behalf of a person by his or her spouse, parent, legal guardian or any other person provided the person is at least 18 or married. If the person is not the spouse, parent, legal guardian, adult child, stepchild or core relative, the representative must have written authorization to act on behalf of the person from the person, person's spouse, parent or legal guardian. The form (DCH-1426-C (04/14)) is attached.

Under the Medicaid Rules, an Authorized Representative must be one of the following:

- An Adult Child or Stepchild;
- A Core Relative;
- Designated in Writing by the Person;
- Court-Appointed.

Core Relative is defined as a parent, including stepparent or grandparent, sibling, niece, nephew, aunt, or uncle. A core relative may be a specified or qualified relative.

Designation of An Authorized Representative is a very specific form of a power of attorney.

More Information on Authorized Representatives can be found in the Bridges Administrative Manuals (105 and 110), which are put out by the State of Michigan, Department of Health and Human Services. They are available online at www.mfia.state.mi.us/olmweb/ex/html .

Uniform Consent Form

The Michigan Department of Health and Human Services has developed a uniform consent form for behavioral health and mental health services that allows an individual (or an authorized representative acting on behalf of an individual) to state in writing who can receive confidential health related information and to limit (when necessary or desired) what information can be released. The form also has a place for the individual to sign to withdraw consent. The form (DCH-3927 (12/14)) is attached. More information on the Uniform Consent Form is online at http://www.michigan.gov/mdch/0,4612,7-132-2941_58005_70642---,00.html.

Representative Payee

The Social Security Administration does not accept any Powers of Attorney and has its own form/procedure for appointing a person to handle all Social Security Benefits (including Supplemental Security Income (SSI)). This person is called a Representative Payee (Form SSA-11).

**POWER OF ATTORNEY FOR MEDICAL TREATMENT AND
SUPPORT DECISIONS**

I am _____. I live at _____, _____, MI _____. I want my Mother, _____, to help me if I am sick and if I need to go to the doctor.

If I am sick, my Mother should take me to the doctor. If she is not at my house when I become sick, please call her to come to the doctor's office (or any other location). I would like the doctor to talk to her and tell her about my illness and if I need medicine or other treatments. After talking to the doctor and talking to me, I want my Mother to decide what care I should have. I want my Mother to be able to look at and have copies of all my medical and hospital records. Please share these records with her and give her copies if she asks for them.

I would also like my Mother to decide if I need to go to the dentist.

If I am very sick, I might need to go to a hospital. My Mother can decide if I need to go to the hospital. I would like all of the people at the hospital to speak with my Mother about what the people at the hospital should do for me. After talking to the doctor and talking to me, I want my Mother to decide what care I should have. This is very important since I want the people at the hospital to try very hard to care for me if I am sick.

I understand that I want my Mother to decide what care I need, and I want people to listen to her about my care. If my Mother is not happy with my doctor or any other care provider, then she is able to get another doctor or provider to care for me.

I would like my Mother to assist me with getting supports from the community mental health agency and any and all other social service agencies. My Mother should

read all the documents from these places and talk to me about them. If my Mother agrees, I will sign the documents, but I want my Mother to sign them too.

If my Mother is, at any time, unable or unwilling to act, I then appoint my Father, _____ as my agent. If my Father is, at any time, unable or unwilling to act, I then appoint my Sister _____, as my agent.

I understand that if I want to change my mind about who makes these decisions, I can destroy this paper or let people know I want to change my mind.

Dated:

Signed by _____ Signed by _____

(Print full name)

(Print full name)

POWER OF ATTORNEY FOR MEDICAL TREATMENT AND SUPPORT DECISIONS

I am _____. I live at _____, _____, MI _____. I want my Mother, _____, to help me if I am sick and if I need to go to the doctor.

If I am sick, my Mother should take me to the doctor, I would like the doctor to talk to her and tell her about my illness and if I need medicine or other treatments. After talking to the doctor, I want my Mother to decide what care I should have. I want my Mother to be able to look at and have copies of all my medical and hospital records. Please share these records with her and give her copies if she asks for them.

I would also like my Mother to decide if I need to go to the dentist.

If I am very sick, I might need to go to a hospital. My Mother can decide if I need to go to the hospital. I would like all of the people at the hospital to speak with my Mother about what the people at the hospital should do for me. After talking to the doctor, I want my Mother to decide what care I should have.

I understand that I want my Mother to decide what care I need, and I want people to listen to her about my care. If my Mother is not happy with my doctor or any other care provider, then she is able to get another doctor or provider to care for me.

I would like my Mother to assist me with getting services and supports from the community mental health agency and any and all other social service agencies. My Mother should read all the documents from these places and talk to me about them. If my Mother agrees, I will sign the documents, but I want my Mother to sign them too.

If my Mother is, at any time, unable or unwilling to act, I then appoint my Father, _____ as my agent. If my Father is, at any time, unable or unwilling to act, I then appoint my Brother, _____, as my agent.

I understand that if I want to change my mind about who makes these decisions,
I can destroy this paper or let people know I want to change my mind.

Dated:

Signed by _____ Signed by _____

(Print full name)

(Print full name)

POWER OF ATTORNEY FOR MEDICAL TREATMENT DECISIONS

I am _____ and I live at _____.
I want my mother, _____ to help me if I am sick and need to see a doctor. I want her to make decisions about my medical care, including medication and surgery.

If my mother, _____ is not available, I would like my _____, _____ to make these decisions instead.

If neither of the above are available, I would like my _____, _____ to make these decisions.

I understand that if I want to change my mind about who makes these decisions, I can destroy this paper or let people know I want to change my mind.

(Date)

(Signed)

Signed by _____ Signed by _____

(Print full name)

(Print full name)

CONSENT TO AUTHORIZE ADVOCACY AND RELEASE OF INFORMATION

I, _____ hereby authorize Community Mental Health to release/
exchange information with my parents, _____,
about my services, programs and living situation. I also wish that my parents be invited
to any and all meetings about me, and I do not want any decisions made without their
input. If CMH has any documents I need to sign, my parents must sign first to
acknowledge their receipt of these documents and their concurrence with them, before I
will sign. This authorization, unless otherwise revoked by me, is intended to remain in
effect for the duration of time I receive mental health services, etc. or until I revoke this
authorization, whichever comes first.

(name)

(date)

APPENDIX C

Assistance with Completing this Application

You can choose an authorized representative.

You can give a trusted person permission to talk about this application with us, see your information, and act for you on matters related to this application, including getting information about your application and signing your application on your behalf. This person is called an "authorized representative." If you ever need to change your authorized representative, contact the Michigan Department of Community Health or CHIP. If you're a legally appointed representative for someone on this application, submit proof with the application.

1. Name of authorized representative (First name, Middle name, Last name)		
2. Address		3. Apartment or suite number
4. City	5. State	6. ZIP code
7. Phone number () -		
8. Organization name		9. ID number (if applicable)
By signing, you allow this person to sign your application, get official information about this application, and act for you on all future matters with this agency.		
10. Your signature		11. Date (mm/dd/yyyy)

For certified application counselors, navigators, agents, and brokers only.

Complete this section if you're a certified application counselor, navigator, agent, or broker filling out this application for somebody else.

1. Application start date (mm/dd/yyyy)	
2. First name, Middle name, Last name, & Suffix	
3. Organization name	11. Date (mm/dd/yyyy)

 **NEED HELP WITH YOUR APPLICATION?** Visit www.michigan.gov/mibridges or call us at **1-855-276-4627**. Para obtener una copia de este formulario en Español, llame **1-855-276-4627**. If you need help in a language other than English, call **1-855-276-4627** and tell the customer service representative the language you need. We'll get you help at no cost to you. TTY users should call **1-866-501-5656**.



MICHIGAN DEPARTMENT OF COMMUNITY HEALTH

CONSENT TO SHARE YOUR HEALTH INFORMATION

THIS FORM CANNOT BE USED FOR A RELEASE OF INFORMATION FROM ANY PERSON OR AGENCY THAT HAS PROVIDED SERVICES FOR DOMESTIC VIOLENCE, SEXUAL ASSAULT OR STALKING. A SEPARATE CONSENT MUST BE COMPLETED WITH THE PERSON OR AGENCY THAT PROVIDED THOSE SERVICES. (See FAQ at www.michigan.gov/bhconsent to determine if this restriction applies to you or your agency)

Individual's Name: _____ **Date of Birth:** _____

Individual's ID Number (Medicaid ID, SSN, other): _____

Your consent is needed to share certain types of your health information including:

- Behavioral and mental health services
- Referrals and treatment for alcohol and substance use disorder
- Communicable diseases such as sexually transmitted diseases and human immunodeficiency virus (HIV Infection, Acquired Immune Deficiency Syndrome or AIDS Related Complex)

This information will be shared to help diagnose, treat, manage and get payment for your health needs. You can consent to share all of this information or just some information. (See FAQ at www.michigan.gov/bhconsent)

I. I consent to share my information among:

(Additional persons or agencies can be added at top of the next page)

- | | |
|----------|----------|
| 1. _____ | 3. _____ |
| 2. _____ | 4. _____ |

II. I consent to share:

- All of my health information listed above
-OR-
 All of my information listed above except:
(list types of health information you do not want to share)

III. By signing this form I understand:

- My information may be shared among each agency and person listed above
- My information will be shared to help diagnose, treat, manage and pay for my health needs
- My consent is voluntary and will not affect my ability to obtain mental health or medical treatment, payment for medical treatment, health insurance or benefits
- My health information may be shared electronically
- This form does not affect the sharing of my physical health information for purposes of treatment, payment, or health care operations or as otherwise allowed by law
- The sharing of my health information will follow state and federal laws and regulations
- This form does not give my consent to share psychotherapy notes as defined by federal law
- I can withdraw my consent at any time; however any information shared with or in reliance upon my consent cannot be taken back
- I should tell all agencies and people listed on this form when I withdraw my consent
- I can have a copy of this form

My consent will expire on the following date, event or condition unless I withdraw my consent.
(If expiration date is left blank or is longer than one year, the consent will expire 1 year from the signature date)

I have read this form or have had it read to me in a language I can understand. I have had my questions about this form answered.

Signature of person giving consent or legal representative _____ Date _____

Relationship to Individual

- Self Parent Guardian Authorized Representative

Additional persons or agencies – continued from previous page

5. _____ 8. _____

6. _____ 9. _____

7. _____ 10. _____

WITHDRAW OF CONSENT

I understand that any information already shared with or in reliance upon my consent cannot be taken back.

I withdraw my consent to the sharing of my health information:

- Between any of the following persons or agencies:

-OR-

- For all persons and agencies

Signature of person withdrawing consent or legal representative _____ Date _____

Relationship to Individual

- Self Parent Guardian Authorized Representative

Verbal Withdraw of Consent:

This consent was verbally withdrawn.

Signature of person receiving verbal withdraw of consent _____ Date _____

- Individual provided copy Individual declined copy

AUTHORITY: This form is acceptable to the Michigan Department of Community Health as compliant with HIPAA privacy regulations, 45CFR Parts 160 and 164 as modified August 14, 2002, 42 CFR Part 2, PA 258 of 1974 and MCL 330.1748 and PA 368 of 1978, MCL 333.1101 et seq and PA 129 of 2014, MCL 330.1141a.

COMPLETION: Is Voluntary, but required if disclosure is requested.

The Michigan Department of Community Health is an equal opportunity employer, services, and programs provider.