

# Incapacity and Powers of Attorney

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- I. Incapacity and Durable Powers of Attorney
- II. Drafting the Medical Durable Power of Attorney
- III. Drafting Financial Powers of Attorney

**Exhibits:**

- Exhibit A:** Assessment of Older Adults with Diminished Capacity
- Exhibit B:** Gift of Life of Michigan Organ Donor Registry Information
- Exhibit C:** Values History Form
- Exhibit D:** Michigan Statutory DNR
- Exhibit E:** Wallet Identification Card
- Exhibit F:** Affidavit for Financial Durable Power of Attorney
- Exhibit G:** Acceptance of Duties of Agent

## **I. Incapacity and Durable Powers of Attorney<sup>1</sup>**

The problem of diminished capacity has caused significant social and legal pressures. We as attorneys are called to sophisticated approaches, especially in the assessment, drafting and use of durable powers of attorney.

The first half of this presentation treats the Medical Durable Power of Attorney -- our main advance directive in Michigan. It offers specific provisions to tailor documents to various client needs. To enable these specialized terms and approaches, this section concentrates on understanding:

1. The numerous and different types of advance directives (both formal and informal);
2. The law surrounding advance directives, specifically the developments under federal constitutional law, federal legislation, Michigan legislation, Michigan common law and instructive laws under other states and legal movements;
3. The fundamental medical conditions, medical treatments and medical systems; and,
4. Your client's capabilities, wishes, preferences and pressures.

The second half of this presentation focuses on the General Durable Power of Attorney ("DPA") – the popular estate planning "workhorse" for management of affairs. Here, too, I offer specific terms and provisions to customize your documents for issues involving incapacity. This section defines:

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<sup>1</sup> Special thanks to Jeffrey D. Ryan, Esq. and Norman E. Richards, Esq. for their assistance in this project.

1. The role of a DPA compared to conservatorship, joint accounts and revocable living trusts;
2. The law surrounding DPAs on questions about capacity, execution and multiple agents;
3. Specific needs during incapacity, specifically handling the house, gift powers, trust powers, retirement plans, 529 plans and disclaimer powers;
4. Ways to curb abuses; and
5. Methods for acceptance by financial institutions.

**A. The Social and Legal Pressures.**

1. **Rising incidence of clients with diminished capacity.** We are now witnessing the aging of our population forecast in the early 80's and the prevalence of disability with our medical advancements.<sup>2</sup> In addition, there are increasing situations where dementia or lack of understanding is not clearly obvious, yet there is *diminished capacity* due to multiple chronic illnesses or neurological deficits.
2. **Increasing litigation involving incapacity.** We are also witnessing increased litigation and concerns about end of life decisions, placement and care decisions, as well as financial abuse under joint account arrangements, gifting and durable powers of attorney. Costly proceedings involving incapacity, undue influence and abuse of fiduciary relationships have resulted, further diminishing the privacy, autonomy, dignity and control of the client.
3. **Prevalence of boilerplate power of attorney forms.** In addition, there is a prevalence of boilerplate forms presuming uniformity of thinking. Many of these forms lack the necessary powers to deal with the particular hardships of a client's chronic illness, costs, accountability and preferences about care. Simple forms are available to the public at low cost and as an integral part of most estate plans. As it has grown omnipresent in use, increasing concerns have existed about **financial exploitation** of the elderly and **lack of accountability**. In addition, generic forms have fallen short to provide the specific legal authority required to address the specialized needs of the elderly, persons with disability and the incapacitated.
4. **Substantial recent statutory and case law developments surrounding incapacity and durable powers of attorney.** Durable powers of attorney are relatively new legal tools. Most of the case law in Michigan surrounding advance directives and financial durable powers of attorney has been in the last ten years.
5. **Ethical dilemmas for the Attorney.** Attorneys attempting to work with clients and with agents under power of attorney have struggled with ethical dilemmas. In particular, ethical tensions have existed under the Michigan Professional Responsibility Code ("MPRC") for these areas:

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<sup>2</sup> Nearly 40 million Americans will be 65 or older by 2010. By 2030, one-fifth of the U.S. Population, more than 70 million people, will be over the age of 65. Year US Census Report.

1. MPRC 1.14 - Screening of capacity for an attorney/client relationship;
2. MPRC 1.2 - Clarification of representation;
3. MPRC 1.6 - Protection of confidentiality; and,
4. MPRC 1.7 - Conflict of interests.

**B. Progress, policy failure or just emotionally difficult?**

1. Clear communications during the time of capacity are the key to preparing for the time of diminished capacity. Although progress has been made since the advent of advance directives in the early 1990's, statistics show most adults have not adequately prepared advance directives,<sup>3</sup> nor financial arrangements for incapacity.<sup>4</sup>
2. Studies have blamed these problems on lack of sufficient information, confusion due to different state laws and lack of proactivity from professionals and family members. Interestingly enough, studies have shown at least as to advance directives that "there is considerable evidence 'that the elderly's action of delaying execution of advance directives and deferring to others is a deliberate, if not an explicit, refusal to participate in the advance directives process.'"<sup>5</sup>

**C. Sophisticated assessments and planning language have developed.**

1. While it is clear that there have been major stumbling blocks surrounding planning for incapacity, sophisticated tools involving incapacity have evolved over the past ten years. Elder law attorneys, psychologists and geriatric care managers have developed specialized incapacity assessments and planning language, particularly for advance directives and the financial durable power of attorney.
2. To address the legal and ethical dilemmas with incapacity, the American Bar Association (ABA) and American Psychological Association (APA) have teamed up to create a practice handbook discussing the if, why, when, and how an attorney should conduct a preliminary assessment of screening of a client

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<sup>3</sup> There apparently, though, has been some progress in preparation of advance directives since the Cruzan case in 1991:

- A Gallup survey in 1991 showed only 20% of persons surveyed had an Advance Directive.
- A 2004 National Consumer Survey conducted by Booth Research showed only 33.5% of persons age 35-49, 42.6% of persons age 50-64 and 64% of persons 65 and older had advanced directives.
- A 2001 AARP reported 47% of respondents (all age 50 or older) had some form of Advance Directive; 35% over age 60 had some format of Advance Directive.

A newly released Gallup Poll showed that 94.5 percent of Americans surveyed support organ donation, and that more than 96 percent of them will carry out a donor's wishes if they are aware of those wishes. Only 50.5 percent of those surveyed, however, had voiced their own donor preferences to their families. Judge Kurtis Wilder, "Encouraging Organ and Tissue Donation," *Winter 2005, p.13 of Michigan Probate & Estate Planning Journal*.

<sup>4</sup> The AARP reports that in a survey approximately 45% of persons over 50 had executed a DPOA and approximately 70% of persons over 70 had completed one. *Where There Is a Will ... Legal Documents Among the 50+ Population: Findings from an AARP Survey*, AARP Research Group, April 2000.

<sup>5</sup> See Carl E. Schneider and Angela Fagerlin, "The Death of the Living Will," *University of Michigan Law School Quadrangle Notes* (Spring 2005).

with diminished capacity. The *Assessment of Older Adults With Diminished Capacity: A Handbook for Lawyers* provides a list of red flags for incapacity and provides a format to structure observations, documentation and conclusions about capacity. **See Exhibit A** for a copy of this evaluation and table of contents to the handbook, reprinted with permission for this seminar only.

3. In addition, elder law and special needs attorneys across the country have concentrated on developing specialized language treating the particular medical and financial problems for incapacitation.
4. The result has been *tailored documents* providing *specific help* in times of incapacity.

## **II. Drafting the Medical Durable Power of Attorney –**

### **Essential Terms and Provisions**

#### **A. Understand the different types of Advance Directives**

**Advance Directive:** *a statement (written or oral) made by a patient before the onset of decisional incapacity which indicates the direction for the patient's treatment when the patient is no longer able to participate in health care decisions for his/her care.*

Each type of advance directive serves a purpose. Use of a combined approach overcomes the particular disadvantages of each format and will provide the most powerful protection for a patient during times of incapacity.

1. **Living Will** – Document for specific care and treatment to be provided or declined under specific circumstances during incapacity for health care decisions. Ordinarily directs restraint on life support and treatments in the event of terminal or irreversible condition. Michigan is one of three states without a statute specifically authorizing living wills.  
Weaknesses: (1) Not recognized in Michigan. (2) Does not involve a specific person or agent with authority to assess the particulars of the situation or adjust to unanticipated conditions and treatments.
2. **Medical Durable Power of Attorney (“MDPOA”) / Patient Advocate Designation (“PAD”)** – Designates an Agent who the person trusts to make health care decisions during any time of incapacity. Recognized in Michigan under the Patient Advocate Act of 1990, effective January 1, 1991, see below.  
Weaknesses: (1) Requires specific guidance for the agent to represent the patient's wishes and to meet legal standards for end-of-life decisions. (2) On its own may not provide a sufficient portrait of the patient's values, wishes and communications.
3. **Family Consent / Informal Agreements** – Allows respect and dialogue for the persons closest to the patient without cumbersome formalities, especially when other advance directives are missing. Quite often the actual operation of hospitals and hospice systems where the closest relatives agree with the treating physician or nurse on the course of action for an incapacitated patient or patient with diminished capacity. Formally recognized only under limited

circumstances with the Michigan Dignified Death Act of 1996, see below.

Weaknesses: (1) Patient's wishes may become subject to disagreements of a committee, conflicts of interest and inadvertent omission of relevant persons. (2) No clear priority established for the patient's decision maker.

4. **Oral Directives** - Nine states now recognize oral directives of a patient recorded in the medical record. Generally not recognized in Michigan. The Michigan Supreme Court sent a clear message with the In re Martin case, discussed below, that mere general oral directives are insufficient, although it left open the possibility for a clear, explicit oral statement addressing the particular situation.

Weaknesses: (1) Lack of recognition; (2) difficulty of proof; and, (3) high probability of error.

5. **Physician's Orders** - Orders entered by the physician in a hospital or hospital-like setting directing or denying medical treatments. Hospitals have patients sign-off about risks and contingencies in anticipation of treatment.

Weaknesses: (1) Physician's records may be inaccessible when needed. (2) Statements made to multiple physicians may conflict.

6. **Hospital Policies Regarding Withdrawal of Treatment** - Hospitals must have an ethics committee to set policies on refusal of additional treatment. In the absence of an advance directive, treatment decisions are to be made in the patient's "best interests."

Weaknesses: (1) Financial pressures for hospitals due to limited resources, limitations by insurance and Medicare may influence decision. (2) Sets a personal decision to an outside committee.

7. **Do Not Resuscitate Order ("DNR")** - An order requesting not to initiate medical interventions in the event of an impending or actual cardiac arrest (when the heart stops beating and breathing ceases). Stops CPR and other medical procedures performed in an attempt to re-start the heart (eg. defibrillation, medications and artificial ventilation). Extended from hospital-like settings to the home by the Michigan Do-Not-Resuscitate Act of 1996, see below.

Weaknesses: (1) Contemplates only one form of life support. (2) Misunderstandings by most people. About the efficacy of CPR and need for a DNR.

8. **Organ Donation Registry** - Allows for a central registry to insure wishes about anatomical gifts are honored, especially when an individual dies suddenly and the Medical Durable Power of Attorney is not on file with the hospital where death occurs. Helpful when the Medical Durable Power of Attorney or driver's license registration cannot be found. "The Gift of Life Registry" in Michigan was established by the First Person Consent legislation passed in Summer 2003 (discussed below). **See Exhibit B.**

Weaknesses: (1) There is a general lack of awareness and education by the public. (2) It is irrevocable by family members or Patient Advocate even if they decide it is not what the donor would have wanted. (3) It should be consistent with other advance directives.

These weaknesses in awareness and communication have been addressed by these recent Michigan Public Acts:

- Public Acts 140,141,142 & 143 – Amends existing laws to strengthen Michigan’s donor registry and increase the number of donors. While states average 40% of the population as registered organ donors, Michigan has only 8%. Effective 1/1/07
- Public Act 176 – Requires county medical examiners to communicate with organ procurement agencies and enter into agreements to make more transplants possible. Effective 10/1905.

**9. Values History Form** - Allows a person to reflect their background and preferences about health care, treatment and end-of-life decisions. The best example through the years has been the University of New Mexico Values Clarification form developed by the University of New Mexico Center for Health Law and Ethics. It is intentionally not copyrighted, unlike other more recent forms. **See Exhibit C** for a copy.

Weaknesses: (1) It is not a binding legal document. (2) It generally lacks specificity. (3) It is cumbersome to fill out.

**10. Plan of Care** – “Long Term Care/Chronic Illness Advance Directive” – Sets forth the preferences and logistics on placement, care, access, safety and supervision. Primarily used for an at home or other long term care setting. Recognizes the specifics of how the person wishes their long term care needs to be met.

Weaknesses: (1) Lack of awareness about this essential role of geriatric care managers. (2) Not a legally recognized document.

**11. Five Wishes Form** - A booklet attempting to combine the separate functions of the living will, the medical durable power of attorney, the values history form in plain English. Substantially complies with the legal requirements in 35 states and the District of Columbia, including Michigan. Popular movement signed by over one million Americans provided by Aging with Dignity ([www.agingwithdignity.com](http://www.agingwithdignity.com)).

- **Wish 1:** Provides for a health care agent and specific powers (MDPOA);
- **Wish 2:** Sets forth desires on life support (Living Will);
- **Wishes 3-5:** Sets forth personal, spiritual and emotional preferences primarily about comfort, treatment and communications during end-of-life care (Values History form).

Weaknesses: (1) Lacks clarification of duties and acknowledgement by the Patient Advocate as required under Michigan law. (2) It is a form document not necessarily tailored under medical or legal professional advice. (3) By language of the form, “As soon as you sign it, it takes away any advance directive you had before.”

**12. Lifeline Registration** - Offers registration of Advance Directive documents for their subscribers. Provides fax forwarding of documents including allergies, current medications, medical conditions and contact persons to the specific institutions in a time of emergency. See [www.lifelinesys.com](http://www.lifelinesys.com) or call 1-800-543-3546. Usual enrollment fee of \$75.00.

Weakness: Lack of awareness about this wonderful service.

## **B. Understanding the Law**

### **1. Federal Constitutional Law**

**Cruzan v. Missouri Department of Health**, 497 U.S. 261 (1990) –

- Recognized a competent person’s right to refuse medical treatment as a protected “liberty interest” under the due process clause.
- Balanced this liberty interest with the state interest in protecting life, protecting minor children, prevention of suicide, and maintaining the integrity of the medical profession.
- Allows states to require “clear and convincing” evidence of an incompetent patient’s desires before removal of nutrition and hydration from a permanently unconscious patient.

**Washington v. Glucksberg**, 521 U.S. 702 (1997) – Rejects a federal constitutional right to assisted suicide under due process clause.

**Vacco v. Quill**, 521 U.S. 793 (1997) –

- Denied that there is a constitutional right to assisted suicide.
- Allowed for states to ban assisted suicide with exception of statutes violating the equal protection clause when they lack a rational basis for distinguishing physicians withdrawing life support and assisting suicide.
- Considered as “similarly situated” physicians who responded to requests of terminally ill, competent patients for self-administered prescribed drugs and physicians who at the request of the patient actively removed life support and administered pain relief drugs which themselves contributed to death.
- Impacts end-of-life health care decisions beyond assisted suicide debate by **questioning whether there is a tangible difference between (1) withdrawal of life support, administration of palliative drugs contributing to death and (2) self-administration of prescribed drugs**

### **2. Federal Legislation**

**Patient Self Determination Act of 1990**, 42 USC §§1395 and 1396 - an information and education mandate about advance directives:

- Requires hospitals, nursing homes and Medicare/Medicaid providers to give all adults upon admission written information about their state law rights on health care decisions;
- Requires requesting about advance directive at admission and noting in medical record; and
- Prohibits discrimination against persons without advance directives

**Health Insurance Portability and Accountability Act of 1996**  
(“HIPAA”), 42 USC 1320d; 45 CFR 160-164 –

- Creates uniform, national standards for maintaining privacy of health-related information (“PHI”).
- Required health professionals to have specific policies and procedures to maintain confidentiality of PHI by April 2003

**3. Michigan Legislation**

**Patient Advocacy Act of 1990**. MCL 700.5006, *et. seq.*, effective January 1, 1991 –

- Establishes the right of a *competent* adult to designate an agent to make health care decisions in the event the person is unable to participate in medical treatment decisions.
- Allows a statement of the patient’s desires on *care, custody and medical treatment*.
- Permits the patient advocate to make a decision to withhold or withdraw treatment which would allow the 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*.

**Dignified Death Act of 1996**, MCL §333.5651, *et. seq.* –

- Requires disclosures by doctors to terminally ill patients.
- Established a limited family consent law when the patient has a “reduced life expectancy due to an advanced illness.”
- A “patient surrogate” then has the right to (1) make an informed decision regarding receiving, continuing and refusing medical treatment and (2) choose palliative care treatment, including hospice care and pain management.
- Provides no clear priority for the patient’s surrogate decision-maker other than a mixture of family members including a parent, a member of the immediate family or next of kin.
- Provides physicians immunity for prescriptions of narcotic drugs in such circumstances.

**Do-Not-Resuscitate Procedure Act of 1996**, MCL §333.20192, *et. seq.* –

- Permits an adult person of sound mind to sign an order (“DNR”) with a doctor directing emergency personnel not to perform CPR in an out-of-hospital setting.
- Stops not only resuscitation, but also de-fibrillation, medications and artificial ventilation implicit with CPR.
- A statutory form is required and found at MCL 333.1055. **See Exhibit D.**
- It may be executed by “another person who, at the time of the signing, is in the presence of the declarant and acting pursuant to the

direction of the declarant.” This has been interpreted to include a patient advocate.

- Individuals who for religious reasons against physician assistance need not obtain the signature of a physician for a valid DNR.

**Ban on Assisted Suicide effective September 1, 1998**, MCL §750.329a –

- Provides for felony when knowledge that an individual intends to kill himself and (a) provision of means or (b) participation in act or (c) helps the individual to plan to kill himself.
- Does not apply to refusing, withholding or withdrawing medical treatment.

**Amendments to EPIC regarding Patient Advocate’s relation to Guardian effective January 1, 2001**

**For Patient Advocate Designations executed *before* the determination of legal incapacity:**

- Removed discretion of a court to grant a guardian the same powers of a patient advocate upon awareness of a validly executed patient advocate.
- Set strict terms for the court-appointed guardian not to override the medical treatment decisions of a Patient Advocate absent specific Petition alleging (1) invalid execution, (2) non-compliance with terms of designation or (3) not acting in the ward’s best interests. MCL §700.5306(5).

**After the determination of legal incapacity and appointment of a guardian a Patient Advocate Designation is not possible:**

- Bars the ability of a legally incapacitated individual with a guardian appointed for medical treatment decisions to “trump” the guardian by appointing another individual to make treatment decisions.
- Prevents an end-run around the process of the Petition for Removal of Guardian.

**End-of-Life Care Amendments of December 2001 and January 2002,**

Public Acts 216, 219, 231, 234-240 –

- Broadened access to end-of-life care for chronic illness by re-defining “terminal illness” from the last six months of life to “limited life expectancy due to advanced illness.”
- Broadened access to pain relieving medication by lowering threshold from “intractable pain” to a finding that the patient is in “pain.”
- Requires hospitals and nursing homes to inform and educate about availability of palliative and hospice care.
- Provides for a sticker to be placed on a driver’s license/senior citizen’s ID informing about the designated patient advocate; provides also for an emergency medical card. **See Exhibit E for a copy of the card.**

**First Person Consent Legislation of Summer 2003**, HB 4479 –

- This bill specifies that an anatomical gift made by a will or a document of gift (e.g. donor registry card) would not be revocable after the death of the donor, making the donor's wishes paramount.
- Adds state ID cards and driver licenses to the list of acceptable documents authorizing an anatomical gift.
- Deletes the requirement on the hospital's organ donor log sheet for the name and signature of the person making a donation request.

**Amendments to Mental Health Code effective January 3, 2005**, (Senate Bills 1464-1472) –

- Allows a Patient Advocate to make certain mental health care decisions on behalf of an individual.
- Recognizes the authority of a Patient Advocate to execute an application for formal voluntary hospitalization.
- Requires informing a Patient Advocate with such authority of a transfer to another hospital.
- Allows waiver by the patient for a 30-day period of the power to revoke the Patient Advocate designation when the Patient Advocate is making mental health care decisions.
- Requires specific statutory language in the Acceptance of Designation by the Patient Advocate recognizing such right of waiver.

**4. Michigan Common Law**

**In re Martin**, 450 Mich 399, 538 NW2d 399 (1995):

- Provided that a court may not authorize a surrogate decision-maker to waive the person's right to continued life-sustaining medical treatment unless it is established by clear and convincing evidence that the person, while competent, stated a desire to refuse life-sustaining medical treatment under the specific circumstances present. Id. at 233.
- After a serious injury from a 1987 car accident, Michael Martin could respond to stimuli, but could not communicate, nor process information. He was dependent on a gastronomy tube, colostomy and substantial supportive care.
- Case did not involve a medically defined persistent vegetative state or terminal illness, but rather a conscious patient of seriously diminished capacity.
- The withdrawal of gastronomy tube by his wife as Guardian was contested by his mother and sister, ultimately denied by the Michigan Supreme Court and denied cert. by the U.S. Supreme Court.
- The court rejected an objective, "best interests" standard except under the limited circumstances where there is no explicit evidence of what the patient would choose; then it would allow evidence of the patient's value system, and attitude toward sickness, medical procedures, suffering and death. Id. 220.

**5. Other Michigan Case Law**

**In re Joelle Rosebush, Minor**, 195 Mich App 675, 680; 491 NW2d 633 (1992): parents were allowed to withdrawal their minor daughter's life-sustaining treatment.

**People v. Messenger**, No. 94-2487FY (Ingham County Circuit Court, February 2, 1995): medical doctor acquitted for withdrawing his infant's life-sustaining medical treatment.

**Osgood (Young) v. Genesys Regional Medical Center**, No. 94-26731 (Genesee County Circuit Court, February 16, 1996) jury award of \$16 million against hospital not honoring advance directive directing termination of life sustaining treatment; jury verdict subsequently reduced to undisclosed amount.

**6. Instructive cases and laws of other states or legal movements:**

**In re Quinlan** - (the "Karen Ann Quinlan case") the first case to focus national attention on the problems created by artificial life support systems, incapacity, prolongation of suffering and permanent unconsciousness. The New Jersey Supreme Court affirmed that Karen's father as her adult guardian could withdraw her ventilator. Surprisingly, she continued to breathe spontaneously for an additional nine years while maintained on artificial feedings.

**In re Guardianship of Schiavo** - (the "Terry Schiavo case") the most recent, tortuous end-of-life struggle over the withdrawal of artificial nutrition and hydration ultimately ending Terry Schiavo's life. National attention centered on the grueling end-of-life litigation, involving legislative intervention temporarily staying the withdraw in the form of Terri's law, a declaration of unconstitutionality of the intervening legislation by the Florida Supreme Court and the decline of the U.S. Supreme Court to hear requests for appeal. Contests arose about her medical status of "persistent vegetative state" as well as her state of responsiveness and possibility of improvement. Nine days after the withdrawal of life artificial nutrition and hydration, Terry Schiavo died on March 31, 2005.

**Uniform Health-Care Decisions Act** - approved by the National Conference of Commissioners on Uniform State Laws, 1993, adopted in seven states and endorsed by the ABA, AARP and ABA Commission on Law and Aging. Not yet adopted in Michigan. Creates a comprehensive family consent law (without the necessity of terminal illness) with statutory priority among family members.

**Oregon's Assisted Suicide Statute** – Allows for self-administered procedures which will prematurely end a life under limited circumstances. No states allow for direct physician assisted suicide and Oregon is the only state to allow self-administered suicide.

## **Understand the Basic Medical Terminology, Medical Treatments and Medical Systems**

It is impossible to contemplate all medical conditions and treatments a patient may or may not desire as the list of possibilities gets longer every day. We generally remind clients that our Patient Advocate Designation is not a Living Will; it appoints generally a person they trust – and to whom they can impart their values and preferences. However, the client is charged with giving that Patient Advocate directions, especially about end-of-life decisions. Consider the Michigan Supreme Court’s dicta in the Martin case treating a patient advocate’s powers:

“A proper designation allows a third person to execute the patient’s treatment decisions, even if the decision will result in death, *provided the patient is in the condition delineated in the patient advocate designation.*”

Although the court acknowledged that the question of specific expression in the patient advocate was not the question before it, it certainly set a strong signal to the legal community to move toward clear and convincing expressions about end-of-life conditions and treatments.

### **1. Understanding and clarifying medical conditions.**

#### **a. Understand and clarify what is “terminal illness”**

Many Patient Advocate Designations still define the standard for hospice coverage under Medicare or less than six months to live for a “terminal illness”. This Medicare definition was developed around acute, hospital-like conditions.

The Michigan Dignified Death Act of 1996 and the “End of Life Care Amendments” of 2001, effective 2002 contemplate a more extensive definition: “limited life expectancy due to advanced illness”.

This definition considers chronic, long-term conditions such as Alzheimer’s disease, Parkinson’s disease, strokes and diabetes, in which it is more difficult to determine when patients are “terminally ill”.

As this is the new default statutory definition in Michigan for “end-of-life” care when a surrogate is appointed, we should offer it as an option to our clients in the end-of-life instructions within the Patient Advocate Designation. We may still want to have the clarity of the “six month” standard when acute illnesses are involved. A more refined approach would use a standard differentiating between acute and chronic terminal illnesses.

**Option #1: Medicare hospice definition** (which focuses on acute terminal illnesses -- as terminal cancer)

*“Terminal condition” means a condition which is reasonably expected to result in my death within six (6) months whether I receive medical treatment or not.*

**Option #2: Michigan statutory default standard for “end-of-life” care** (which is broadened to contemplate chronic illness)

*“Terminal condition” means a condition which involves a limited life expectancy due to advanced illness.*

**Option #3: Combination-standard differentiating between acute illnesses and chronic illnesses**

*“Terminal condition” means a condition: in the case of acute illness, a condition which is reasonably expected to result in my death within six (6) months whether I receive medical treatment or not; and in the case of chronic illness, where there is a limited life expectancy due to advanced illness.*

**b. Know the difference between “loss of cognitive/sapient state,” “coma,” “vegetative state” and “brain death” – your client likely doesn’t.**

A recent study found approximately 37 percent of patients after more than one month with a brain injury were diagnosed with a coma or persistent vegetative state *inaccurately*. The errors in diagnosis were believed to be the result of confusion in terminology, lack of extended observation of patients, and lack of skill or training in the assessment of neurologically devastated patients. N.L. Childs, et. al., “Accuracy of Diagnosis of Persistent Vegetative State,” 43 *Neurology* 1465-67 (1993).

If doctors are confused, how can we and our clients understand these terms in our advance directives? Reliance on general parlance from the news, etc. surely is not sufficient. Fortunately, there have been some clarifying efforts. **Here are some specific definitions.**<sup>6</sup>

- **Loss of cognitive/sapient state:** a qualitative state involving the loss of the ability to understand and reason. This could include later stages of dementia and Alzheimer’s disease, a person in a coma or a person in a vegetative state; the key is the loss of self-awareness and intellectual capacity to interact humanly with one’s family and friends.
- **Coma:** a clinical state of **unarousable** psychological **unconsciousness** in which the patient lies with his or her **eyes closed**.<sup>7</sup> Appears **unawake**, but distinguishable from sleep in that the person **does not respond** to external stimulation (e.g. sound, light or touch), nor to his or her inner needs (e.g., a full bladder.)

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<sup>6</sup>For the definitions under this section, we relied largely on John B. Oldershaw, M.D., J.D., Jeff Atkinson, J.D. and Louis D. Boshes, M.D., F.A.C.P., “Persistent Vegetative State: Medical, Ethical, Religious, Economic and Legal Perspectives,” 1 *DePaul J. Health Care L.* (Spring 1997) 495. This article compiled numerous medical treatises, ranging from government councils, to positions by the AMA and American Academy of Neurology.

<sup>7</sup>See *Id.*; see also the *American College of Physicians Complete Home Medical Guide*; see also *The AMA Home Medical Encyclopedia*.

- **Vegetative State:** a clinical state in which the patient **lacks** evidence of any **adaptive response** to the external environment, i.e. the absence of any evidence of a functioning mind which is either receiving or projecting information in a patient who has **long periods of wakefulness**. Patients in a vegetative state are able to open and move their eyes, have normal sleep/wake cycles, and may even spontaneously smile, chew and swallow. Motor movement is limited to posturing and reflexive withdrawal responses. *The difference between a coma and vegetative state is that a coma is a closed-eye state of unresponsiveness, whereas a vegetative state is an open-eyed condition with no evidence of **conscious** awareness.*
- **Brain death** refers to a **complete failure** of the functioning of the cerebral cortex of the brain (responsible for consciousness, emotions, higher mental functions) and the lower brain stem (responsible for vital automatic body functions as independent breathing, heart rate, coughing and swallowing).<sup>8</sup> *Versus* a vegetative state involves the loss of the functioning of the higher functions in the cerebral cortex of the brain. *Versus* a coma involves damage to the “reticular-activating system,” which results in an inability to arouse the patient. A person in a vegetative state or coma may eventually lose vital automatic brain functions irreversibly, causing death without the assistance of life-support machines and place them in a condition of brain death.

Providing for more exacting definitions in your Advance Directives can assist the Agents and caregivers in discerning the intentions of the patient:

**Definition #1: “Irreversible loss of awareness”** means a loss of consciousness or other condition from which there is no reasonable likelihood that I will recover to a cognitive (capable of understanding) or sapient (capable of reasoning) certified by two physicians who have personally examined me, one of whom shall be my attending physician.

**Definition #2: “Irreversible coma”** means an unarousable state of unconsciousness in which there is no reasonable likelihood that I will recover responsiveness to external stimuli as certified by two physicians who have personally examined me, one of whom shall be my attending physician.

**Definition #3: “Persistent vegetative state”** means the absence of any evidence of a functioning mind which is either receiving or projecting information (whether or not there are periods of wakefulness) in which there is no reasonable likelihood that I will

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<sup>8</sup> The Uniform Determination of Death Act specifies that a patient can be determined to be dead if the person has sustained **irreversible cessation of all functions of the entire brain including the brain stem**. See President’s Commission for the Study of Ethical Problems in Medicine and BioMedical Behavioral Research, *Defining Death: Medical, Legal and Ethical Issues in the Determination of Death* (U.S. Gov’t Printing Office, 1981).

*recover conscious awareness as certified by two physicians who have personally examined me, one of whom shall be my attending physician.*

**c. Understand and define what makes a coma “irreversible” and a vegetative state “persistent”.**

Clients regularly relate stories of the person who miraculously awoke from the coma or regained awareness after a vegetative state. The “time” element of this determination is often crucial for even the most life-support adverse clients (“give me at least some time to come out of it before they pull the plug” or “allow me to go if I’m ever in that state”).

This is one of the most important issues impacting their care, costs, prolongation of suffering and potential contests, as illustrated nationally by the Shiavo case. Studies show that most patients are in a vegetative state for one month or more and do not recover to a level of independent function. The American Academy of Neurology recommends a waiting period of three months to establish the diagnosis of “persistent vegetative state”. The American Medical Association recommends a twelve month waiting period to confirm the diagnosis and prognosis of “persistent vegetative state”.

The Schiavo case illustrates that medical experts can disagree well after a year into the onset of the vegetative state.

Because the decision to refuse and withdraw life support in Michigan is based on a subjective standard, the client has the opportunity define this time element and consider the degree of confirmation necessary for the trigger.

**Option #1:** require certification by two physicians of the irreversible nature of the coma or persistent nature of the vegetative state

**Option #2:** Set a relatively tight time frame for the determination of “irreversible” or “persistent”, to ease the burden of determination. For example, at least one week for a frail elderly client with multiple chronic conditions may be the preference. Other persons more concerned about holding out as a healthier, younger individual may set that period longer – as one year or more.

**d. Consider a definition based on loss of quality of life or functional abilities, but beware of vagueness or overly-broad authority which would be mistaken with euthanasia.**

Most states permit the removal of life-sustaining treatment only if the patient is in a terminal condition or is permanently unconscious. A few states – Hawaii, Maryland, New Jersey and Oregon – permit withdrawal of life support based on functional criteria and quality of life.

Michigan’s Health Care Power of Attorney statute has no express

limitation on this trigger for withholding or withdrawing treatment, other than ensuring clear and convincing expression and the acknowledgement it could result in the patient's death. MCL §700.5507(4). In addition, there is a restriction on this authority insofar as it would condone suicide or homicide. MCL §700.5512(4).

The statewide form circulated by the Michigan Bar and Michigan Hospital Association has provided for an option for refusal or termination as follows:

***Sample language:***

*Under any circumstances where my medical condition is such that the burdens of the treatment outweigh the expected benefits. In weighing the burdens and benefits of treatment, I want my Patient Advocate to consider the relief of suffering and the quality of life as well as the extent of possibly prolonging my life.*

***Weakness:*** The danger is understanding with enough specificity for what constitutes "quality of life" according to the subjective standard mandated under medical ethics, the Cruzan case and the Martin case. According to Martin there must be some form of explicit statement that meets the standard of "clear and convincing evidence". Mere general statements are insufficient.

Commentators have criticized the "quality of life" criteria suggesting an inordinate frequency of "bargaining down," in which many patients upon actually experiencing the condition, are willing to accept far less than what they originally would accept.<sup>9</sup>

***Solution:*** Consider a more functional definition, which provides specific measurable abilities as "recognition" and "interaction" with others and "total physical dependence." In addition, note that the withholding or withdrawal of treatment merely allows death through natural causes:

***Sample language:***

*If I am cognitively impaired to the extent that I have irrevocably lost my ability to recognize and interact meaningfully with my family and other loved ones and I have become totally dependent on others for my physical needs, as certified by two physicians who have personally examined me, one of whom shall be my attending physician, I desire to be permitted to die of natural causes.*

- e. **Understand that Alzheimer's is a condition, not a cause of death.**  
"Strictly speaking, no one dies of Alzheimer's. Rather, the die of a condition created by Alzheimer's. Most often this is pneumonia. The reason for this is that a person with advanced Alzheimer's loses the

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<sup>9</sup> See Carl E. Schneider and Angela Fangerlin, "The Death of the Living Will," *University of Michigan Quadrangle Notes* (Spring 2005).

ability to swallow, causing aspiration problems.” From Thomas J. Murphy, “Recent Developments in End-of-Life Decision Making,” *NAELA News* 10 (October 2004).

**2. Understand generally medical treatments, interventions and levels of care**

**a. The contentious issue: refusal or withdrawal of artificial nutrition & hydration** – There are various medical mechanical means to provide food and hydration when the person is unable to participate in manual drinking and feeding. Examples are:

- **IV** – a regular IV generally providing hydration with basic mineral/vitamin supplement.
- **Naso-gastric tube** – a feeding tube through the nostril into the stomach (long term health risk is infection and pneumonia)
- **Peg tube (gastrostomy)** – permanent opening through the abdominal wall inserting feeding tube
- **Total parenteral nutrition** – a solution of water, protein, fat, vitamins and minerals through a more permanent IV.

The client may want to differentiate between manual feeding used to provide nutrition and hydration and these mechanical means.

The U.S. Supreme Court in the Cruzan decision recognized artificial nutrition and hydration as a “medical treatment” subject to the right to withhold or withdraw. The Michigan Health Care Power of Attorney statute does not exclude hydration and nutrition as a treatment.

Significant moral and religious differences exist in this area (see statement issued by Pope John Paul II on March 20, 2004 considering artificial nutrition not a medical treatment, and thus withdrawal as morally wrong). This issue was the primary battle in the Martin case, as well as the Schiavo case.

Because of the hot contests in this area, specific authority again is key. Use a values history form to allow guidance under the client’s moral and religious perspective.

***Option #1 (allowing refusal or withdrawal of artificial nutrition and hydration):***

*My Patient Advocate may decide if artificially provided fluids and nutrition, such as by feeding tube or intravenous infusion, shall be instituted, or if previously instituted, that they be discontinued, even if other life-sustaining treatment is withheld or withdrawn.*

***Option #2 (requiring artificial nutrition and hydration if medically appropriate):***

*My Patient Advocate shall ensure provision of manual feeding used to provide me with nourishment and hydration, and if this is not medically possible, then institute artificially provided fluids and nutrition, such as by feeding tube or intravenous infusion, if*

*medically appropriate. I do not wish to have the withholding or withdrawal of artificially provided fluids and nutrition unless medically inappropriate.*

**b. Access to pain relief and palliative care – to what degree?**

International guidelines recommend the types of painkillers that are most effective for different levels of pain. This is known as the “analgesic ladder” and recommends specific types of painkiller for mild pain, moderate pain and severe pain.

- **Mild pain** -- Mild painkillers or anti-inflammatory drugs (e.g. aspirin or ibuprofen) in conjunction with other drugs
- **Moderate pain** -- Weak opioid painkillers (e.g. codeine) in conjunction other drugs
- **Severe pain** -- Strong opioid painkillers (e.g. morphine) in conjunction with other drugs.

There is a point where the administration of morphine and other severe pain relief medications will be addictive and may hasten death. Unconventional pain-relief therapies may cause legal controversy.

Allow the client to clarify his or her viewpoint on maximum levels of pain control and unconventional therapies in a values history form. Specify authority in the Patient Advocate. Consider requiring frequent assessments when the client is unable to communicate.

**Option #1 (Maximum pain relief; unconventional authorized):**

*To consent to and arrange for the administration of pain-relieving drugs of any kind or surgical or medical procedures calculated to relieve my pain, including unconventional pain-relief therapies, that my Agent believes may be helpful to me, even though such drugs or procedures may lead to permanent physical damage, addiction, or an earlier death, although not intentionally caused.*

**Option #2 (limitation on hastening death):** same as above, except striking the italicized phrase and providing “*except insofar as such pain relief would hasten death.*”

**Option #3 (frequent assessment):** *I request my Patient Advocate ensure that frequent assessments are made of any condition which may cause pain in the event I am unable to communicate directly the experience of such pain.*

**Option #4: (painful treatments):** *I request my Patient Advocate to refuse treatments which may cause me chronic pain.*

**c. Consider how the client will address other “life-sustaining treatments”**

Artificial respiration, kidney dialysis, antibiotics, chemotherapy, blood transfusion, surgery and invasive diagnostic tests are current examples of other “life-sustaining” treatment.

The Health Care Power of Attorney statute and the Martin decision encourage specificity, especially as to withholding or withdrawing life-sustaining treatments.

Since the Martin decision, there have been various suggested means for clients to provide directions to their Patient Advocate.

**Option #1:** Attach a chart delineating different life-sustaining treatments and the client's perspective.

**Weaknesses:**

The client will not be able to conjure up preferences for unspecifiable future circumstances and treatments. The chart is a "static" time capsule for the client and likely to change. Studies show elderly clients change preferences depending on the description of the treatment See Fagerlin and Schneider, supra, at 33.

**Option #2:** Give direct authority about the decision of life support with an accompanying definition of "life-sustaining treatments" supplemented by a values history form clarifying perspectives on various treatments.

*"Life-sustaining treatments" means the use of any medical device or procedure, drugs, surgery, or therapy that uses mechanical or artificial means to sustain, restore, or supplant a vital body function and thereby increases the expected life span of a patient.*

**d. Other questions for the client's preferences (which can also be addressed in a supplementary values history form). Does the client wish:**

- to refuse life-sustaining if it is unproven and/or experimental when it would only prolong an imminent dying process?
- to limit blood transfers to family members?
- to refuse chemotherapy if death imminent?
- to have an informal duty of consultation with other family members (as the client's child)?

**Option : Consultation.** *I would prefer that, if circumstances allow, my Patient Advocate discuss any decision to withhold or terminate life support with my children. However, this expression is precatory and my Patient Advocate shall be my sole representative.*

**e. Consider that most persons misunderstand the efficacy of CPR and need to be informed when to trigger a Do-Not-Resuscitate Order (DNR)**

Studies show that people overestimate the effectiveness of CPR and in fact do not know what it is.<sup>10</sup>

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<sup>10</sup>See K.M. Coppola, et. al., "Perceived Benefits and Burdens of Life-Sustaining Treatments: Differences among Elderly Adults, Physicians, and Young Adults," 1 *Journal of Ethics, Law and Aging* 4, 3-13 (1998).

In fact, one study of long term care residents showed that 0%-4% of patients survive to leave hospital if high burden of chronic disease and 12%-32% of patients survive to leave hospital if little accompanying pathology.<sup>11</sup>

Provide guidance on executing and registering a DNR for both the hospital and non-hospital setting (including home), especially for the frail elderly client

Many Medical Durable Powers of Attorney still lack specific authority of the Patient Advocate to sign a DNR order in accordance with Michigan law.

**f. Discuss organ donation, “Gift of Life” registration and the Patient Advocate’s role after death.**

**Option: Anatomical Gift.** *As authorized by the Michigan Uniform Anatomical Gift act (M.C.L. Section 333.10101, et al.), and in the hope that I may help others, I hereby make an anatomical gift of any of the useable and needed organs and parts of my body for the purposes of transplantation, therapy, medical research or education, without limitation. I make this gift without specifying a donee. I also authorize my Patient Advocate, pursuant to MCL Section 700.5506(1), et seq., to take whatever action is needed at or near my death to coordinate and facilitate the timely execution of my anatomical gift upon my death.*

**g. Specifically treat authority on mental health treatment**

Prior to the recent amendments to the mental health code, discussed above, Patient Advocates had little, if any, recognition of authority in the mental health setting. Inevitably the Patient Advocate had to seek court intervention through guardianship. This meant a public declaration of incapacity.

New powers allow the client suffering from bouts of depression, paranoia, schizophrenia or other mental illnesses, who acknowledges the need for help, to waive the right of revocation of the Patient Advocate for periods of involuntary hospitalization.

In addition, the Patient Advocate can have authority to deal with administration of medications, assisted outpatient treatment and release of information in the mental health setting.

**Mental Health Treatment Provisions.**<sup>12</sup>

*In this document, the term “medical treatment” includes “mental health treatment.”*

- a. *I authorize my Patient Advocate to obtain all information about my mental health treatment and I consent to the*

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<sup>11</sup>Murphy, “Do-Not-Resuscitate Orders: Time for Reappraisal in Long-Term-Care Institutions,” 260 JAMA 2098-2101 (1988)

<sup>12</sup> From Robert Anderson, Esq. per Elder Law Listserve.

- releases of such information to my Patient Advocate.*
- b. *I authorize my Patient Advocate to make a petition for an Assisted Outpatient Treatment (AOT) as an alternative to hospitalization.*
  - c. *I authorize my Patient Advocate to consent to forced inpatient hospitalization for mental health treatment.*
  - d. *I authorize my Patient Advocate to consent to the administration of medication for mental health treatment.*
  - e. *I waive my right to revoke this designation of my Patient Advocate for up to thirty days as permitted by Michigan statute.*

**h. Discuss the effects of acute and chronic illnesses on the different routes of care in light of the client's condition and concerns**

For acute (hospital-like) care, our medical systems provide an array of covered treatments and supports, largely covered by Medicare and health insurance. A statement about advocacy for sufficient hospital-stays and sufficient skilled therapies is increasingly useful to empower the Agent as Advocate.

**Option:** *I request and empower my Agent to appeal inappropriate discharges and denials of coverage necessary for my recovery and to take steps to ensure continued provision of skilled care, including directing continued provision of such care, even if it results in private payment pending determination by Medicare or health insurance.*

Chronic illnesses have suffered from lack of insurance coverage, as well as lack of adequate and appropriate access to pain and symptom management. Exhaustion of financial resources is much more likely, and quite often feared by clients.

**Option:** *Before undergoing expensive treatments or care which would merely prolong my life and not cure my chronic conditions of diabetes, multiple strokes, etc., I direct my Agent consider the impact on my financial resources, especially those assets I have saved for my dependent child/spouse.*

**C. Understand the client's capabilities, wishes, preferences and pressures.**

1. **Is the client capable? Assessing capacity:** This legal phrase has deeper roots in determinations of testamentary capacity for a will. It is presumed that an individual has the legal capacity to execute such a document. At the time of execution, the client must be of "*sound mind*". However, the specifics of possessing a "*sound mind*" are not defined under the Michigan Health Care Power of Attorney Act. The operative questions presumably are similar to the medical-ethics standards for determinations of capability of *informed consent*, specifically:

- Understanding – Does the patient comprehend the nature of the decisions the patient is authorizing and to whom these are being delegated?

- Appreciation – Does the patient her own situation and appreciate the role of the Patient Advocate in this situation?
  - Reasoning – Can the patient evaluate options involved in the decision delegated?
  - Expression of choice – Can the patient communicate the decision to delegate? The more serious the more important to describe, discuss and document in specific terms:<sup>13</sup>
  - Easy, effective treatments and ineffective, useless treatments have the least stringent standard. There is a presumption of capacity.
  - Less certain treatments require that the client understand the risks and outcomes of different options and be able to make a decision based on this understanding.
  - Dangerous treatment decisions which violate reasonableness and are counter to professional and public rationality involves the most demanding standard of competence. The client must appreciate with the highest degree of understanding the medical options, implications and be able to give personal reasons involving critical reflection.
2. **Consider your philosophy statement. Is it generic or is it the client's?** Try incorporating your client's philosophy and wishes into the document through attaching a values clarification form and/or letter of instruction. This treats the religious, moral and quality of life preferences of the client that might not be able to be captured through the structure of the Patient Advocate Designation.
- Is there any disagreement between the wishes of the patient, the family members and the patient advocate?
  - Implement steps to resolve disagreements and future ones, perhaps by excluding a difficult family member from input about care in the event of probate contest and nominating the Patient Advocate as the Guardian.
3. **Consider incorporating into the document an evolving Plan of Care.** Consider an advance directive about long term care – expressing preferences about care and placement in the event of chronic illness and loss of functioning. A geriatric care manager's interview of the client's preference and development of a letter of intent about care can forestall a probate battle about placement and care – especially when nasty or intermeddling children are expected to fight over the issues of care and costs.

**Sample language engaging instruction and periodic evaluation of geriatric care manager for plan of care:** *I direct my Patient Advocate seek instructions from \_\_\_\_\_, my geriatric care manager, or equivalent person, as selected by my Patient Advocate, about my preferences on placement, care, psycho-social functioning, safety and visitors in the event I am unable to care for myself or function independently. I intend for an evaluation of my condition and the appropriateness of my placement at least every six months or sooner,*

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<sup>13</sup> Hastings Center Report, Vol. 15:2, April 1985 and Laurretta Murphy, "Who Decides? Health Care Decision Making After In Re Martin," ICLE, 1996 *Medicaid and Health Care Planning Update*.  
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*depending on any changes identified by my Patient Advocate.*<sup>14</sup>

4. **Consider subtle and overt pressures for refusal of care due to determinations of “futility.”** Be sensitive to the effect of subtle (if not overt) pressures of economics and the influence over determinations of withdrawal of care. We increasingly witness inappropriate discharges of patients quicker and sicker due to lack of Medicare or health insurance determinations about coverage. Consider the subtle forms of “rationing” care as financial considerations dominate much of care decisions today in the health industry. Hospitals have the right to define and determine clear standards on “futility of treatment.”<sup>15</sup>

### **III. Drafting Financial Powers of Attorney**

#### **A. The DPA Defined:**

1. A DPA is a written instrument or contract in which a person (the “principal”) appoints one or more persons (the “agent” or “attorney-in fact”) and confers authority for the agent to perform certain acts for the principal.
2. It is **durable** because, unlike other agency relationships, there is specific reference for it not terminating upon the incapacity of the principal.
3. **DPA distinguished from other legal mechanisms for incapacity:**
  - a. **Conservatorships** are a public, time-consuming and expensive default mechanism through the Probate Court to provide for management of the affairs of an incapacitated individual.

#### *Reasons why a Conservatorship may be the only alternative:*

- Upon contractual incapacity, the “planning window” or opportunity to delegate authority through a DPA may be lost, leaving only probate court assistance as a last resort.
- Even when a DPA exists, probate court intervention in the form of a Protective Order or Conservatorship may be necessary because of *lack of adequate authority* in the DPA for the Agent to address the particular task.
- In addition, the “informality” of DPAs often leads to *conflicts over communications, duties and accountings*, which bring about this need for probate court intervention and the formal duties/procedures of the Conservatorship.
- DPAs are often rejected by financial institutions primarily due to policies about fraud. The lack of acceptance may be due to lapse of time, other execution requirements or simple intransigence preferring a sealed court order.

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<sup>14</sup>Special thanks to Laurel Felsenfeld, BSN, RN, CRRN, geriatric care manager, for her collaboration in the development of this concept.

<sup>15</sup>See Andrew Broder, “Between a Rock and a Hard Place: Hospital and Physician Refusal to Honor P.A.D.s”, ICLE, *1997 Medicaid and Health Care Planning Update*.

*How does a DPA affect a Conservatorship (and vice versa)?*

- A valid DPA with specific authority which is accepted by third parties assists in avoidance of court intervention through conservatorship upon the incapacity of the principal. The key components to avoiding the conservatorship are the validity, specific authority and acceptance. Court intervention may still be necessary when there are contests about the agent exceeding the scope of the authority or abusing the fiduciary position through self-dealing, undue influence or even coercion.
- An appointment of a conservator does not automatically revoke the authority of the agent. Rather, the conservator stands in the shoes of the incapacitated individual and is given the power to revoke or amend the power of attorney. MCL §700.5503(1). In addition, the agent is accountable to the conservator as well as the principal. *Id.*
- To reign in possible legal contests and concerns about the appointment of a guardian and conservator, EPIC does allow the principal to nominate the agent as his or her guardian or conservator. Only for good cause or disqualification of the agent can a court make a different appointment.

**Sample language:**

*Appointment of Conservator.* Pursuant to MCL 700.5409 and 700.5503, if it is determined by a probate court having jurisdiction over me that I am a protected individual in need of a conservator, I hereby specifically designate as my conservator my Agent in the order of priority designated in this General Durable Power of Attorney

- b. Joint Accounts** have been a default mechanism of financial institutions to enable access to particular financial accounts even during incapacity. The simplicity, cheapness and convenience has made this probably the most prevalent form of management for persons assisting an incapacitated individual.

*Reasons why DPAs are a better management mechanism than joint accounts:*

- Joint accounts do not give the authority to handle other affairs like a DPA like IRA elections or sales of real estate.
- DPAs entail a clear fiduciary relationship, unlike joint account arrangements. With proper education to the Agent on duties, accountability and limitations, the conflicts surrounding joint accounts can be avoided.
- In addition, DPAs are the legal mechanism for more complex transactions under a joint account than mere access to the account. For example, specific legal authority is required in a DPA or under a court order before a person can gift the property of an incapacitated individual to anyone, especially to himself or herself.

- There can be confusion about contribution to the joint account and ownership, especially at the death of one the joint owners.
  - Actions or the mere status of being a joint account owner can cause problems with federal estate taxes, federal gift taxes and Medicaid, especially if the joint owner commingles funds or withdraws funds for himself or herself.
- c. **Revocable Living Trusts** are contracts which can be extremely helpful for private management of affairs of an incapacitated individual. Unlike DPAs, which cease in authority at death, the revocable living trust bridges life and death, avoiding probate.

*Reasons why DPAs are essential management tools even when there is a revocable living trust:*

- Trusts can only manage assets in the name of the trust. Certain assets cannot or should not be named in the trust. The DPA is the only tool for access to these assets during incapacity of the owner, short of a Conservatorship. See discussion below on real estate and retirement plans.
- Trusts only affect certain assets – they do not provide for the broad scope of management for affairs outside of those assets.
- Even still, trusts often have a higher degree of acceptance by institutions because the title of the trust is registered right on the asset and because of the formal recognized fiduciary duties of trustees versus the informal arrangements involving agents under DPAs.
- The two instruments – the DPA and the Trust – should **work together through cross-references**, see examples below.

## **B. Understand the law affecting DPAs**

1. **DPAs are relatively new legal tools.** All fifty states did not have DPA statutes until 1987. It is now guided under the Estates and Protected Individuals Code (EPIC) with very simple formal requirements.

It must be **in writing** with the words “*This Power of Attorney is not affected by the principal’s disability or incapacity, or lapse of time*” or “*This Power of Attorney shall become effective upon the disability or incapacity of the principal*” or similar words of intent. MCL §700.5501.

2. EPIC has only a few other provisions about DPAs – affecting Conservatorships, revocation and sworn statements – all detailed below. The rest of the law comes from the **common law of agency** – primarily since the late 80’s.
3. Most of the DPA case law involves the fiduciary relationship between the principal and agent and violations of the fiduciary relationship. For an excellent annotation of the cases, see John Bos, “Drafting the Durable Power of Attorney and Patient Advocate Designation,” ICLE *Fundamentals of Estate Planning*, October 17, 2003.
- a. The main case to be aware of is *In re Susser Estate*, 234 Mich.App. 232

(2002) which formally recognized the fiduciary relationship between a principal and agent and required the agent to act in the principal's best interest.

4. Quite instructive on the law of DPAs is the *Restatement (Second) of Agency*, a massive legal work written in 1959. This is especially helpful in cases contesting the authority or actions of an agent under the DPA.

**5. Is the client capable?**

- The capacity requirement for the execution of a Financial Power of Attorney involves “contractual capacity,” not just “a sound mind.” When the principal has a mental impairment, the lawyer must make the same functional determinations of “informed consent” to the delegation. As outlined above, the lawyer must determine whether the understanding, appreciation, reasoning and communication for the affairs delegated.
- The client can only delegate to his agent what the client is capable of at the time of execution that is the financial knowledge, skills and judgment to handle at that time. Operative questions then are:
  - Knowledge of finances – Can the client discuss bank statements, check ledgers, particular investments and personal financial data?
  - Skills for practical financial procedures or actions– Can she write checks? Can she make change?
  - Judgment – Is he sensitive to fraud or undue influence? Does she consider prudent investment principles?
- The Michigan Courts in *Persinger v. Holst*, 248 Mich. App. 499, 639 N.W.2d 594 (2001) must be competent enough to understand in a reasonable manner the nature and effect of the act in which the person is engaged. This is particularly important when dealing with a Durable Power of Attorney and empowering the Agent with the power to do gifting.

**6. What are the execution requirements?**

- Only a signed writing under EPIC. Practically, however, it should be at least witnessed by two independent witnesses (not a person benefiting in the arrangement) and notarized.
- Michigan recording standards require the notarization of the principal's signature before the DPA can be recorded.
- To ensure validity in other states, the DPA should be witnessed and the notary's signature should be sealed. (Michigan abandoned its seal requirement).
- For more, see the section on “Acceptance of the DPA,” below.

**7. Can I have multiple agents?**

- There is no limitation under the law. Some commentators have suggested requiring co-agents as a ‘check and balance’ from abuse. Practically, though, it is often an invitation to disaster for families who cannot get along. One or both of the agents often get frustrated with the requirement

that both agents must sign. The Restatement of Agency requires both signatures of agents unless expressly provided otherwise.

- We instead have strict reporting requirements, accountability and approval by successor agents or persons considered to be “adverse” under federal tax regulations as a ‘check and balance,’ particularly for gifting and self-dealing transactions.
- If there are disputes among agents, the DPA should have a mechanism for arbitration and name the arbiter.

**Sample language:**

**Arbitration.** *If my agents cannot agree on a decision or action under this DPA, then the dispute shall be resolved by arbitration carried out under the rules of the Michigan Uniform Arbitration Act by a single arbiter, who shall be \_\_\_\_\_ if he or she is available.*

**C. Address specific needs during incapacity**

**1. Handling the house and other real estate**

**a. Legal descriptions no longer required.**

Michigan no longer requires specific reference to the legal description of the real estate in the DPA for the agent to convey or otherwise exercise a power over real estate. MCL §700.5502. Other states, however, may require the legal description, and as such, we always attach an adaptable Schedule A in which we list the legal description, address and parcel ID for all parcels.

**b. Statement of Intent to Return Home.**

- This statement protects against assertions of the house as a “countable” asset under Medicaid for a single individual because of the physical impossibility of returning home and it is not occupied by other persons otherwise entitled to keep the home. Michigan rules currently do not allow for Medicaid to force the sale of the house as a spend-down measure when there is an intent to return home, regardless of physical impossibility. See Michigan Program Eligibility Manual Item 400, p.18.
- Other states, however, are not as lenient. For example, in Connecticut, the applicant must prove the intent to return home is “reasonable.” In New Jersey, a home must be sold within six months of the date of an application for Medicaid if the applicant does not actually return home.
- In addition, there is an exception under federal Medicaid regulations for “estate recovery” when for hardship when there is a “home of modest value.” HCFA Transmittal No. 75 §3810C defines a home of modest value as one having a value of 50 percent or less of homes in the county where the home is located.

**Sample language:**

**Intent to Return Home and to Maintain Residence.** *It is my preference and intention to dwell in my home as long as possible. In the event that I am admitted to a care facility, including a nursing home or other assisted living facility, it shall always be my intention to return to my home and occupy it as my primary residence. My Agent shall have discretion to maintain my home for me in order to permit me to return to my home in the event I am admitted to a care facility of any kind, even though it may be considered a imprudent investment. In addition, my Agent may obtain loans for expenses in preservation and maintainance of the property in the event I have insufficient income and assets to pay for such expenses.*

**c. Authority to add the property to a revocable living trust and to direct the trustee to remove the property from the revocable living trust**

- There are a number of common instances where this power is extremely helpful:
  - A residence in a Medicaid applicant's name is an exempt asset in determinations of Medicaid eligibility. Michigan PEM Item 401. However, if the residence is in a trust it is a countable asset.
  - When there is a spouse in the nursing home, we generally want to ensure the community spouse can fund his or her trust (which may disinherit the Medicaid spouse or provide for a testamentary trust for the Medicaid spouse).
  - Most mortgage underwriters require removal of the house from the trust name to the name of the grantor(s) for purposes of refinancing.

**Transfer Assets to Revocable Trust and Withdrawal of Assets.** *To transfer any property I own, real, personal or mixed, wherever located, to the trustee(s) (or a nominee for said trustee(s)) of any revocable trust I have created or shall create at any time, including THE «TrustName» LIVING TRUST, whether or not I amend the trust after the date of this power (even though my Agent is a trustee of such trust), and to remove any of my assets from any such trust to the extent necessary or appropriate in the implementation of any power I have granted my Agent under this power of attorney*

**d. Authority to Engage Payments for Home Care and Chores.**

Medicaid presumes “divestment” when family members are paid for providing care except when an obligation existed at the time services were rendered. Michigan Medicaid Program Eligibility Manual Item 405.

This specific language verifies this obligation, clarifies payment amounts, services, “at-will” employment and requires approval by an “adverse party”:

**Sample language:**<sup>16</sup>

**Payments for Care of Assistance in Home.** *I intend to remain in my own home, despite any worsening medical condition. Should I need assistance with day to day tasks or direct care, I authorize my Agent to use my income and savings to pay for home services or care, whether provided by family members, friends or others in the business of providing such services. Should any agent, family member, or any other friend provide care or services for me in my, her or his home when I am in need of help, then my agent shall compensate that agent, family member or friend as follows:*

- a. *If the family member or other person resigns from or takes a leave of absence from paid employment in order to care for me, that person shall be compensated at not less than the amount that he or she would have been paid at the job which he or she has left or from which he or she has taken a leave of absence. I intend that the employed care giver be fully reimbursed for loss of income or benefits.*
- b. *If the family member of other person is unemployed while providing care, or is employed but spends free time helping me, he or she shall be compensated at the then current fair market rate for the in-home services being provided.*

*The type of services which I understand can keep me in my home despite a deteriorating medical condition include: home and yard maintenance, house cleaning, laundry, shopping, food preparation, security services, telephone call-in service, in-home personal care (such as bathing or medication management), taxi/transportation service, companion care and nursing care. These service all have value to me, although I understand that certain services would cost more on the open market. I direct my Agent to arrange for reasonable compensation to any person, including the agent, who provides these services to help me stay in my home*

*I direct my Agent reflect this caregiving arrangement in writing in the form of a caregiving contract which allows either person to act “at-will” with no obligation for life care arrangements. In addition, I direct that my Agent make payment for services at the time they are rendered to avoid implications of divestment under Michigan Program Eligibility Manual Item 405 or the equivalent state and federal regulations then in existence for Medicaid at that time.*

*To the extent my Agent is involved personally as a caregiver, and receives payment or benefit, my Agent shall defer decisions regarding payment to a*

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<sup>16</sup> Adapted from Cynthia Barrett, “Elder Law Incapacity Planning,” *University of Wisconsin /ABA Estate Planning Conference* (Summer 1999).

*person having a substantial interest in the property subject to this payment, which is adverse to the exercise of this payment power in favor of Agent.*

## 2. Gifting Powers in the DPA

- a. **Educate the principal and agent about the implications of gifting,** especially with Medicaid, transfer tax consequences and fiduciary duties.
- b. **Gifts by the agent without express authority make the gift void for tax purposes and voidable for probate purposes.**
  - The Internal Revenue Service requires express donative powers in the durable power of attorney for gifting authority to exist. PLR 9231003. Otherwise, the gift is not considered valid, and thus is not exempt for gift tax purposes.
  - The Estates and Protected Individuals Code (EPIC) has no requirement for express gifting authority in the durable power of attorney.
  - However, MCL §700.1214 prohibits self-dealing by a fiduciary. As a general rule powers of attorney must be “strictly construed and powers cannot be implied. *Long v. City of Monroe*, 265 Mich 425, 427, 251 NW 582 (1933).
  - A similar rule has been implied under Medicaid, although there is no requirement for express gift authority in the Medicaid regulations.
- c. **An agent owes fiduciary obligations to act in the principal’s best interests, not to self-deal, not to subvert the principal’s estate plan and to account.**
  - The *principal’s need for the funds and loss of control* upon gifting should always be considered before granting powers of the agent to gift in the DPA.
  - Absent express authority authorizing the Agent to gift, actions weakening the principal’s position through gifting are at the very least a violation of the duty to act in the principal’s best interests, and worse, can be considered **conversion of assets**, subject to civil and criminal penalties. Conversion of assets by a fiduciary results in **double damages** to the principal under EPIC. MCL §700.1205(4).
  - See *Hackney v. Onaway Community Federal Credit Union*, Michigan Court of Appeals No. 246196 (decided October 21, 2004, UNPUBLISHED) denying rights of agent in joint c.d. when no express authority for gift to agent existed in DPA; but see also *Murphy v. Hegyi (in re Estate of Commin)*, Michigan Supreme Court, SC: 129622 (decided April 26, 2006) reversing court of appeals imposition of constructive trust for recovery of proceeds against agent when **knowledge and consent of principal** existed, even after passage of time and decline in principal’s mental status.
  - As the fiduciary is in a **close and confidential position** to a vulnerable person, the fiduciary is under a **higher duty** to justify

actions causing disparities or deviation from the intent of the testator. Self-dealing and excessive gifts without express authority are *prima facie* evidence of abuse. **Incapacity, undue influence, coercion and abuse** of delegated authority become easy arguments when the estate plan is subverted.

- d. **Gifts are not illegal under Medicaid (at least today).** However, the agent should consider any potential divestment penalties and be prepared to verify statements back three years if Medicaid becomes necessary. (5 years upon implementation of the new rules under the Default Reduction Act, effective 4/1/06, not yet implemented in MI). If the need for Medicaid is anticipated, gifting authority should be considered to a community spouse, child with a disability, minor children, child caregivers who reside in the house and siblings who reside in the house.
- e. For estates exceeding the current lifetime estate tax exemption of \$1,500,000, consider **full use of gifting through the annual exclusion of \$11,000 as well as qualified health and education gifts.**
- f. Gifting appreciated assets “in kind” may result in **unnecessary capital gains taxes** at death with the loss of the stepped-up basis at death.
- g. **Avoid clauses based on prior gifting history**, as prior patterns rarely exist and may not be applicable. Rather, we carefully look at the family circumstances and overall intent on distributions.
- h. **Beware of the express or implied *general power of appointment* . . .**
  - Even if the client does not have a taxable estate, there can be dangers to the agent with the deeming of the principal’s assets into the agent’s estate if the agent predeceases the principal because of an express or implied “general power of appointment.” Painful transfer tax consequences may result to the agent with a taxable estate even if the agent did not in fact benefit personally.
  - A general power of appointment is defined in IRS regulations as a power “that is exercisable in favor of the power holder, his estate, his creditors, or the creditors of his estate.” I.R.C. §2041. Property subject to a general power of appointment is included in the estate of the deceased power holder. A “power of appointment” includes “all powers which are in substance and effect powers of appointment” without regard to what they are called. Treas. Reg. §20.2041-1(b).
  - This problem arises if the Agent has too broad of authority, either expressly because of an unrestricted power to gift, or implicitly, because of a power to discharge a legal obligation of support or create estate plan arrangements that may benefit the Agent.
  - **There are a variety of means to *cleanse* the DPA from an express or implied “general power of appointment”:**
    - **Restricting gifting to a class of persons and/or charities AND/OR**  
*To make gifts as my Agent deems proper, with any of my real estate or personal property including my business interests, to*

*my spouse (if I am married), any of my children, their spouses, or their descendants (and their spouses), or to any charitable organization.*

- **Restricting gifting to the annual gift tax exclusion, exempt gifts and gifts under the marital deduction AND/OR**

*No gifts to a single person except to my spouse in a calendar year shall exceed the annual federal gift tax exclusion, as indexed for inflation (presently \$11,000.00 per donee under Internal Revenue Code Section 2503(b) except for direct payment of health and education expenses qualified for exclusion under Internal Revenue Code Section 2503(e).*

- **Restricting gifting to an ascertainable standard AND/OR**

*Any gifts my Agent may make to him or herself as a permissible donee hereunder shall be limited by an ascertainable standard related to my Agent's health, education, support and maintenance, and my Agent may not make gifts that would discharge my Agent's legal obligation of support.<sup>17</sup>*

- **Requiring approval by an “adverse” party for tax purposes AND/OR**

*All gifts shall be made as my Agent deems proper and the sole discretion of my Agent; however, any gift my Agent makes to himself or herself shall be approved by a Successor Agent considered to be adverse for federal estate and gift tax purposes or other person considered to be adverse (or legal representative of that person considered to be adverse).*

- **Provide a general restriction against general powers of appointment:**

*It is not my intention that this power grant to my Agent a power of appointment which would result in the inclusion of any assets of mine and my Agent's estate.*

**i. Consider an equalization clause among family lines to remove disincentive from gifting in the taxable estate**

- When there is a *taxable estate* and death is imminent, we generally advise clients to maximize use of annual exclusion gifting, as well as health and education gifting, to as many family members with whom the client is comfortable receiving benefits. This may include in-laws and grandchildren for this limited purpose. These actions, though, can lead to disparities among the children or family lines. We have found a general reluctance to gift unless there is a provision for equalization. In response to this, I developed the clause below, which authorizes gifting in excess of the annual gift tax exclusion to ensure equality is kept. A similar make-up equalization clause then exists within the trust. We will then track that for the client.

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<sup>17</sup>This sample language inherited from Sebastian Grassi, Esq. and William Wright, Esq.  
*Institute of Continuing Legal Education*

**Sample language**

*My Agent may make gifts to my children and among the persons in their respective family lines in excess of the federal gift tax exclusion to the extent necessary to make an equal aggregate gift distribution among my children and their respective family lines for the maximum amount of aggregate gifts made to any particular child and his or her respective family line in that calendar year. "Family line" is comprised of the child himself or herself, the spouse of that child, the child's descendants and the spouses of those descendants.*

**j. Consider controlling funds gifted to minors and charities:**

**Sample Language**

*All such gifts may be made outright, in trust, including charitable trusts and split interest charitable trusts, in charitable gift funds, in §529 accounts, and/or to any legal guardian or custodian under any applicable Uniform Transfers (or Gifts) to Minors Act, as my Agent deems appropriate, even if my Agent is such trustee, guardian or custodian. I grant my Agent the power to establish such trusts or accounts to the extent necessary to effectuate said gifts.*

**k. Gifting authority for special needs situations**

- We especially customize the gifting authority when there is a special needs situation or a long term care spend-down is anticipated. These clauses may be the most crucial estate planning protection for such situations, especially when there is both a parent needing nursing care and a child with a disability at home.

**Sample Language**

*To make unlimited gifts and transfers to or for the benefit of my child/relative, [insert name], who is disabled, and to create an irrevocable or revocable trust agreement on my behalf for full support or special needs only, for the benefit of [insert name], with such trustee(s) as my Agent shall select, with due consideration to my then existing estate plan. My Agent is further authorized to assign, transfer, deliver and convey any or all of my assets to any revocable or irrevocable trust for the benefit of [insert name] which may be then created, or which I have established prior to this date, or may establish in the future, as my Agent may determine advisable in his or her sole and absolute discretion.*

**l. Gifts in the event of a long term care spend-down**

As to a situation where long term care and Medicaid are expected, **as a last resort**, we provide language enabling more extensive gifting. The client's justification for such power to gift is usually a desire for peaceful family members to hold funds, rather than losing the funds to a complete spend-down, especially if care needs change and private payment is necessary to access good care.

- Enabling serial and lump sum divestment, but limit the dollar amount to that expected to be necessary to shelter for obtaining eligibility and to preserve the house. We do not make these restrictions for the spouse and any child with a disability as such gifts are exempt from divestment penalty.
- To curb abuse and protect against intermeddlers, absent informed consent from the principal/client, we require consent from all family members who have a 10% or more interest in the residuary estate (probate and non-probate assets).
- We usually will have an informal meeting between the client, agent and donees whereby they agree to hold the gifted asset together in a joint account, with an understanding *under moral obligation only* to return the money if mom and/or dad needs the money. They all realize there is no legal obligation to return the funds. This avoids Medicaid implying a constructive trust. The joint account keeps the funds among the surviving donees.
- Because of the loss of control, the agent is required to confirm that the donees are free of creditors or predators.
- We do not put express language about intent to protect the client from unforeseen changes in the law which may bar gifting based on intent.

**Sample Language:**

**Gifts –Restricted.** *To make gifts as my Agent deems proper, with any of my real estate or personal property, to my spouse (if I am married), any of my children, or to any charitable organization. No gifts except to my spouse or a child with a disability shall exceed [\$ - insert value – include value of all anticipated serial or lump sum gifts for the year, and possibly the value of the house ] in aggregate gifts for the year. My Agent shall first obtain my written consent, or if I am not capable of giving informed consent, then the written consent of all adult members of my family (other than my Agent) who would be entitled to more than a 10% interest in my estate (probate and non-probate) if I died immediately before the transfer was made. Before gifting to any of the above-referenced persons, my Agent shall confirm (orally or in writing) that the donee is not subject to any creditor problems or risk of loss due to financial irresponsibility, chemical or substance abuse or marital distress.*

**m. Gifts of the house to the spouse, caregiver child or resident sibling**

- Adding or removing a name from the residence or gifting the residence normally results in a long divestment penalty. However, a gift of the residence does not result in a divestment penalty when the residence is gifted to the following persons:
  - i. a spouse
  - ii. a child under 21
  - iii. a child who is blind or disabled

- iv. a *caregiver child* who has lived in the homestead at least two years prior to the client's admission to a nursing home or the home and community-based waiver program, or
  - v. a *brother or sister who is part owner* of the homestead and lived in the homestead for at least one year immediately before the client's admission to a nursing home or the home and community-based waiver program.
- This gift is also exempt from "estate recovery" under the federal regulations. "Estate recovery" is the 1993 federal mandate for states to file a lien on the house of the Medicaid recipient at the death of the recipient to recover funds paid by Medicaid. The lien is deferred for situations involving persons in the home listed above. Michigan is the last state not to implement estate recovery. The Governor's proposal dated January 2005 set implementation of "estate recovery" as a high priority for attempts to reign-in Medicaid costs.

**Sample language:**

**Gift of residence.** *I give my Agent the power to gift my residence located at \*\*\* to [my spouse], [my child who has resided in my residence and provided the equivalent of nursing care for a period of at least two years], [my sibling who has co-owned the residence and resided with me for at least one year]. To the extent my Agent may benefit personally from this gift, directly or indirectly, my Agent shall defer such decisions to a person having a substantial interest in the property subject to this gifting power, which is adverse to the exercise of this gifting power in favor of Agent.*

**n. Consider powers dealing with trusts and coordinating with trusts:**

**Can a DPA create or change an estate plan?**

- The Michigan DPA Act does not contain any restrictions on the authority which can be delegated to an Agent. As a general rule, though, the power to make a will is nondelegable according to the Restatement (Second) of Agency §17.
- A legitimate question exists if other "testamentary" arrangements are possible if the power to make a will is barred. A trust with testamentary provisions can certainly provide the same effect as a will.
- EPIC recognizes the distinction between wills and trusts in regard to court protective orders. The probate court is granted an extensive array of powers over the estate and business affairs of an incapacitated individual after hearing and protective order for, including gifts and establishing revocable or irrevocable trusts, *except the power to make a will.*
- Similarly, a person after careful thought and in anticipation of incapacitation should be able to provide for authority to an Agent to establish trusts, to make gifts to these trusts and to establish other "testamentary" arrangements short of a will. A higher level of capacity is required for the principal to authorize these powers, as discussed in the "capacity" section above. If the principal at the time

of execution of the DPA cannot do it, then the only alternative is the probate court.

- If it appears that the client may lose capacity before the actual estate plan can be drafted, signed and funded, specific authority to implement the plan is very helpful. At the very least, such specific authority gives the probate court judge a solid basis to implement such strategies in a protective order.
- Our firm has established trusts, private annuity arrangements and other vehicles through specific authority under the DPA. At the same time, if any question exists as to the Principal's capacity at the time of the DPA, we have sought court backing through the use of Protective Orders. We have found judges to be quite supportive with proper explanation of the situation.
- These sample clauses should only be used with caution and tailored to the circumstances, especially for dangers of subverting existing estate plan arrangements and creating unwanted estate and gift tax implications for the Agent.

**Sample Language to create a general revocable trust** (when there is a concern the client may fall incapacitated before execution):

**Power to create a general revocable trust.** *To create a revocable trust agreement on my behalf with such trustee(s) as my Agent shall select. The revocable trust shall provide that during my lifetime the trustee(s) shall distribute income or principal as I direct or as the trustee(s) shall determine for my benefit. At my death, the remaining trust assets shall be distributed to [name(s) of residuary beneficiary] or [any one or more of my spouse, my descendants, charitable organizations as my Agent, in his or her sole and absolute discretion, determines advisable]. The trust shall provide that I may amend or revoke the trust at any time. My Agent is further authorized to assign, transfer, deliver and convey any or all of my assets, including any rights to receive income or assets from any source, to the trustee(s) of any such revocable trust created by my Agent.*

**Sample power to create and fund a trust for a child (or relative) with a disability:**

**Gifts or Trust for Disabled \*\*Son/Daughter, [child's name].** *To make unlimited gifts and transfers to or for the benefit of my disabled \*\*son/daughter, [insert child's name], and to create an irrevocable or revocable trust for full support or special needs only for the benefit of my disabled \*\*son/daughter, [insert child's name], with due consideration to my then existing estate plan, and to transfer any assets to any revocable or irrevocable trust for the benefit of my \*\*son/daughter which may be then created, or which I have established prior to this date, or may establish in the future, as my Agent may determine in the Agent's sole and absolute discretion. I authorize my Agent to petition the Probate Court of relevant jurisdiction if necessary to establish and to fund any trust for the benefit of [insert child's name]. My Agent shall have the express power to exercise or*

*perform any act, power or right whatsoever that I have individually to transfer my assets into the above-mentioned Trust.*

**Other helpful sample powers coordinated with trusts:**

**Receive Income or Principal from a Trust.** *To receive on my behalf income and/or principal of a trust to which I may be entitled.*

**Incapacity as Trustee.** *In the event that I am trustee of a trust of which I am the Trustmaker and if there is some reason to believe, because of my physical or mental incapacity, that I am unable to continue to effectively act as trustee of such trust, to advise the successor trustee(s) of such possible incapacity and to take such steps in conjunction with the successor trustee(s) to determine whether or not I am in fact unable to act.*

**Distributions from Estates and Trusts.** *To act in matters involving any trust or decedent's estate in which I now have or may hereafter have an interest, including, but not limited to, the right to approve or take exception to any inventory, payment, distribution in kind, accounting or tax; to receipt for any notice, item, payment or distributive share; to exercise or disclaim any right to receive or any power to which I might be entitled from any trust, estate, non-testamentary disposition or intestate succession; and to make any election which I am permitted by law to make. As a part of, but not in limitation of, the powers which I have granted in the foregoing sentence, I specifically grant to my Agent the power to withdraw cash or other property from any inter vivos trust which I have created, and further, after taking possession of and/or title to such property in my name and on my behalf, to make gifts thereof as otherwise permitted in this instrument.*

**o. Managing Retirement Plans**

- Retirement Plans as a 401(k), 403(b) or IRA do not permit trusts to be named as the owner – only the individual employee or contributor. Upon incapacity of the client, the only access for withdrawals, rollovers, beneficiary designations and other elections occurs through specific authority under the DPA or a Conservatorship.
- Key events under the retirement plan in situations of incapacity:
  - Rollover of a company-held plan to an IRA upon retirement (allowing for the stretch-out for non-spousal beneficiaries not possible with many company-held plans);
  - Rollover of a Traditional IRA to a Roth IRA (which may work better with a special needs trust);
  - Conducting a custodian to custodian transfer of an IRA (when the financial institution is not allowing for otherwise permissible steps)
  - Separation of IRAs (to create different IRAs with different purposes and to ensure the ability to use the separate life expectancies of beneficiaries for a “stretch-out” rather than being stuck with the life of the oldest beneficiary)
  - Disclaimer of beneficiary rights received at death (to allow funding of a credit-shelter trust for estate tax savings or to allow

for other beneficiaries lives to be used to achieve a longer “stretch-out” of the IRA from income taxes)

- Designation of beneficiaries (which may be necessary for a spouse upon rollover of inherited benefits from a pre-deceased spouse).

**Sample language adapted primarily from Natalie Choate’s Life and Death Planning for Retirement Benefits, 4<sup>th</sup> Ed., with paragraph about annuities from John Bos:**

*In connection with any pension, profit sharing or stock bonus plan, individual retirement arrangement, Roth IRA, §401(k) plan, §403(b) annuity or account, §457 plan, or any other retirement plan, arrangement or annuity in which I am a participant or of which I am a beneficiary (whether established by my Agent or otherwise) (each of which is hereinafter referred to as “such Plan”), my Agent shall have the following powers, in addition to all other applicable powers granted by this document.*

- To make contributions (including “rollover” contributions) or cause contributions to be made to such Plan with my funds or on my behalf or on behalf of my spouse.*
- To receive and endorse checks or other distributions to me from such Plan, or to arrange for the direct deposit of the same in any account in my name or any trust created by me or for my benefit.*
- To elect a form of payment of benefits from such Plan, and/or to withdraw benefits from such Plan, and/or to borrow from such Plan, even though this power causes a taxable event.*
- To make, exercise, waiver or consent to any and all elections and/or options that I may have regarding any such Plan, including but not limited to minimum distribution elections.*
- To make, exercise, waiver or consent to any and all elections and/or options that I may have as a beneficiary of any such Plan of my deceased Spouse.*
- To waive and rights or benefits that I may have in any such Plan of my Spouse.*
- To direct all investments in such Plans, including but not limited to investing or reinvesting in loans, stocks, bonds, securities, life insurance, annuities (including a Medicaid single premium immediate annuity) or combinations thereof, or in any other investment which my agent may deem proper.*
- To consent to and comply with the terms of a Court Order directing the segregation or transfer of some or all of the assets in such Plan to my Spouse or to such Plan of my Spouse.*
- To designate one or more beneficiaries or contingent beneficiaries for any benefits payable under such Plan or rollover or custodian to custodian changed account on account of my death, and to change any such prior designation of beneficiary made by me or by my Agent; provided, however, that my Agent (other than my spouse)*

*shall have no power to designate my Agent directly or indirectly as a beneficiary or contingent.*

**p. Authority to Disclaim or Release Property Interests and Rights**

- **Common situation needing power of disclaimer:** For taxable estates, after the death of a spouse, a surviving spouse may receive insurance or retirement benefits through a beneficiary designation or property through right of survivorship, which should have been sheltered in the trust of the deceased spouse. To ensure routing of property to the deceased spouse's credit shelter trust, a qualified disclaimer under EPIC and federal tax regulations is the only way to ensure getting the property in the proper location without gift tax consequences. If the surviving spouse is incapacitated, this allows the clean-up through a disclaimer by the Agent under the DPA.
- **Common situation needing power of waiver/release:** For the spouse in the nursing home who is incapacitated, the power to sign a release is invaluable to ensure waiver of elective rights and spousal rights in the community spouse's estate, especially with disinheritance or sheltering of assets in a testamentary trust.

**Sample Language:**

***Disclaim, Renounce, Release or Abandon Property Interests.** To renounce and disclaim any property or interest in property or powers to which, for any reason and by any means I personally may become entitled, whether by gift, trust, beneficiary designation, right of survivorship (including but not limited to surviving interest as tenant by the entirety, testate or intestate succession; to release or abandon any property or interest in property or powers which I personally or as a fiduciary may now or hereafter own, including any interests in or rights over trusts (including the right to alter, amend, revoke or terminate) and to exercise any right to disclaim an elective share and any spousal rights in any estate or under any will; in exercising such discretion, my agent may take into account such matters as shall include, but shall not be limited to, any reduction in estate or inheritance taxes on my estate, and the effect of such renunciation or disclaimer upon persons interested in my estate and persons who would receive the renounced or disclaimed property interest.<sup>18</sup>*

**q. Managing Education Plans**

Over the past five years education plans have dramatically increased in popularity due to their income tax free growth, their ability to maintain control over the investment and their unique flexibility with changing the beneficiary. Specific authority in the DPA is crucial to continuing such management in the event of incapacity.

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<sup>18</sup> This sample adapted from John Bos, Id. at 9-40.

**Sample Language:**

**529 Plans.** *To establish a §529 account, or accounts, or arrangements (collectively referred to as an account under this Section), for any person; to make investment changes to any §529 account that I have established, and to terminate any existing §529 account. Included within the scope of this power is the specific authority:*

- a. *To establish other §529 account or accounts for any person or persons, including myself;*
- b. *To make investment changes to any § 529 account that I have established for the benefit of myself or for another person or persons;*
- c. *To make additional contributions to §529 accounts including any election to treat the contribution as made over a five (5) calendar year period;*
- d. *To change beneficiaries of any existing §529 account or accounts, at any time and for any reason, but only so long as the new beneficiary is treated as a “member of the family” of the previous named beneficiary as that term is described in Proposed Treasury Regulation §1.529-3(c)(1)).*
- e. *To transfer funds from one state’s §529 account to another state’s §529 account, or to transfer funds from one §529 account investment to another account investment in the same state’s qualified tuition program, if permitted by the sponsoring state;*
- f. *To designate a new contingent account owner of any §529 account;*
- g. *To direct or authorize qualified withdrawals or authorize new reimbursements from a §529 account, including: (a) a “qualified withdrawal” (i.e., a withdrawal from a §529 account that is used to pay the “qualified higher education expenses of the designated beneficiary,” such expenses defined to include only tuition, fees, the cost of books, supplies and equipment required for the enrollment or attendance of a designated beneficiary at an eligible educational institution and room and board in some cases); or (b) a withdrawal due to the disability of, or scholarship award to, the designated beneficiary;*
- h. *To make a non-qualified withdrawal from a §529 account in the sole discretion of my Agent, if my Agent determines that my financial circumstances warrant such a withdrawal, with the recognition that such withdrawal will result in the imposition of taxes and penalties to my estate.*

**D. Curbing Abuse:**

**1. The simplicity of use of the DPA lends itself to potential abuse. As a fiduciary, an agent owes the principal the following duties:<sup>19</sup>**

- Duty of care and skill (as compliance with the Michigan Prudent Investor Rule);
- Duty to keep records and render accounts;
- Duty to not exceed scope of authorized powers;
- Duty of loyalty (not to self-deal or receive gifts unless specifically authorized);
- Duty to avoid conflicts of interest; and
- Duty to not commingle the principal and agent's property.

**2. Statistics:<sup>20</sup>**

- The National Center on Elder Abuse estimates that over one million elders were victims of various types of domestic abuse in 1996, and that 12.3 percent of these cases involved financial abuse or material exploitation.
- A 1994 survey responded to by 854 ABA members in the Real Property, Probate and Trust law section showed:
  - 40% of attorneys were aware of one or more DPA that had been misused
  - 91% estimated the misuse occurred in 5 percent or less of cases
  - Transfer of assets was cited as the major area of abuse, with transfers averaging 50% of the principal's estate.

**3. Suggested steps:**

- **Adequate education of the agent of fiduciary duties and standards.**
- **Require approval self-dealing or gifting to agent by successor agent considered to be an "adverse party" – see discussion and sample language under gifting section above.**
- **Document authority to release confidential information to the agent(s).** We often dictate a memorandum on these understandings in the presence of the client. The client then signs my notes and acknowledges the incorporation of the corresponding dictation.
- **Provide accountings appropriate to the situation.**

**Sample Language:**

*[Flexible] Upon my request, or the guardian/conservator of my estate or the personal representative of my estate, the Agent shall account for all actions taken by the Agent for or on my behalf.*

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<sup>19</sup>See Restatement (Second) of Agency §13; see also Andrew H. Hook, "Durable Powers of Attorney and Advance Directives" @oasthook.com

<sup>20</sup> See Julia C. Calvo, "Reforming Durable Power of Attorney Statutes to Combat Financial Exploitation of the Elderly." 24 *Bifocal* 1, ABA Commission on Law and Aging (Winter 2003).

**[Strict]** *Within thirty days after my agent begins to act under this agency document, my agent shall notify me and any successor agent named in this power. Also, my agent shall account for his or her agency by providing a statement of account showing all receipts, disbursements, and asset changes or investment transactions since the prior statement of account and an inventory of my then-current assets known to the agent. The accounting shall be made at least once a year, and copies shall be sent to me and to any named successor agent. The statement of account shall be deemed to have been furnished to the person entitled thereto when it has been placed in the United States Mail addressed to that person at the person's last known address even if that person is under a legal disability. Copies of documents evidencing ownership of assets and a copy of my most recent personal tax return shall be attached to the accounting.*<sup>21</sup>

### **E. Acceptance of the DPA (and overcoming third party resistance)**

There are several common reasons that DPAs are resisted or rejected by financial institutions:

- 1. Boilerplate provisions of DPA do not contemplate the specific type of account/asset or transaction sought.**
- 2. Protectionist attitude of the financial institution arising from:**
  - Suspicion of a stranger to the account who may also be unknown to the institution;
  - Difficulty verifying validity of the document presented;
  - Specialized internal rules and policies regarding DPAs;
  - Concerns over “Aged” document;
  - Preference for “standard forms” used by the institution;
  - Multi-state use of DPA (commonly encountered with institutions out East); and
  - Fear of legal liability to account holder or the account holder’s estate.
- 3. Potential liability to an institution for accepting DPAs:**
  - State law may provide limited protection in situations of fraud.
  - Consider *In re Estate of Davis*, 634 N.E. 2<sup>nd</sup> 64 (Ill. App. Ct. 1994) where **DPA was forged** by a relative who presented original signed document to bank and withdrew all assets. **Bank was held liable for entire loss** despite a state law providing that “Any person who acts in good faith reliance on a copy of the agency will be fully protected and released to the same extent as though the reliant had dealt directly with the principal as a fully-competent person” *Id.* at 66. Because the document was forged no agency relationship existed, and the bank was denied a good-faith defense of relying on an apparently valid DPA because a valid agency relationship did not exist.

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<sup>21</sup> Language from Cynthia L. Barrett, *Id.*  
*Institute of Continuing Legal Education*

**4. Presumption of revocation due to age of the DPA.**

- **The Stale DPA.** It is common for DPA's to be rejected because of their age. Institutions may have policies requiring a power of attorney to be signed within 90 days to six months of the date an attempted transaction under the document. This is a protectionist policy based on the presumption that an older document is more likely to have been revoked (by death or otherwise) or superseded than a newer one. There is some validity to this presumption based on Restatement (Second) of Agency, §38.
- EPIC specifically provides that a **DPA is valid notwithstanding the lapse of time** since execution of the instrument, unless the power states a time of termination. MCL §700.5502.
- Additionally, MCL §700.5504 (1) protects an act done in good faith reliance on a PAD without actual knowledge of revocation due to death of the principal.

**5. Risk of liability due to Attorney-in-fact exceeding authority.**

- A financial institution is responsible for knowing the extent of the authority of an attorney-in-fact acting under a DPA. The institution must also enforce any limitation on the powers of the attorney-in-fact. Restatement (Second) of Agency §311.
- Combine this with the agency principle that a document conferring agency authority must be narrowly construed, and there is added reason for institutions to be concerned about accepting a DPA. Restatement (Second) of Agency §37. This is especially true where the document has ambiguous provisions because the institution will not want to risk liability for permitting actions not explicitly authorized.

**6. Suggestions for minimizing and overcoming third party resistance to DPAs:<sup>22</sup>**

- Execute the DPA with all possible legal formalities such as witnesses and notary. Consider applying the **raised notary seal** which gives additional credibility.
- Provide a **certification** that the agent can execute if requested by a third party to confirm that to the agent's knowledge the principal is alive, the DPA has not been revoked, and that the DPAD is in effect. **See Exhibit F** for sample Affidavit. Attorneys are advised not to certify a PAD for a client unless they possess current and first hand knowledge that the client intends for the PAD to remain in effect.
- Reference specific EPIC provisions affirming **limited liability of third parties** relying in good faith on DPA. For added measure, include **indemnification language** extending protection to third parties who rely on the agent's powers under the DPA.

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<sup>22</sup> See Daniel A. Wentworth, "Durable Powers of Attorney: Considering the Financial Institution's Perspective," *The ElderLaw Report*, Vol. XVI, No. 3 (October 2004) for a more detailed outline of these points from the financial institution's perspective.

- Provide **multiple originals** to the client so that each institution can be provided with an original document to keep on file or process through their legal department.
- Itemize **specific accounts** that the client wishes to be made subject to the DPA. Clarify, if appropriate, that the list is not exhaustive and consider combining specific and general comprehensive provisions. There is a danger that by listing a specific account that accounts later opened or inadvertently omitted may be excluded from the scope of the DPA by a third party. A periodic updating of the accounts subject to the DPA is recommended if an itemized list of accounts is used.
- Allow for **photocopies** to have the same effect as a signed original.
- Authorize the agent to **seek judicial intervention** for non-recognition of DPA by third parties and to seek **sanctions** for costs of having to seek intervention or enforcement because of unreasonable resistance to the DPA.

**Sample language:**

*My Agent is authorized, at the expense of my estate, to seek interpretation and/or enforcement of any power granted to my Agent under this document from a court of competent jurisdiction. My Agent may seek any appropriate legal remedy including, but not limited to, declaratory judgments, temporary or permanent injunctions, and actual or punitive damages against any person or entity who unreasonably, negligently or willfully fails or refuses to follow my Agent's instructions with respect to a power granted to my Agent under this document. (paraphrased from John Bos, Drafting the Durable Power of Attorney and Patient Advocate Designation, p9-41, ICLE Fundamentals of Estate Planning, October 17, 2003)*

- Use **springing powers sparingly** because of complications with proving the triggering event and the loss of valuable time.
- When using **co-agents, make it very clear** whether they serve together or whether either may serve independently. Additionally, consider allowing agents to delegate to co-agents or to successor agents.
- **Specify succession.** “Unable and willing to serve” may be too ambiguous for an institution to rely on. Consider an objective standard (such as a statement from the primary agent that he/she is not able to serve) that the third party can rely on to accept the authority of a successor agent.
- **Update DPAs regularly**, but no less than when the estate plan is revisited. Request that the principal or family members request an update when mental or physical decline is anticipated or suspected.
- Advise the client to **present the DPA** to their financial institutions sooner than later in order to deal with any institutional objections as early as possible.
- Consider utilizing the institution's **internal power of attorney** form in conjunction with the DPA.
- **Make yourself available** to work through issues with an institution who resists the DPA. When working with an institution be patient and

considerate of their concerns, but insist on dealing with a manager or legal counsel to resolve objections to the DPA.

**Exhibit A**  
**Excerpts from Assessment of Older Adults with Diminished Capacity**

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## Capacity Worksheet for Lawyers

Source: *Assessment of Older Adults with Diminished Capacity: A Handbook for Lawyers*, by the ABA Commission on Law and Aging and the American Psychological Association (2005).  
Please read and review the handbook prior to using the worksheet.

Client Name: \_\_\_\_\_ Date of Interview: \_\_\_\_\_

Attorney: \_\_\_\_\_ Place of Interview: \_\_\_\_\_

### A. OBSERVATIONAL SIGNS

◆ Cognitive Functioning	Examples
Short-term Memory Problems	Repeats questions frequently Forgets what is discussed within 15-30 min. Cannot remember events of past few days
Language/Communication Problems	Difficulty finding words frequently Vague language Trouble staying on topic Disorganized Bizarre statements or reasoning
Comprehension Problems	Difficulty repeating simple concepts Repeated questioning
Lack of Mental Flexibility	Difficulty comparing alternatives Difficulty adjusting to changes
Calculation/Financial Management Problems	Addition or subtraction that previously would have been easy for the client Bill paying difficulty
Disorientation	Trouble navigating office Gets lost coming to office Confused about day/time/year/season
◆ Emotional Functioning	Examples
Emotional Distress	Anxious Tearful/distressed Excited/pressured/manic
Emotional Lability	Moves quickly between laughter and tears Feelings inconsistent with topic

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Capacity Worksheet for Lawyers

◆ Behavioral Functioning	Examples
Delusions	Feels others out “to get” him/her, spying or organized against him/her Fearful, feels unsafe
Hallucinations	Appears to hear or talk to things not there Appears to see things not there Misperceives things
Poor Grooming/Hygiene	Unusually unclean/unkept in appearance Inappropriately dressed
<b>Other Observations/Notes of Functional Behavior</b>	
<b>Other Observations/Notes on Potential Undue Influence</b>	
Mitigating/Qualifying Factors Affecting Observations	Ways to Address/Accommodate
Stress, Grief, Depression, Recent Events affecting stability of client	Ask about recent events, losses Allow some time Refer to a mental health professional
Medical Factors	Ask about nutrition, medications, hydration Refer to a physician
Time of Day Variability	Ask if certain times of the day are best Try mid-morning appointment
Hearing and Vision Loss	Assess ability to read/repeat simple information Adjust seating, lighting Use visual and hearing aids Refer for hearing and vision evaluation
Educational/Cultural/Ethnic Barriers	Be aware of race and ethnicity, education, long-held values and traditions

**B. RELEVANT LEGAL ELEMENTS** - The legal elements of capacity vary somewhat among states and should be modified as needed for your particular state.

General Legal Elements of Capacity for Common Tasks	Notes on Client's Understanding/ Appreciation/Functioning Under Elements
<p><b>Testamentary Capacity</b> - Ability to appreciate the following elements in relation to each other:</p> <ol style="list-style-type: none"> <li>1. Understand the nature of the act of making a will.</li> <li>2. Has general understanding of the nature and extent of his/her property.</li> <li>3. Has general recognition of those persons who are the natural objects of his/her bounty.</li> <li>4. Has/understands a distribution scheme.</li> </ol>	
<p><b>Contractual Capacity</b> The ability to understand the nature and effect of the particular agreement and the business being transacted.</p>	
<p><b>Donative Capacity</b> An intelligent perception and understanding of the dispositions made of property and the persons and objects one desires shall be the recipients of one's bounty.</p>	
<p><b>Other Legal Tasks Being Evaluated &amp; Capacity Elements:</b></p>	

**C. TASK-SPECIFIC FACTORS IN PRELIMINARY EVALUATION OF CAPACITY**

The more serious the concerns about the following factors...	The higher the function needed in the following abilities...
<p>Is decision consistent with client's known long-term values or commitments?</p>	<p>Can client articulate reasoning leading to this decision?</p>
<p>Is the decision objectively fair? Will anyone be hurt by the decision?</p>	<p>Is client's decision consistent over time? Are primary values client articulates consistent over time?</p>
<p>Is the decision irreversible?</p>	<p>Can client appreciate consequences of his/her decision?</p>

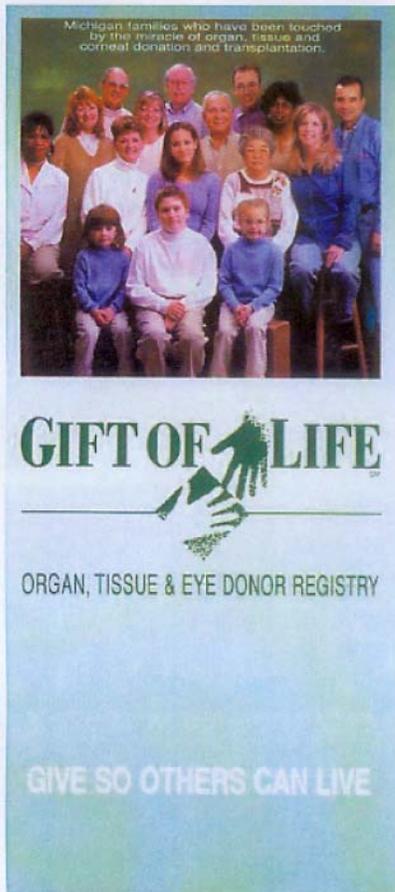
Capacity Worksheet for Lawyers

**D. PRELIMINARY CONCLUSIONS ABOUT CLIENT CAPACITY - After evaluating A, B, and C above:**

<input type="checkbox"/> <b>Intact</b> - No or very minimal evidence of diminished capacity	<i>Action:</i> Proceed with representation and transaction
<input type="checkbox"/> <b>Mild problems</b> - Some evidence of diminished capacity	<i>Action:</i> (1) Proceed with representation/transaction, or (2) Consider medical referral if medical oversight lacking, or (3) Consider consultation with mental health professional, or (4) Consider referral for formal clinical assessment to substantiate conclusion, with client consent
<input type="checkbox"/> <b>More than mild problems</b> - Substantial evidence of diminished capacity	<i>Action:</i> (1) Proceed with representation/transaction with great caution, or (2) Medical referral if medical oversight lacking, or (3) Consultation with mental health professional, or (4) Refer for formal clinical assessment, with client consent
<input type="checkbox"/> <b>Severe problems</b> - Client lacks capacity to proceed with representation and transaction	<i>Action:</i> (1) Referral to mental health professional to confirm conclusion (2) Do not proceed with case; or withdraw, after careful consideration of how to protect client's interests (3) If an existing client, consider protective action consistent with MRPC 1.14(b)

**CASE NOTES:** Summarize key observations, application of relevant legal criteria for capacity, conclusions, and actions to be taken:

**Exhibit B**  
**Gift of Life Donor Registration Brochure Request**



The Gift of Life Organ, Tissue & Eye Donor Registry is the best way to indicate one's wish to become a donor. The driver's license is rarely accessed at the time of death, but the Gift of Life Donor Registry is accessed each time a patient dies in a Michigan hospital.

**To order FREE Gift of Life Donor Registry brochures,**  
 please return this form (fax: 734-973-3133) or contact us at  
 info@giftoflifemichigan.org or 800-482-4881.

Organization:	Contact Person:
Shipping Address: <i>(no PO Boxes)</i>	
City:	State: MI      ZIP:
Daytime Phone: (    )	Email:
Number of Donor Registry Brochures requested:	Date materials needed: <i>(please allow 2-3 weeks for shipping)</i>

**Exhibit C  
Values History Form**

**Values History Form<sup>23</sup>**

Name: \_\_\_\_\_

Date: \_\_\_\_\_

If someone assisted you in completing this form, please fill in his or her name, address, and relationship to you.

Name: \_\_\_\_\_

Address: \_\_\_\_\_

\_\_\_\_\_

Relationship: \_\_\_\_\_

**OVERALL ATTITUDE TOWARD LIFE AND HEALTH**

What would you like to say to someone reading this document about your overall attitude toward life?

What goals do you have for the future?

How satisfied are you with what you have achieved in your life?

What, for you, makes life worth living?

What do you fear most? What frightens or upsets you?

What activities do you enjoy (e.g., hobbies, watching TV, etc)?

How would you describe your current state of health?

\_\_\_\_\_

<sup>23</sup> Developed by the University of New Mexico Health Sciences Center Institute for Ethics-intentionally not copyrighted

If you currently have any health problems or disabilities, how do they affect: you, your family, your work, your ability to function?

If you have health problems or disabilities, how do you feel about them? What would you like others (family, friends, doctors) to know about this?

Do you have difficulties in getting through the day and performing activities such as: eating, preparing food, sleeping, dressing, and bathing? Etc.

What would you like to say, about your general health, to someone reading this document?

### **PERSONAL RELATIONSHIPS**

What role do family and friends play in your life?

How do you expect friends, family and others to support your decisions regarding medical treatment you may need now or in the future?

Have you made any arrangements for family or friends to make medical treatment decisions on your behalf? If so, who has agreed to make decisions for you and in what circumstances?

What general comments would you like to make about the personal relationships in your life?

### **THOUGHTS ABOUT INDEPENDENCE AND SELF-SUFFICIENCY**

How does independence or dependence affect your life?

If you were to experience decreased physical and mental abilities, how would that affect your attitude toward independence and self-sufficiency?

If your current physical or mental health gets worse, how would you feel?

### **LIVING ENVIRONMENT**

Have you lived alone or with others over the last 10 years?

How comfortable have you been in your surroundings? How might illness, disability, or age affect this?

What general comments would you like to make about your surroundings?

### **RELIGIOUS BACKGROUND AND BELIEFS**

What is your spiritual/religious background?

How do your beliefs affect your feelings toward serious, chronic, or terminal illness?

How does your faith community, church, or synagogue support you?

What general comments would you like to make about your beliefs?

### **RELATIONSHIPS WITH DOCTORS AND OTHER HEALTH CAREGIVERS**

How do you relate to your doctors? Please comment on: trust, decision making, time for satisfactory communication, and respectful treatment.

How do you feel about other health care providers, including nurses, therapists, chaplains, social workers, etc.?

What else would you like to say about doctors and other health care providers?

### **THOUGHTS ABOUT ILLNESS, DYING AND DEATH**

What general comments would you like to make about illness, dying, and death?

What will be important to you when you are dying (e.g., physical comfort, no pain, family members present, etc.)?

Where would you prefer to die?

How do you feel about the use of life-sustaining measures if you were suffering from an irreversible chronic illness (e.g., Alzheimer's disease), terminally ill, or in a permanent coma?

What general comments would you like to make about medical treatment?

## **FINANCES**

What general comments would you like to make about your finances and the cost of health care?

What are your feelings about having enough money to provide for your care?

## **FUNERAL PLANS**

What general comments would you like to make about your funeral and burial or cremation?

Have you made your funeral arrangements? If so, with whom?

## **Optional Questions**

How would you like your obituary (announcement of your death) to read?

Write yourself a brief eulogy (a statement about yourself to be read at your funeral).

What would you like to say to someone reading this Values History Form?

## **II. LEGAL DOCUMENTS**

What legal documents about health care decisions have you signed? (Each state has its own special form-feel free to add yours to the list.)

**Advance Directive for Health Care – New Mexico? Yes\_\_\_ No\_\_\_**

Where and with whom can it be found?

Name\_\_\_\_\_

Address\_\_\_\_\_

\_\_\_\_\_

Phone\_\_\_\_\_

**Living Will? Yes\_\_\_ No\_\_\_**

Where and with whom can it be found?

Name\_\_\_\_\_

Address\_\_\_\_\_

\_\_\_\_\_

Phone\_\_\_\_\_

**Durable Power of Attorney for Health Care Decisions? Yes\_\_\_ No\_\_\_**

Where and with whom can it be found?

Name\_\_\_\_\_

Address\_\_\_\_\_

\_\_\_\_\_

Phone\_\_\_\_\_

**Health Care Proxy? Yes\_\_\_ No\_\_\_**

Where and with whom can it be found?

Name\_\_\_\_\_

Address\_\_\_\_\_

\_\_\_\_\_

Phone\_\_\_\_\_

**Exhibit D**  
**Michigan Statutory Do-Not-Resuscitate Order**

DO-NOT-RESUSCITATE ORDER

I have discussed my health status with my physician, \_\_\_\_\_. I request that in the event my heart and breathing should stop, no person shall attempt to resuscitate me.

This order is effective until it is revoked by me.

Being of sound mind, I voluntarily execute this order, and I understand its full import.

(Declarant's signature)	(Date)
(Type or print declarant's full name)	
(Signature of person who signed for declarant, if applicable)	(Date)
(Type or print full name)	
(Physician's signature)	(Date)
(Type or print physician's full name)	

**ATTESTATION OF WITNESSES**

The individual who has executed this order appears to be of sound mind, and under no duress, fraud, or undue influence. Upon executing this order, the individual has (has not) received an identification bracelet.

(Witness signature)	(Date)	(Witness signature)	(Date)
(Type or print witness's name)		(Type or print witness's name)	

THIS FORM WAS PREPARED PURSUANT TO, AND IS IN COMPLIANCE WITH, THE  
MICHIGAN DO-NOT-RESUSCITATE PROCEDURE ACT.

**Exhibit E**  
**Wallet Identification Card**

**Front of Identification Card**

<b>Wallet Identification Card</b> <b>IMPORTANT NOTICE</b> <b>TO EMERGENCY MEDICAL PERSONNEL</b>	<i>DNR</i> <i>ON FILE</i>
I, ( _____ ), Patient's Name	
have executed a Durable Power of for Health Care pursuant to 1990 Public Act 312, MCL 700.496. If I am unable to make my own health care decisions, my Patient Advocate has the legal authority to make those decisions on my behalf, including decisions concerning life-sustaining treatment. In such an event, one of the persons listed on the reverse of this card who has a copy of my Durable Power for Health Care should be contacted immediately, in the order listed. ( <i>See Reverse</i> )	

**Back of Identification Card**

1. Patient Advocate: _____ Work: ( ) _____ Home: ( ) _____
2. Successor Patient Advocate: _____ Work: ( ) _____ Home: ( ) _____
3. Other: _____ Work: ( ) _____ Home: ( ) _____
Organ Donor Yes _____ No _____

**Exhibit F**  
**Affidavit for Financial Durable Power of Attorney**

**APPENDIX A**

**AFFIDAVIT**

On (Date) \_\_\_\_\_, I, «Primary\_Agent», affirm that:

1. I am the Attorney-in-Fact under a durable power of attorney executed by «ClientName»,
2. that such power of attorney is on the date of this affidavit in full force and effect in all respects,
3. that I have no reason to believe that this power of attorney has been revoked, or that I have in any way been deprived of the authority granted in the said power of attorney to act in «ClientName»'s behalf,
4. that I have no reason to believe that «ClientName» is deceased.

\_\_\_\_\_  
«Primary\_Agent»

County of                    } <sup>ss</sup>  
State of

Subscribed and sworn to before me this (Date) \_\_\_\_\_.

\_\_\_\_\_  
Notary Public, \_\_\_\_\_ County, \_\_\_\_\_  
My commission expires: \_\_\_\_\_  
Acting in the Count of \_\_\_\_\_

**Exhibit G  
Acceptance of Duties of Agent**

**IMPORTANT INFORMATION FOR AGENT**

You have been appointed an Attorney-in-Fact ("Agent") under a Durable Power of Attorney ("DPA") by "SettlorFullName" (the "Principal") who has great trust in your ability to handle numerous financial and legal matters for the Principal with the utmost integrity and fidelity. Therefore, as Agent, you must:

- (1) Do what you know the Principal reasonably expects you to do with the Principal's property.
- (2) Act in good faith with care, competence, and diligence for the best interest of the Principal. This means you, as Agent, are a fiduciary and must act in a manner which is strictly for the benefit of the Principal rather than for yourself, except as specifically authorized by the DPA
- (3) Avoid conflicts that would impair your ability to act in the Principal's best interest.
- (4) Never mix the Principal's property or funds with your property or funds. All funds collected or expended on behalf of the Principal must be accounted for and should never be mixed with your own personal or business funds.
- (5) Keep a complete record of all receipts, disbursements, and transactions conducted for the Principal (such as a permanent notebook with entries by date). Records of all transactions should be kept by you and should be kept separate from your own personal or business records. All correspondence, financial institution records, cancelled checks, etc., should be retained by you in a safe place. Your activities as an Agent may be subject to review by a court of law, and you may be required to account for your actions.
- (6) Do nothing beyond the authority granted in this DPA.
- (7) Be careful about making gifts. Preserve the Principal's estate plan to the extent you know the plan, unless preserving the estate plan is inconsistent with the Principal's best interest.
- (8) Stop acting on behalf of the Principal if you learn of any event which your authority under this DPA terminates (such as a revocation of your authority by the Principal), or if the DPA terminates due to the death of the Principal. Please note that the incapacity or disability of the Principal does not terminate the DPA.

Because you will be acting in a fiduciary capacity, any actions which you take on behalf of the Principal should be made in a prudent manner and it is recommended that the actions always be taken following a discussion with the Principal, if the Principal is available and not incapacitated.

You should seek competent legal advice if there is anything about this DPA or your duties that you do not understand.

The undersigned accepts appointment as an Agent, and acknowledges that he or she has read the above responsibilities of an Agent and agrees to abide by them.

Dated: \_\_\_\_\_  
"Agent1"

Credit for this particular form goes to Sebastian Grassi, posted on Michigan Elder Law Listserv – March 2006.