Mark Twain Behavioral Health

Inspiring Hope & Wellness For Those We Serve

About MTBH

Mark Twain Behavioral Health (MTBH) is a private, not-for-profit Certified Community Behavioral Health Organization (CCBHO) serving the citizens of Northeast Missouri since 1975.

We are committed to caring for the individuals and families we serve by providing comprehensive programs and services to those affected by mental illness and/or substance use.

OUR SERVICES

MTBH provides a wide range of services for youth, adults, couples, and families, which include, but are not limited to:

- Access Crisis Intervention/24 Hr Crisis Service
- Adolescent Diversion Education Program (ADEP)
- Clinical Intervention Program (CIP)
- Community Psychiatric Rehabilitation Program (Case Management)
- Consultation & Educational Services (Community & School)
- Education & Supportive Groups
- Individual, Couples, & Family Therapy
- Offender Education Program (OEP)
- Psychiatry & Medication Therapy
- SATOP
- Substance Use Social Detoxification (Detox)
- Substance Use Treatment
- Weekend Intervention Program (WIP)

Contact us today to see how we can help you be well!

Enhancing the Overall Health and Wellbeing of Those We Serve.

154 Forrest Drive
Hannibal, MO 63401
P. (573) 221-2120
F. (573) 221-4380

146 Communications Drive
Hannibal, MO 63401
P. (573) 248-1196
F. (573) 248-1259

105 Pfeiffer Ave
Kirksville, MO 63501
P. (660) 665-4612
F. (660) 665-4635

1119 S Missouri, Ste E
Macon, MO 63552
P. (660) 395-9114
F. (660) 395-9115

www.mtbh.org

Mark Twain Behavioral Health

Client Orientation Information

Acknowledgement

I have received a copy of the following information or it has been verbally explained to me:

1. An agency brochure that describes hours of operation and services offered;

2. Crisis line access information – If you are experiencing a crisis, call our toll-free crisis line at 1-800-356-5395; In the event of a natural disaster, go to your local Red Cross, local hospital, or local law enforcement office.

3. Privacy practices – a copy can be provided to you if you desire;

4. Client's Rights and Responsibilities;

5. Familiarization with premises, including emergency exits or shelter, fire suppression equipment and first aid kits;

6. Advance Directives;

7. Informed consent regarding services and payment for services;

8. An initial assessment with you and your team members will be held to help us all learn more about your needs and goals of treatment. The information gathered from the discussion will be used to develop the treatment plan that will guide the services and interventions to help you on your journey to health.

9. Treatment planning is a team event. A staff member will be assigned to you to develop an individual plan. Your input is required regarding the treatments that are chosen to participate in while receiving services here to reach the goals and objectives that have been agreed upon by you and your treatment team. A staff member will review with you, the treatment plan and the options that the course of treatment may include, initially and periodically to make updates and consider progress along the way.

10. Transition plans may be made with a specialized staff person if it is determined movement to another level of services is best for you. You and your clinician will communicate to prepare the transition plan and make arrangements as necessary.

11. Early in your treatment planning process, plans will be made for discharge and to support you to be successful. Your input in this plan will be requested and steps necessary for successful discharge from the program will be reviewed with the client by the staff member.

12. Although some referrals for services are mandatory, Mark Twain Behavioral Health will strive to do the following:
    - All proper releases for information will be obtained to exchange information with referral sources.
    - The clinician will work with you to establish a cooperative treatment plan.
    - The clinician will explore your motivation to change in determining the treatment plan.
    - You will be assigned a specialized staff for coordination of care.

Mark Twain
Behavioral Health

Client Rights

Each client in treatment at Mark Twain Behavioral Health has these rights:

1. To receive behavioral healthcare services and treatment in as open a setting as possible.
2. To have alternatives for care and treatment fully explained.
3. To have a treatment plan and to fully participate in its formulation.
4. To know the name of the person who is in charge of your treatment.
5. To participate in transition/discharge planning to assist with your continued support and success when moving to another level of service.
6. To be referred to prompt medical treatment when ill.
7. To be treated courteously and with dignity and respect.
8. To be treated in an environment free of seclusion and restraint.
9. To a safe, clean, and therapeutic environment, free from neglect and verbal, physical and sexual abuse.
10. To be free from financial abuse or other use for profit or personal gain.
11. To be free of retaliation (revenge) or humiliation (being put down).
12. To treatment by staff who uphold the standards of the agency and the ethics of their profession.
13. To prompt care and treatment on a scheduled or emergency basis.
14. To decline to be the subject of research.
15. To request a different therapist, community support specialist or physician.
16. To express grievances to the program supervisor, the privacy officer, and the Chief Executive Officer (and Board).
17. To refrain from working for the program.
18. To refuse treatment.
19. To review your records upon written request with a program representative.
20. To receive a copy of your records upon written request.
21. To treatment regardless of race, color, religion (creed), gender, gender expression, age, national origin (ancestry), disability, marital status, sexual orientation, military status, or any other characteristic protected by law.
22. To have bills and charges for services explained.
23. To privacy and confidential records. (See Notice of Privacy Practices)
24. To know what medication has been prescribed for you and why.
25. To request and pursue a second opinion.
26. To have the same legal rights and responsibilities as any other citizen, unless otherwise stated by law.
27. To receive an impartial review of alleged violations of rights.
28. To provide feedback regarding the services that you receive at our Center. This may be done through surveys available in the reception area or offered periodically from your service provider or at check-in or to group participants.

Mark Twain Behavioral Health

Client Grievance Procedures

As a client, you have a right to express your opinion, recommendations and complaints. If you believe your client rights have been violated by any employed staff member or contract employee you may file a complaint by requesting a grievance form and writing out your specific complaint. This will be reviewed by the appropriate program director and you will be contacted, interviewed and an outcome will be reached, the results of which you will be informed. Additional steps, if necessary, will be taken to address your complaint.

In addition, you may contact the Dept. of Mental Health Client Rights Monitor at P.O. Box 687, Jefferson City, MO 65102; 800-364-9687. For hearing impaired: TT573-751-8017.

Client's Responsibilities to Mark Twain Behavioral Health

We expect the following from you:

1. Be prompt for your appointments.
2. Give us at least 24 hours notice if you are unable to keep your appointments. If you fail to keep 3 scheduled appointments with your doctor, nurse practitioner or therapist, you may be discharged.
3. Actively participate toward established treatment goals.
4. Notify us if there are any changes in your address, telephone number, income or family size.
5. Make payment at the time services are rendered regardless of insurance coverage.
6. Behave in respectful manner to other persons in the Center. Aggressive or other inappropriate behaviors may result in a termination of services. Some examples of inappropriate behavior include hitting, yelling, threatening and fighting.
7. Do not carry any weapons or other dangerous or hazardous devices or illegal substances onto the property of Mark Twain Behavioral Health as they are not allowed on our property. In response to crises, we strive to use non-violent intervention strategies.
8. Do not smoke in unapproved areas. Smoking is not allowed in the building or in prohibited areas of agency property.

Mark Twain Behavioral Health's Responsibilities to the Client

1. We will provide the most appropriate and professionally competent service possible.
2. You will be seen at the appointed date and time.
3. We will respect your "client rights".
4. We will treat you with respect and dignity.
5. We will uphold your right to confidentiality.
6. We will report any instance of physical, sexual abuse or class I neglect to the appropriate licensing agency.
7. For mandated services, we may report to the appropriate authorities about your treatment and your response to treatment.

I acknowledge that the client rights, responsibilities, and grievance procedures have been reviewed with me.

Acknowledgement of Notice of Privacy Practices

I hereby acknowledge that I have received and had an opportunity to ask questions concerning MTBH's Notice of Privacy Practices with an effective date of September 23, 2013.

Mark Twain
Behavioral Health

AUTHORIZATION FOR DISCLOSURE OF INFORMATION

I hereby authorize Mark Twain Behavioral Health, to disclose information listed below as follows.

Disclosure Authorized: To Missouri Purchase of Service Program

My last name
My patient identifying number, the nature
and extent of services received by me, identified
by code.

Purpose: The purpose and need for such disclosure is to obtain payment for services rendered to me from the State of Missouri Purchase of Service Program.

Expiration: This authorization will expire when payment is received for services rendered.

II.

Disclosure Authorized: To the State of Missouri, and auditors employed by it in the event of an audit of the Program is made.

All my records both financial and clinical pertinent to an audit of the Purchase of Service Payments and Program.

Purpose: The purpose and need for such disclosure is to facilitate verification of the treatment received if the State is making a fiscal audit, monitoring management, and/or evaluating the program.

Expiration: This authorization will expire when the time provided for audit of Center's purchase of service records has elapsed.

I understand that no report, audit, or evaluation shall identify me by name or otherwise and that my anonymity will be preserved.

EITHER CONSENT SET FORTH ABOVE MAY BE REVOKED AT ANY TIME, EXCEPT TO THE EXTENT THAT ACTION HAS BEEN TAKEN IN RELIANCE THEREON.

Mark Twain
Behavioral Health

Explanation of Insurance and Fees

I, the undersigned, a Mark Twain Behavioral Health client, understand I must provide my Medicaid card or any private insurance card at the time my services are rendered. If I have private insurance and am responsible for any portion of my payment, it is necessary for me to pay the full cost for each visit until my insurance company processes my claims to determine my financial responsibility. Any overpayment will be refunded or applied to future services. If I have a co-pay on my insurance, I am responsible for paying my co-pay at the time of service. Then, when an insurance payment is received by the agency, the insurance payment will be applied toward the remainder of my bill. If the amount of insurance payment does not cover the amount of my remaining bill, I will be responsible for the outstanding balance.

Assignment of Insurance Benefits

I have given MTBH my current insurance information, including company name, policy holder name, employer, policy number/group ID, and social security number. I hereby instruct and direct the insurance company(s) to pay by check made out and mailed to:

Mark Twain Behavioral Health

154 Forrest Drive

Hannibal, MO 63401

If my current policy(s) prohibits direct payment to a facility or provider, I hereby instruct and direct the insurance company(s) named above to make out the check to me and mail it to:

Mark Twain Behavioral Health

154 Forrest Drive

Hannibal, MO 63401

I authorize payment for the professional or medical expense benefits allowable, and otherwise payable to me under my current insurance policy, as payment toward the total charges for the professional services rendered. THIS IS A DIRECT ASSIGNMENT of my rights and benefits under this policy. This payment will not exceed my indebtedness to the above mentioned assignee, and I have agreed to pay, in a current manner, any balance of said professional service charges over and above this insurance payment.

A photocopy or electronic copy of this assignment shall be considered as effective and valid as the original.

I authorize the release of any information pertinent to my treatment to any insurance company, adjuster, or attorney involved in this case. I also authorize Mark Twain Behavioral Health to initiate a complaint to the Insurance Commissioner for any reason on my behalf.

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Behavioral Health

Notice of Cost

It is my understanding that I am responsible for charges made for these services based on the following fees:

$100 per session for therapy

$250 per psych eval

$150 per med check

$0 per school based therapy visit

Client or Responsible Party is required to provide insurance information. Failure to release this information will result in the charges to be assessed at actual cost. Insurance companies will be billed the actual cost of the services provided.

Clients with MO HealthNet or Managed Care coverage will have a $0.00 fee for all services. The charges were determined by application of the Standard Means Test (Section 630.210, RSMo. and 9 CSR 10-31.011). The cost is the Department of Mental Health's actual cost of providing the services or its contract cost for purchasing the service. The charge is redetermined annually or at any time it is known that changes have occurred in the financial ability of the client (or the person responsible for the client) to pay. The difference between the cost of care and treatment and the amounts received in payment may be a claim upon the client's estate at death by the Department of Mental Health (Section 473.398, RSMo.).

Informed Consent for Treatment

It is the policy of MTBH that all consumers entering treatment sign a Consent for Treatment Form regarding treatment for their stated condition. The clinical staff member engaging in treatment will review the following areas of informed consent:

- The nature of the treatment (e.g., explanation of therapy or medication management process)
- Potential benefits, risk, or side effects of the treatment, including any potential setbacks that might occur
- The likelihood of achieving treatment goals
- Reasonable treatment alternatives (e.g., self-help programs)
- The possible result of not receiving treatment
- Any limits on confidentiality (e.g., mandated reporting)

Adult consumers or guardians of youth consumers may give valid informed consent. If they are not available onsite, the forms may be faxed or mailed to the responsible party.

I, as the client/parent/legal guardian, do hereby give my consent for myself/minor child/ward, to receive services from Mark Twain Behavioral Health.

Mark Twain Behavioral Health

Activities Permission Form

I give my permission for myself/minor child/ward to ride with Mark Twain Behavioral Health's staff members, including transportation from schools, while participating in activities provided by Mark Twain Behavioral Health. I understand that some of these activities may be out of town. I/minor child/ward will be supervised by Mark Twain Behavioral Health.

Title VI Public Notice

Mark Twain Behavioral Health (MTBH) operates its programs and services without regard to race, color, or national origin in accordance with Title VI of the Civil Rights Act of 1964.

MTBH posts Title VI notice on our agency's website and in public areas of our agency.

If you believe you have been discriminated against on the basis of race, color, national origin by Mark Twain Behavioral Health, you may file a Title VI complaint by completing, signing, and submitting the agency's Title VI Complaint Form.

How to file a Title VI complaint with Mark Twain Behavioral Health:

1. Obtain a Title VI Complaint Form from the receptionist at one of our locations or download the form from our website: www.mtbh.org.

2. In addition to the complaint process at Mark Twain Behavioral Health, complaints may be filed directly with the Federal Transit Administration, Office of Civil Rights, Region 7, 901 Locust Street Suite 404, Kansas City, Missouri 64106.

3. Complaints must be filed within 180 days following the date of the alleged discriminatory occurrence and should contain as much detailed information about the alleged discrimination as possible.

4. The form must be signed and dated, and include your contact information. If information is needed in another language, contact 573.221.2120.

5. Return completed Title VI Complaint Form to Mark Twain Behavioral Health, Attention Celia Hagan, 154 Forrest Drive, Hannibal, MO 63401.

Nondiscrimination obligations and complaint procedures may be translated as needed.

Persons interested in knowing more about the nondiscrimination obligations of Mark Twain Behavioral Health may submit their request to Celia Hagan, 154 Forrest Drive, Hannibal, MO 63401.

Mark Twain Behavioral Health

ADA Public Notice

Mark Twain Behavioral Health (MTBH) is committed to ensuring that its transportation services are accessible to all persons and strictly prohibits discrimination based on disability. If you have a complaint about the accessibility of our services or believe you have been discriminated against because of your disability, you can file a complaint.

MTBH posts ADA notice as well as our non-discrimination statement on our agency's website and in public areas of our agency.

If you have a complaint about the accessibility of our services or believe you have been discriminated against because of your disability, you can file a complaint. Please provide all facts and circumstances surrounding your issue or complaint so we can fully investigate the incident.

How do you file an ADA complaint with Mark Twain Behavioral Health?

1.Obtain an ADA Complaint Form from the receptionist at one of our locations or download the form from our website: www.mtbh.org.

2.You may file a signed, dated and written complaint no more than 180 days from the date of the alleged incident. The complaint should include:

- Your name, address and telephone number. (See Question 1 of the complaint form.)
- How, why, and when you believe you were discriminated against. Include as much specific, detailed information as possible about the alleged acts of discrimination, and any other relevant information. (See Questions 6, 7, 8, 9,10, and 11 of the complaint form.)
- The names of any persons, if known, whom the director could contact forclarity of your allegations. (See Question 11 of the complaint form.)
-

Please submit your complaint form to address listed below:

Celia Hagan, Title VI Coordinator
Mark Twain Behavioral Health
154 Forrest Drive
Hannibal, MO 63401
Email: chagan@mtbh.org Fax: 573.221.4380

Do you need complaint assistance?

If you are unable to complete a written complaint due to a disability or if information is needed in another format, such as braille or large print, we can assist you. Please contact us at (573-221-2120) or (chagan@mtbh.org).

Mark Twain Behavioral Health

If CPR services are requested/suggested, the following is information regarding this program:

COMMUNITY PSYCHIATRIC REHABILITATION PROGRAM

What is it?

The Community Psychiatric Rehabilitation Program (CPR Program) is a program that serves individuals diagnosed with severe and persistent mental illnesses along with other psychiatric disorders, such as Posttraumatic Stress Disorder.

Services

It provides an evaluation of their illnesses and needs, community support, medication services, crisis intervention, and psychosocial rehabilitation.

Where can community support be provided?

Community support is generally provided in the individual's home and/or home community.

Goal of the program

The goal of the program is to help reduce the number of psychiatric hospitalizations that mentally ill individuals tend to have, to assist with stabilization of symptoms, to keep individuals functioning as independently as possible, and to promote community integration.

Program Requirements

You are required to meet with your Community Support Specialist (CSS) within 4 weeks of your enrollment in the program or you may be discharged from all our agency services.

At your first meeting with your Community Support Specialist (CSS), you and your CSS will determine the frequency of your meetings. Failure to follow through will require discharge from all our agency services.

MTBH CPRP Staff shall not administer medications, but will assist clients in complying with self-administration. Only certified staff in accordance with medication administration policy can administer medications. Clients who self-administer medications will be expected to keep their own medications.

Clients who are transported in agency vehicles and who do not administer their own medications will have their medications stored in a locked box on the van/bus for transportation purposes. For clients being transported to a PSR site, these medications will then be transferred by the driver to the PSR staff person in charge where they will then be placed in a locked storage unit.

Failed appointments

We are always concerned as to how you are doing. Please keep us informed. If you fail to keep an appointment for any services you have at our agency, your CSS will try to contact you within 24 hours to check on how you are doing.

Mark Twain
Behavioral Health

Recovery Program Contract Agreement:

1. I am actively seeking services for my alcohol/drug use problem and agree to voluntarily participate in services.

2. I understand that should I possess alcohol/drugs while in treatment, I will be discharged immediately.

3. I consent to follow up activities after my discharge from treatment.

4. I consent to being photographed and this becoming a part of my record.

I have read and understand the above statements and I understand that my signature pertains to each item.

Recovery Program Release of Responsibility Agreement

1. I voluntarily agree to completely release Mark Twain Behavioral Health and all employees/Board Members of any financial/individual responsibility in regard to any theft, illness, or accident befalling me while a Consumer of Mark Twain Behavioral Health.

2. I agree that Mark Twain Behavioral Health's employees may dispose of any/all personal property of mine left on the premises thirty (30) days following my discharge from the program.

3. I understand that any medications brought to this agency that are not properly labeled and in the original bottle will be disposed of upon admission. Any medications that are discontinued by the prescribing physician will also be disposed of and not returned to me.

4. I am physically fit to participate in physical activities and have no limitations placed on my activities by a physician.

5. I agree to Emergency Medical Care if/when determined necessary by Mark Twain Behavioral Health's staff. I understand that local EMS or 9-1-1 will be called in the case of an emergency.

I have read and understand the above statements and I understand that my signature pertains to each item.

Mark Twain Behavioral Health

What is Telehealth?

Telehealth at Mark Twain Behavioral Health (MTBH) provides a new way to deliver and receive existing services. It is not a new or different health care service, but a way to deliver health care through the use of telecommunication technologies.

Using live, interactive video conferencing, clients can have a live, real-time visit with their provider almost as if they are in the same room even though they are in different locations. The client views the provider over the television, computer or other device at his/her location and can hear and see the provider. The provider views the client over the television, computer or other device at his/her location and can hear and see the client.

Benefits of telehealth include:

- Increased access to care
- Saving time and money by reducing travel time while still receiving quality care from the provider

Limitations of telehealth include:

- Impact of the client/provider relationship by not being physically in the same room with the provider
- Clients may have discomfort with the technology or seeing the provider on television
- Privacy concerns

A MTBH representative will obtain client or parent/guardian consent to deliver services via telehealth. At the time of the appointment, the provider will initiate the connection and introduce all persons at both sites who are participating in the encounter. When the client is at a non-MTBH location, the client and/or parent/guardian will ensure privacy at their location with closed doors and private environment to ensure only intended participants have access to the content of the encounter. The client will communicate with the provider about their needs/concerns or healthcare progress and the provider will share recommendations and make follow-up plans as needed.

Clients are always welcome to drive to a location and see the provider in person when possible at the next available appointment.

Mark Twain Behavioral Health

Treatment Planning Process

An initial assessment with you and your team members will be held to help us learn more about your needs and goals of treatment. The information gathered from the discussion will be used to develop the treatment plan that will guide the services and interventions to help you on your journey to health.

Treatment planning is a team event. A staff member will be assigned to you to develop an individual plan. Your input is required regarding the treatments that are chosen to participate in while receiving services here to reach the goals and objectives that have been agreed upon by you and your treatment team. Non-monetary motivational incentives may be utilized and will be indicated in your individualized treatment plan. A staff member will review with you, the treatment plan and the options that the course of treatment may include, initially and periodically to make updates and consider progress along the way.

Transition plans may be made with a specialized staff person if it is determined movement to another level of services is best for you. The staff member assigned to you will communicate with you to prepare the transition plan and make arrangements as necessary.

Some referrals for services are mandatory. We at Mark Twain Behavioral Health will strive to obtain proper releases to allow us to exchange information with referral sources, explore your motivations to aid us in determining an appropriate treatment plan and ensure you have a staff member assigned for coordinating your care.

Early in your treatment planning process, plans will be made for discharge and to support you to be successful. Your input in this plan will be requested and steps necessary for successful discharge from the program will be reviewed with the client by the staff member.

Durable Power of Attorney for Health Care and Health Care Directive

How to make your end-of-life care wishes known and the tools to help you do so:

- Answers to frequently asked questions
- Instructions
- Forms

Who needs these forms?

- Anyone 18 or older.
- Anyone with a family.
- Anyone who wants to unburden their family from making uninformed health care decisions for them.

THE MISSOURI BAR

Distributed as a public service by The Missouri Bar, the organization of all lawyers liscensed to practice in Missouri. This is developed and updated by Missouri lawyers to be in compliance with Missouri laws.

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INTRODUCTION

It's not fun to talk about end-of-life care wishes, but doing so can help take stress off loved ones later. The Missouri Bar – the organization of all lawyers liscenced to practice in the state – provides free end-of-life decision materials, authored by volunteer lawyers, to the public. The public may review and complete this Durable Power of Attorney for Health Care and/or Health Care Directive form, as well as the HIPAA Privacy Authorization Form. This booklet also provides instructions and answers to common questions about advance-care planning to help Missourians best complete these important forms. The forms are usually copied and given to health care providers without the instructions. The copies are intended to be accepted as the originals.

The form may not meet every person's needs or contain every person's choices. However, efforts were made to prepare a form to meet the needs of many people. If either form does not meet your needs in specifying your wishes, consult with a lawyer who practices in these areas to be sure that your choices for care and treatment, as well as decision-makers, are properly addressed and followed.

The information in this booklet, as well as the forms that you can complete, do not take the place of meeting with and receiving advice and counsel from a lawyer experienced in assisting clients with completing these forms. Often lawyers who do estate planning, elder law, and general practice focusing on those areas can assist you with your health care advance planning. Please contact a lawyer if you have any questions.

FREQUENTLY ASKED QUESTIONS

Do I need a lawyer to complete this Durable Power of Attorney for Health Care and/or Health Care Directive form?

No. If you do not feel that this form meets your needs or if you have questions, you may want to consult a lawyer. If you have questions about medical care and treatment, your physician, social workers, registered nurses, and other health care providers also may be able to help you and answer your questions.

Why does the Durable Power of Attorney for Health Care and/or Health Care Directive form have three parts?

This form has three parts because Part 1 is your Durable Power of Attorney for Health Care; Part 2 is your Health Care Directive; and Part 3 is your form instructions and notary acknowledgement.

What is a Durable Power of Attorney for Health Care (Part 1)?

The Durable Power of Attorney for Health Care (Part 1) is a document that lets you appoint someone to be your health care decision-maker if you become unable to make health care decisions for yourself, as determined by your doctors, to make or communicate decisions on your behalf. The people you name in Section 1 and 2 of the form are your "attorney-in-fact" or "agent." These health care choices include advocating for care and treatment that you need but also may include decisions to withdraw or withhold life-prolonging procedures when certain conditions specified by you are met.

You should name backup agents (in Section 2 of the form) if the first person you name in Section 1 cannot serve. Finally, list the powers that you want your agent to exercise for you if you cannot make those decisions.

What is a Health Care Directive (Part 2)?

The Health Care Directive (Part 2) is a document that lets you state your care and treatment choices about life-prolonging procedures if you are found to be persistently unconscious or at the end-stage of a serious incapacitating or terminal illness and you cannot speak or communicate your choices. Your choices should be usually given in advance to provide guidance and support to your agent if you are unable to make or communicate the decisions yourself.

What is the form instructions and notary acknowledgement (Part 3)?

Part 3 instructs your agent how to use the form when making decisions and the need for a notary to acknowledge it before it can be used. If Part 2 is completed, the form must also be witnessed. The notary acknowledgment must be done for either Part 1 or Part 2.

When completed with Part 3, Part 1 can be used with or without Part 2.

Do I need both a Durable Power of Attorney for Health Care and a Health Care Directive?

This is your choice. If you want someone to speak for you concerning your future medical care and treatment, you need to appoint an agent to do so in the Durable Power of Attorney (Part 1). Please do Part 1 if you have someone in mind to appoint. If you only want to name a decision-maker without including directions to follow in making decisions, then complete parts 1 and 3 without Part 2.

If you want to indicate your choices in advance about your end-of-life care and treatment, including life prolonging procedures, you need to complete the Health Care Directive (Part 2). The Health Care Directive (Part 2) can provide guidance and support to your agent in following your choices. If you do not want to appoint an agent to make your decisions, then complete Parts 2 and 3 without Part 1 (however, be sure to indicate your name and identifying information on top of the first page of the form even if not using Part 1).

What are the requirements for a person to serve as my agent?

You may select a person 18 or older, who has the mental capacity to make these decisions. Your agent is usually a close relative or friend that you trust to respect and advocate for your case and treatment preferences. The agent cannot be your doctor or an owner/operator or employee of a health care facility where you are a patient or resident, unless you are related to that person.

Can your agent request that tube feeding be withheld or withdrawn?

Yes, if you specifically give your agent this authority. The Durable Power of Attorney for Health Care (Part 1) requires that you indicate whether you allow your agent to withhold or withdraw artificially supplied nutrition or hydration (*i.e.*, tube feeding). You also can explain your choice about withholding and withdrawing artificially supplied nutrition and hydration and the serious conditions to be met before the life-prolonging procedures indicated in the Health Care Directive (Part 2) are withheld or withdrawn.

When can my agent act?

The Durable Power of Attorney for Health Care (Part 1) only becomes effective for making health care decisions when you are determined to be incapacitated and unable to. Section 4 on the form enables you to choose whether you want one physician or two to determine if you lack capacity to make health care decisions. Unless you indicate otherwise, Missouri law requires two physicians to make this determination about incapacity. Many people choose just one physician. Please consider whether two physicians would be available when your agent needs to make emergency health care decisions for you. Some other powers take effect immediately without a finding of incapacity in Part 1, Section 6.

If I already have a Durable Power of Attorney form completed, should I complete a new Durable Power of Attorney for Health Care (Part 1)?

This depends upon whether you want to update and replace what you have with something that complies with current Missouri law. Your existing Durable Power of Attorney may not cover health care, may have been prepared in another state, may not be up to date, or you may decide that you want to name a different person to make your decisions as your agent. For example, the “Right of Sepulcher” will need to be specified in your Durable Power of Attorney if you want your agent to handle the disposition of your body.

If I already have a living will or other advance directive, should I complete a new Health Care Directive (Part 2)?

This depends on what your documents say in specifying your current choices. Many living wills only apply when you are expected to die within a short period of time and do not allow for the withholding or withdrawal of artificially supplied nutrition and hydration. Often living wills do not name agents to follow your choices when you lack capacity, and you may want to complete Part 1 to do that. Some living wills do not cover the condition of being persistently unconscious.

What is the difference between an Out-Of-Hospital Do-Not-Resuscitate (OHDNR) Order and a Health Care Directive?

The OHDNR Order is a physician's order under Missouri law that the patient will not be resuscitated (usually through CPR) if the patient stops breathing or the patient's heart stops. This order must be signed by a physician and the patient (or if the patient lacks capacity, the patient's agent under a health care durable power of attorney or the patient's guardian). This form pertains to resuscitation in a non-hospital setting, usually by EMS or other emergency first-responders who may be called. EMS and other emergency first-responders cannot follow your preferences as expressed in your health care directive because it is not a physician order. A Health Care Directive states the patient's choices about several types of treatment if certain conditions happen in the future. Please visit with your health care provider if you have further questions.

Does the authority of my agent under my Durable Power of Attorney for Health Care end at my death?

Yes, with a few exceptions. In Section 6 of the Durable Power of Attorney for Health Care (Part 1), you can give your agent the following special powers to act for you after you die: (A) to choose and control the burial, cremation, or other final disposition of your remains (called the "right of sepulcher"); (B) to consent to an autopsy; and (C) to delegate the health care decision making to another person. In Section 6, you can also give your agent the power to consent to or prohibit anatomical gifts of organs or tissue.

What is right of sepulcher? Can I name my agent to have this right?

The right of sepulcher is given to a person to control your burial, cremation, or other final disposition of your body. You can authorize your agent to have this right in Section 6 of the Durable Power of Attorney for Health Care (Part 1).

If you do not authorize your agent to have this right, Missouri law gives the right to your spouse or other family members, in a certain priority, to have control. You should inform your agent about your wishes for what you want to happen to your body after you die. You may obtain more information about right of sepulcher from a funeral home.

After I complete the Durable Power of Attorney for Health Care (Part 1) and/or the Health Care Directive (Part 2), do I need to do anything else?

You should do several things after you have completed the form. First, you should detach and give copies of the form to your agent, your physician, and any other health care provider. Second, you should discuss your wishes with your agent, your physicians, and your family and friends, including clergy. Finally, you should review your form to keep it up to date and remind your agent, your physicians, and your family and friends of your wishes on a periodic basis.

It is especially important to discuss your end-of-life treatment wishes as expressed in your Health Care Directive because Missouri law allows a health care provider (physician, hospital, etc.) to not follow your preferences if they have strongly held religious beliefs or moral convictions that are contrary to your wishes. If this is the case, they must offer to transfer your care to a health care provider who will honor your end-of-life treatment wishes, but you need to know if your physician will honor your wishes. If you become incapacitated and unable to make health care decisions for yourself and are unable to express your wishes, your agent needs to have this conversation with your physician.

What is the HIPAA Privacy Authorization Form?

The HIPAA Privacy Authorization Form should be filled out if you would like someone other than yourself to have access to your medical records and information. This form allows health care providers to release your health information to the people you have named.

SPECIFIC INSTRUCTIONS ABOUT COMPLETING THE DURABLE POWER OF ATTORNEY FOR HEALTH CARE AND HEALTH CARE DIRECTIVE FORM

The Durable Power of Attorney for Health Care and Health Care Directive form is designed for you, as the principal, to state your specific choices. Neatly print your full name on the first blank line at the top of page 1 of the form because you are the principal. Complete your current address, city, state, and zip code on the second blank line at the top of page 1. Remember to print your name and address at the top of the form regardless of if you are completing all or some of the sections of the form.

INSTRUCTIONS FOR PART 1 – DURABLE POWER OF ATTORNEY FOR HEALTH CARE

If you choose to name an agent to make your health care decisions when you are incapacitated and unable to make and communicate a health care decision, complete Part 1. If you do not choose to name an agent, mark an "X" through Part 1 on pages 1 and 2 of the form and proceed to Part 2 for your Health Care Directive (see corresponding instructions for Part 2 below).

Section 1 - Selection of agent

Please think carefully about the person you want to be your agent to make health care decisions for you because you will trust that person to make decisions about your life. Rather than name the oldest child, you might consider how the person would communicate your choices to health care providers. You want someone who is good in a crisis, decisive, diplomatic, and reliable in following your choices. Your agent needs to keep the family informed and try to reach agreement with them about life-prolonging procedures when possible. You do not have to name a family member as your agent, however.

You cannot name your doctor or an employee of your doctor as your agent unless they are also your close relative. If you are a resident of a health care facility, you cannot name an owner, operator, or employee of the health care facility as your agent.

It is suggested that you name only one agent to serve at a time. Naming more than one person to make decisions can cause confusion for your family and the health care staff and delay action in an emergency. If more than one agent serves at a time, it is best to specify that each one can act individually on their own.

Section 2 - Alternate agent

You should name alternates to act if your first agent resigns or is not able or available to act. You should try to pick someone with similar qualities as those you were looking for in your first agent. At least two alternate agents are recommended.

Section 3 - Durability

This is the standard clause required for a Durable Power of Attorney for Health Care to be effective in Missouri after the principal becomes incapacitated.

Section 4 - Effective date as to health care decision making

The agent you designate in your Durable Power of Attorney for Health Care may only act to make your health care decisions after one or two physicians determine that you lack capacity and are unable to make and communicate a health care decision. Please mark whether you want one or two physicians to determine when

you are incapacitated. If you fail to make this clear, then the law presumes that you want two physicians.

Please remember that in some parts of the state and in certain health care facilities during after-hours emergencies, it may be difficult to find a second physician to determine your capacity to have someone advocate for your health care.

Section 5 - Agent's powers

Some of the listed powers are obvious and do not require you to choose from options, but give your agent the power to advocate for your care and treatment and make necessary decisions to provide informed consent for your health care. One listed power requires you to choose from some options.

Subsection 5A

Mark your choice by checking one of the two boxes stating whether you give your agent the power to withhold or withdraw artificially supplied nutrition or hydration such as a feeding tube or IV fluids. Please remember euthanasia (also known as assisted suicide) in Missouri is illegal. This subsection only allows you to choose whether to give your agent the power to remove you from artificially supplied nutrition or hydration.

Section 6 - Effective date as to other authority

You may spell out certain additional powers for your agent as follows:

- To have the right of sepulcher to be designated "next of kin" under Missouri law to have custody and control for the disposition of your body through methods like burial or cremation.

- To consent to an autopsy after your death.

- To delegate decision-making power to another person. This can be useful if your agent might be temporarily unavailable.

- To authorize anatomical gifts, such as organ donation, by initialing the shaded box with a range of stated options for you to choose from to further check off. Or you may choose to prohibit anatomical gifts by initialing the second shaded box.

Be sure to initial the bottom of pages 1, 2, and 3 of the form.

INSTRUCTIONS FOR PART 2 – HEALTH CARE DIRECTIVE

If you choose to give directions to your agent or your health care providers about what life-prolonging procedures you want or do not want if you are in a persistently unconscious or terminally ill condition, complete Part 2 of the form. If you choose not to give your agent or health care providers direction, mark an "X" through Part 2 on pages 2 and 3 and proceed to Part 3 to sign your form.

Section 1 states your intent for the directive under Missouri law to provide clear and convincing proof of your choices and instructions about life-prolonging treatment.

Section 2 indicates that life-prolonging procedures are to be withheld or withdrawn only under two conditions: either you are in a persistently unconscious condition with no reasonable chance of medical recovery, or you are at the end-stage of a terminal condition. Where the line is drawn on such issues often depends upon what

your medical providers determine and tell you. You're agent may find other providers who have differing opinions.

Certain life-prolonging procedures are listed for you to mark that you choose to withhold or withdraw by putting your initials in the shaded boxes when you are in a persistently unconscious condition or you are at the end-stage of a terminal condition. If you know of a procedure that you do not want but it is not listed, you can spell it out by writing the procedure's name in the blank line given.

Section 3 states that if providing any life-prolonging procedures might result in a recovery that you define as reasonable, then you want that procedure done. This section also allows you to choose to do any of the initialed life-prolonging procedures if the reason for doing them is to relieve your pain or provide comfort to you in addition to prolonging your life.

Section 4 asks whether you want certain comfort measures if you choose to not have any life-prolonging procedures.

Section 5 only applies if you have consented to make anatomical gifts of your organs or tissues to carry out your choice to do them.

INSTRUCTIONS FOR PART 3 – GENERAL PROVISIONS INCLUDED IN THE DURABLE POWER OF ATTORNEY FOR HEALTH CARE AND HEALTH CARE DIRECTIVE

Part 3 must be completed for the Durable Power of Attorney for Health Care (Part 1) and the Health Care Directive (Part 2) to be effective.

Section 1 - Relationship between Durable Power of Attorney for Health Care and Health Care Directive

If you have completed both the Durable Power of Attorney for Health Care (Part 1) and the Health Care Directive (Part 2) or you have just completed the Durable Power of Attorney for Health Care (Part 1), then this section sets out steps for your agent to consider and follow in making decisions about life-prolonging procedures for you.

First, your agent should follow your choices as stated in your Health Care Directive (if you completed it) or, if you did not complete it, then they should make decisions from knowing you or having had various discussions with you about making decisions regarding life-prolonging procedures.

Second, if your agent does not know your choices for the exact decision at hand but your agent has evidence or information of what you might want, your agent can try to determine how you would decide. This is called substituted judgment, and it requires your agent to imagine themself in your position. Your agent should consider your values, religious beliefs, past decisions, and past discussions. The aim is to have your agent choose as you would probably choose, even if it is not what your agent would choose for themself.

Third, if your agent has very little or no knowledge of choices that you would want, then your agent and the doctors will have to decide based on what a reasonable person in the same situation would decide. This is called making decisions in your best interest. You should have confidence in your agent's ability to make decisions in your best interest if your agent does not have enough information to follow your preferences or use substituted judgment. If this is the case, you authorize your agent to make decisions using their best judgment, which might even be in conflict to your directive.

Finally, if the Durable Power of Attorney for Health Care is determined to be ineffective, or if your agent (or your named alternate) is not able to serve, the Health Care Directive (if you completed it) is meant to be used on its own as firm instructions to your health care providers about life-prolonging procedures.

Section 2 - Protection of third parties who rely on my agent

Health care providers who act in good faith are not liable for following the direction(s) of the person you appoint as your health care agent.

Section 3 - Revocation of prior Durable Power of Attorney for Health Care or Health Care Directive

If you have completed one or both of Parts 1 and 2 of the Durable Power of Attorney for Health Care and Health Care Directive form, you are ending and replacing any earlier versions of durable power of attorney containing health care terms, health care directive, or living will. You should give copies of your most recent completed forms to your agent and alternate, your doctor, other health care providers, and your family members.

Section 4 – Validity

This document will be considered valid and lawful in Missouri, and it should be recognized in other states and countries on a temporary basis when you are traveling. If you change your residency, you should complete the form that your new home state recognizes. Because you need to give the documents to many people, including health care providers, copies are considered as valid or lawful as the original.

Signature

You must sign the form in the presence of two witnesses if you complete Part 2 and a notary public if you complete Part 1 (or both witnesses and a notary if you complete Parts 1 and 2).

Witnesses

Because Missouri requires clear and convincing evidence of any wishes you express in the Health Care Directive (Part 2), two witnesses are required. Thus, witnesses are required if both the Durable Power of Attorney for Health Care (Part 1) and Health Care Directive (Part 2) are completed or only the Health Care Directive (Part 2). It is suggested that the witnesses not be related to you and be at least 18 years of age.

Notary acknowledgement

The notary acknowledgment is required by Missouri law if you appoint an agent and complete a Durable Power of Attorney for Health Care (Part 1), or if you complete both Parts 1 and 2.

Need help talking about your choices or choosing someone to carry them out?

Visit
TheConversationProject.org

DURABLE POWER OF ATTORNEY FOR HEALTH CARE AND/OR HEALTH CARE DIRECTIVE OF

(Print your full legal name here) _____

(Address, City, State, Zip)_____

(Pronouns and chosen name)_____

PART 1 - DURABLE POWER OF ATTORNEY FOR HEALTH CARE

(If you *DO NOT WISH* to name someone to serve as your decision-making Agent, mark an "X" through Part 1 on pages 1 and 2 and continue on to Part 2.)

1. **Selection of Agent**. I, (your name printed) _____, currently a resident of _____ County, Missouri, appoint the following person as my true and lawful attorney-in-fact ("Agent"):

Name: _____

Address: _____

_____

Phone(s): 1st _____ 2nd _____

2. **Alternate Agent**. If my Agent resigns or is not able or available to make health care decisions for me, or if an Agent named by me is divorced from me or is my spouse and legally separated from me, I appoint the following persons in the order named below to serve as my alternate Agent and to have the same powers as my Agent:

First Alternate Agent:

Name: _____

Address: _____

_____

Phone(s): 1st _____

2nd _____

Second Alternate Agent:

Name: _____

Address: _____

_____

Phone(s): 1st _____

2nd _____

3. **Durability**. This is a Durable Power of Attorney, and the authority of my Agent, when effective, shall not terminate or be void or voidable if I am or become disabled or incapacitated or in the event of later uncertainty as to whether I am dead or alive.

4. **Effective Date as to Health Care Decision Making**. This Durable Power of Attorney is effective as to health care decision making when I am incapacitated and unable to make and communicate a health care decision as certified by ***(check one of the following boxes):*** ☐ one physician **OR** ☐ two physicians.

5. **Agent's Powers**. I grant to my Agent full authority as to health care decision making to:

A. Give consent to prohibit or withdraw any type of health care, long-term care, hospice or palliative care, medical care, treatment, or procedure, either in my residence or a facility outside of my residence, even if my death may result, including, but not limited to, an out-of-hospital do-not-resuscitate order, with the following specific authorization ***(initial one of the following boxes to state your choice):***

_____ **Initials** I wish to AUTHORIZE my Agent to direct a health care provider to withhold or withdraw artificially supplied nutrition and hydration (including tube feeding of food and water);

_____ **Initials** OR I DO NOT AUTHORIZE my Agent to direct a health care provider to withhold or withdraw artificially supplied nutrition and hydration (including tube feeding of food and water);

B. Make all necessary arrangements for health care services on my behalf and to hire and fire medical personnel responsible for my care;

C. Move me into, or out of, any health care or assisted living/residential care facility or my home (even if against medical advice) to obtain compliance with the decisions of my Agent;

D. Take any other action necessary to do what I authorize here, including, but not limited to, granting any waiver or release from liability required by any health care provider and taking any legal action at the expense of my estate to enforce this Durable Power of Attorney for Health Care;

E. Receive information regarding my health care, obtain copies of and review my medical records, consent to the disclosure of my medical records, and act as my "personal representative" as defined in the regulations [45 C.F.R. 164.502(g)] enacted pursuant to the Health Insurance Portability and Accountability Act of 1996 ("HIPAA");

6. **Effective Date as to Other Authority.** In addition to the powers set forth above, I authorize effective upon my signature and without the need for a physician's certification of incapacity that my Agent be authorized to have one or more of the following powers ***(initial your desired choices):***

_____ **Initials** Determine what happens to my body after my death (authority for right of sepulcher);

_____ **Initials** Give consent after my death to an autopsy or postmortem examination of my remains;

_____ **Initials** Delegate health care decision-making power to another person ("Delegee") as selected by my Agent, and the Delegee shall be identified in writing by my Agent;

With respect to anatomical gifts of my body or any part (*i.e.,* organs or tissues), please initial your desired choice below:

_____ **Initials** **AUTHORIZATION OF ANATOMICAL GIFTS**. I wish to AUTHORIZE my Agent to make an anatomical gift of my body or part (organ or tissue).

My donations are for the following purposes: (check one)	GIFT SPECIFICATIONS: (check one)
☐ Transplantation ☐ Therapy ☐ Research ☐ Education ☐ All the above	I would like to donate ☐ Any needed organs and tissues, as allowed by law. ☐ Any needed organs and tissues as allowed by law, with the following restrictions:

_____ **Initials** **PROHIBITION OF ANATOMICAL GIFTS**. I DO NOT AUTHORIZE my Agent to make an anatomical gift of my body or any part (organ or tissue).

7. **Agent's Financial Liability and Compensation**. My Agent, acting under this Durable Power of Attorney for Health Care, will incur no personal financial liability. My Agent shall not be entitled to compensation for services performed under this Durable Power of Attorney for Health Care, but my Agent shall be entitled to reimbursement for all reasonable expenses incurred as a result of carrying out any provisions hereof.

PART 2 - HEALTH CARE DIRECTIVE

(If you *DO NOT WISH* to make a health care directive but only wish to have an Agent make your decisions without the directive, be sure that you have completed Part 1 on pages 1 and 2, mark an "X" through Part 2 on pages 2 and 3, and continue to Part 3.)

1. I make this HEALTH CARE DIRECTIVE ("Directive") to exercise my right to determine the course of my health care and to provide clear and convincing proof of my choices and instructions about my treatment.

2. If I am persistently unconscious or there is no reasonable expectation of my recovery from a seriously incapacitating or terminal illness or condition, I direct that all of the life-prolonging procedures that I have initialed below be withheld or withdrawn.

_____ Initials	**artificially supplied nutrition and hydration (including tube feeding of food and water)**		
_____ Initials	**surgery or other invasive procedures**	_____ Initials	**heart-lung resuscitation (CPR)**
_____ Initials	**antibiotics**	_____ Initials	**dialysis**
_____ Initials	**mechanical ventilator (respirator)**	_____ Initials	**chemotherapy**
_____ Initials	**radiation therapy**		
_____ Initials	**other procedures specified by me (insert) _____**		
_____ Initials	**all other "life-prolonging" medical or surgical procedures that are merely intended to keep me alive without reasonable hope of improving my condition or curing my illness or injury**		

3. However, if my physician believes that any life-prolonging procedure may lead to a recovery significant to me as communicated by me or my Agent to my physician, then I direct my physician to try the treatment for a reasonable period of time. If it does not cause my condition to improve, I direct the treatment to be withdrawn even if it shortens my life. I also direct that I be given medical treatment to relieve pain or to provide comfort, even if such treatment might shorten my life, suppress my appetite or my breathing, or be habit-forming.

4. If I have chosen to not have life-prolonging procedures (any and all of the boxes above having been checked), **(please check one of the following boxes)**: ☐ I do want OR ☐ I do not want palliative care; hospice care; medication for anxiety, pain, and/or discomfort; ice chips; mouth swabs; and any other measures to keep me comfortable.

5. If I have already consented to be on the Missouri organ and tissue donor registry or my Agent has authorized the donation of my organs or tissues, I realize it may be necessary to maintain my body artificially after my death until my organs or tissues can be removed.

IF I HAVE NOT DESIGNATED AN AGENT IN THE DURABLE POWER OF ATTORNEY, PART 2 OF THIS DOCUMENT IS MEANT TO BE IN FULL FORCE AND EFFECT AS MY HEALTH CARE DIRECTIVE.

PART 3 - GENERAL PROVISIONS INCLUDED IN THE DURABLE POWER OF ATTORNEY FOR HEALTH CARE AND HEALTH CARE DIRECTIVE

1. Relationship Between Durable Power of Attorney for Health Care and Health Care Directive. If I have executed both the Durable Power of Attorney for Health Care and Health Care Directive, I encourage my Agent to:

A. First, follow my choices as expressed in the above Directive or otherwise from knowing me or having had various discussions with me about making decisions regarding life-prolonging procedures.

B. Second, if my Agent does not know my choices for the specific decision at hand, but my Agent has evidence of my preferences, my Agent can determine how I would decide. My Agent should consider my values, religious beliefs, past decisions, and past statements. The aim is to choose as I would choose, *even if it is not what my Agent would choose for themself.*

C. Third, if my Agent has little or no knowledge of choices I would make, then my Agent and the physicians will have to make a decision based on what a reasonable person in the same situation would decide. I have confidence in my Agent's ability to make decisions in my best interest if my Agent does not have enough information to follow my preferences.

D. Finally, if the Durable Power of Attorney for Health Care is determined to be ineffective, or if my Agent is not able to serve, the Health Care Directive is intended to be used on its own as firm instructions to my health care providers regarding life-prolonging procedures.

2. Protection of Third Parties Who Rely on My Agent. No person who relies in good faith upon any representations by my Agent or Alternate Agent shall be liable to me, my estate, my heirs or assigns, for recognizing the Agent's authority.

3. Revocation of Prior Durable Power of Attorney for Health Care or Health Care Directive. I revoke any prior living will, declaration, or health care directive executed by me. If I have appointed an Agent in a prior durable power of attorney, I revoke any prior health care durable power of attorney or any health care terms contained in that other durable power of attorney and intend that this Durable Power for Attorney for Health Care (if completed) and this Health Care Directive (if completed) replace or supplant earlier documents or provisions of earlier documents.

4. Validity. This document is intended to be valid in any jurisdiction in which it is presented. The provisions of this document are separable, so that the invalidity of one or more provisions shall not affect any others. A copy of this document shall be as valid as the original.

IF YOU HAVE COMPLETED THE ENTIRE DOCUMENT OR ONLY THE HEALTH CARE DIRECTIVE (PART 2), YOU MUST SIGN THIS DOCUMENT IN THE PRESENCE OF TWO WITNESSES.

IN WITNESS WHEREOF, I signed this document on _____(month, date),_____(year).

_____
Signature
Printed Name: _____

WITNESSES: The person who signed this document is of sound mind and voluntarily signed this document in our presence. Each of the undersigned witnesses is at least eighteen years of age.

Signature	_____	Signature	_____
Print Name	_____	Print Name	_____
Address	_____	Address	_____
	_____		_____

NOTARY ACKNOWLEDGMENT
(Only required if Part 1 or entire document completed.)

STATE OF MISSOURI)
) SS
COUNTY OF _____)

On this _____ day of _____ (month), _____ (year), before me personally appeared _____ _____, to me known to be the person described in and who executed the foregoing instrument and acknowledged that he/she executed the same as his/her free act and deed.

IN WITNESS WHEREOF, I have hereunto set my hand and affixed my official seal in the County or City and state aforementioned, on the day and year first above written.

_____

_____, Notary Public
(Name Printed)

HIPAA Privacy Authorization Form

Authorization for Use or Disclosure of Protected Health Information
(Required by the Health Insurance Portability and Accountability Act — 45 CFR Parts 160 and 164)

1. I hereby authorize all medical service sources and health care providers to use and/or disclose the protected health information (“PHI”) described below to my agent identified in my durable power of attorney for health care named _____.

2. Authorization for release of PHI covering the period of health care (check one)
   a. ☐ from (date) _____ - to (date)_____ OR
   b ☐ all past, present and future periods.

3. I hereby authorize the release of PHI as follows (check one)**:**
   a. ☐ my complete health record (including records relating to mental health care, communicable diseases, HIV or AIDS, and treatment of alcohol/drug abuse). OR
   b. ☐ my complete health record *with the exception of the following information* (check as appropriate):
      ☐ Mental health records
      ☐ Communicable diseases (including HIV and AIDS)
      ☐ Alcohol/drug abuse treatment
      ☐ Other (please specify): _____ .

4. In addition to the authorization for release of my PHI described in paragraphs 3 a and 3 b of this Authorization, I authorize disclosure of information regarding my billing, condition, treatment and prognosis to the following individual(s):

   Name _____ Relationship _____

   Name _____ Relationship _____

   Name _____ Relationship _____

5. This medical information may be used by the persons I authorize to receive this information for medical treatment or consultation, billing or claims payment, or other purposes as I may direct.

6. This authorization shall be in force and effect until nine (9) months after my death or _____, (date or event) at which time this authorization expires.

7. I understand that I have the right to revoke this authorization, in writing, at any time. I understand that a revocation is not effective to the extent that any person or entity has already acted in reliance on my authorization or if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.

8. I understand that my treatment, payment, enrollment, or eligibility for benefits will not be conditioned on whether I sign this authorization.

9. I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law.

_____ Date: _____
Signature of Patient

Tear off, keep original, and give copies to your health care provider, agent and family members

INSTRUCTIONS FOR HIPAA PRIVACY AUTHORIZATION FORM

You are entitled to keep your health information private. The HIPAA Privacy Authorization Form should be completed if you would like some person other than yourself to have access to your medical records and information. This form gives your health care providers written authorization to release your health information to the people you have named.

Since a Durable Power of Attorney for Health Care form is only effective after you have lost your capacity to make or communicate decisions and does not authorize release of medical information to your agent or alternate while you remain competent, it is necessary to complete and sign the HIPAA Privacy Authorization Form.

You may complete a HIPAA Privacy Authorization Form regardless of if you have a Durable Power of Attorney for Health Care. This HIPAA Authorization Form is to be used along with the Durable Power of Attorney for Health Care form.

In **Section 1** of the HIPAA Privacy Authorization Form, insert the name of your agent named in your Durable Power of Attorney for Health Care.

In **Section 2(a)**, indicate what time period is covered by the authorization, either with the specific dates or by checking the box that permits the release of medical information for all past, present, and future periods.

In **Section 2(b)**, check the box if you want to include all your medical records.

In **Section 3(a)**, check the box to indicate whether you want your complete health record – which includes records related to mental health, communicable diseases, HIV or AIDS, and the treatment of alcoholism or drug abuse – to be released.

In **Section 3(b)**, check the box to indicate which records you want to exclude, if you want any excluded. Please note that if you do not want to authorize the release of your complete health record, you must indicate with a check which records you want excluded.

In **Section 4**, insert the name of the person or individuals and the relationship to you to whom you give permission to receive your medical information, in addition to the agent named in your Durable Power of Attorney for Health Care. Oftentimes people want other family members or friends to find out how you are doing in addition to your agent. It is recommended that you name the alternate agents from your Durable Power of Attorney for Health Care in this section.

In **Section 6**, fill in the date if you want this authorization to expire; otherwise, the authorization will remain in effect until nine months after your death.

Read **Sections 5, 7, 8, and 9** before signing your name and dating the form. After you have completed the HIPPA Privacy Authorization Form, detach or print the completed form from this booklet, make copies, and give those copies to your health care providers. Also let the individuals listed in the HIPAA Privacy Authorization Form know of the form's existence.

WHAT TO DO AFTER COMPLETING THE FORMS

After you have completed the forms and stated or marked your choices, you should do the following:

- **Make copies** of the forms for your agent and any alternates, your doctor (take them to your next appointments), and your health care providers when you are admitted (*e.g.*, hospitals, clinics, nursing homes, assisted living facilities, hospice and palliative care providers, and home health agencies). You will be asked about them each time you are admitted, and you should give them new copies each time you change your form.

- **If you have choices that you want followed about life-prolonging procedures and other end-of-life considerations, please discuss what you want** with your family, your doctors, your clergy, and your agents. You may get assistance with such planning from lawyers who can help you make your wishes clear in writing.

- **Discuss, discuss, discuss with your family, your agent, your physicians, and your health care providers your choices, wishes, and views about your health conditions, the treatments that you want, the care or treatment that you want to avoid, and what choices you would want your agent to make** – if health care providers propose life-prolonging procedures for you when you are persistently unconscious or when you are at the end stage of a serious incapacitating or terminal illness or condition.

- After you have completed the Durable Power of Attorney for Health Care form and given it to your agent, **you should tell your agent that you will make your own decisions until you are certified as being incapacitated.** Tell your agent that they will be asked to make any treatment decisions for you if and when you have been certified as incapacitated.

- When your agent signs your consent and other forms to carry out your choices, **you should tell your agent to sign your name first and sign their name afterwards to state that your agent is signing for you using your Durable Power of Attorney for Health Care.** For example, your agent would sign "John H. Doe, by Sally I. Smith, POA." Make sure your agent knows that they cannot just sign your name alone because they are not you. They should also not just sign their name because that could make them responsible for situations or items they sign for you. For example, they could become responsible for paying your hospital bill if they sign something with their name.

ORDER INFORMATION

The forms with information from this booklet are available for download on The Missouri Bar website for the public at **MissouriLawyersHelp.org**. Both forms may be filled out online, but the Durable Power of Attorney for Health Care and/or Health Care Directive form must be signed in front of a notary.

Printed versions of this booklet with forms may be ordered from The Missouri Bar at no charge. You can order copies of this booklet by visiting **MissouriLawyersHelp.org** or **emailing brochures@mobar.org.**

This booklet with forms may be copied for use by other persons.

Revised July 2023

Brief Guide to Psychiatric Advance Directives

Do you want more say in your mental health treatment?

If you are someone who is in psychiatric treatment, you might be interested in finding out how to have more say in your treatment, especially when you are in crisis. This guide will help you understand how a psychiatric advance directive (PAD) might be useful to you.

It's always a good idea to start with your psychiatrist or other mental health treatment provider if you are interested in creating your own PAD. Ask if they know about PADs, and if they can help you create one. If they don't know about them, you can share this brochure with them so they can learn more, too. There are also volunteers in your community who will help you create a PAD.

What is a psychiatric advance directive?

A psychiatric advance directive is a legal document that tells treatment providers your preferences for treatment in a crisis. It goes into effect if you are incapacitated – that means if you are in a state of mind where you cannot speak for yourself. An example of being incapacitated would be if you were unconscious, or couldn't speak, or were experiencing significant confusion, psychosis or mania.

If you have a wellness plan or crisis plan, there are some similarities with a PAD. A PAD is different because it is a legal document. To make it official, it must be signed in front of a notary public and two witnesses.

Treatment providers are required to follow your wishes stated in the PAD, unless those wishes include something they cannot do (like send you to a hospital in another state, or to a hospital that has no beds available), or it's an emergency and they need to preserve your safety or the safety of others.

Where did the idea for PADs come from?

Medical advance directives have been used in medical settings for years for people who wanted more control over their medical care at times when they had a serious medical illness and knew they would not be able to express their wishes on their own – like if someone was at the end of life, or had a very serious illness or injury. They were created as the result of the Patient Self-

Determination Act of 1990, a federal law designed to give all patients more say in healthcare decisions.

Are PADs always respected?

We hear from some people that their PAD was not followed when they wanted it to be followed. They are not used often, and medical providers are just starting to learn more about them. By getting more PADs out there, we hope to strengthen the voice of people who live with mental health conditions and to encourage more shared decision making with their treatment providers.

Do you have a trusted family member or friend who can help you in a crisis?

A psychiatric advance directive can include a health care power of attorney (HCPA). The HCPA is a legal document that lets you put someone in charge of communicating your wishes to medical providers if you are not able to. The person appointed by the HCPA is called your health care agent. That person can speak for you in a crisis. It's your choice to have a health care agent or not. Sometimes family members are in this role, and sometimes friends or another person you trust and who can help you in a crisis. You can work with your agent to understand what you would want, and they can have your written advance instructions to guide them in speaking for you.

Are there other benefits to having a PAD?

The process of creating a PAD helps you think through what you can do to prevent a crisis, what to do during a crisis, and how best to recover from a crisis. The conversations with your treatment providers, your family and friends, can help you take control of your mental health and improve communication between all the people who support you.

What do I need to think about before I create a PAD?

What kind of treatment is helpful to you? What medications work for you? What medications don't work for you? Is there a hospital that you prefer? Who should be contacted if you are in a mental health crisis?

Where can I get more information about PADs?

National Resource Center on Psychiatric Advance Directives: http://www.nrc-pad.org/ For information about PADs nationwide.

How to be an Effective Health Care Agent

For family members and friends who are willing to serve in the role of a health care agent for a person with mental illness, here are some things to consider:

- ⇒ Are you able to represent the wishes and best interests of the person?
- ⇒ Do you know the person, and do they trust you?
- ⇒ Do you know how to navigate in crisis situations?
- ⇒ Are you able to communicate assertively?
- ⇒ Are you accessible and willing to help?
- ⇒ Are you good at thinking ahead and problem solving?
- ⇒ Do you know who to contact and where to go to access help in a crisis?
- ⇒ Do you have PAD documents accessible, and in a shareable form (the notebook or the file)?

Crisis Intervention knowledge and skills

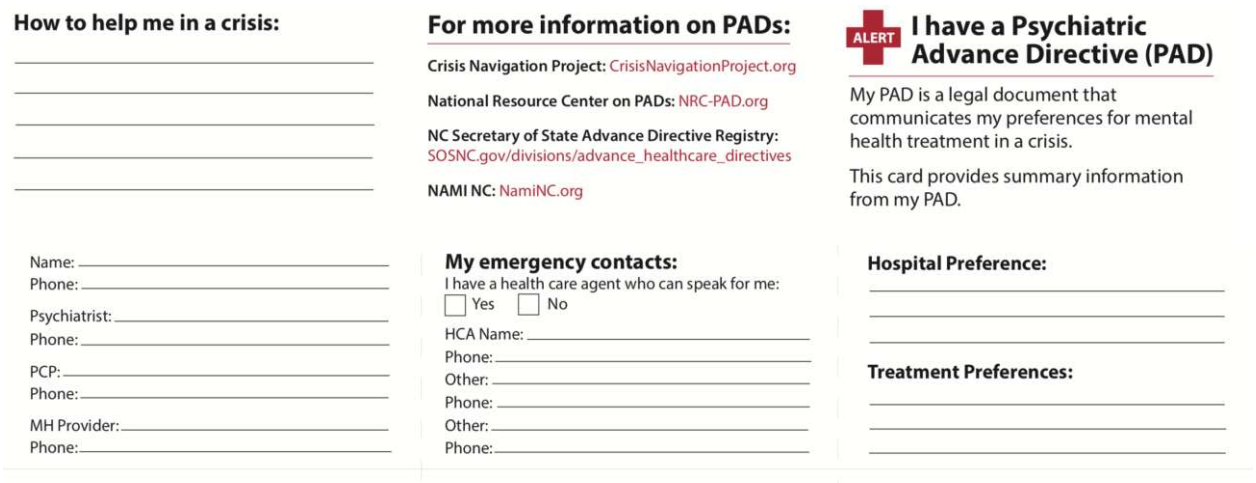
- ⇒ Safety first
- ⇒ Remain calm
- ⇒ Communicate clearly
- ⇒ Be accessible

Who to call/where to go

- ⇒ Psychiatrist, therapist and other service providers
- ⇒ Managed care organization
- ⇒ Crisis facility
- ⇒ Mobile crisis
- ⇒ ED: may be best choice if medical issues involved
- ⇒ 911 – immediate danger, other routes not working
    - ask for a police officer who has gone through Crisis Intervention Training

Essential knowledge and skills for the advocate in crisis settings

- ⇒ Know the person you are advocating for
    - History of illness, prior treatment
    - Preferences
- ⇒ Know patient rights and responsibilities
- ⇒ Know how the system works
- ⇒ Follow up if things don't go well
    - Patient advocates in the hospital/contacting executives/state agencies
- ⇒ Know when to take care of yourself



Sample wallet card – printed double-sided, folded in thirds to fit in a wallet.

U.S. FOOD & DRUG ADMINISTRATION

Overdose Prevention Framework

FDA Priorities

In 2021, a record number of Americans – more than 107,000 – died from drug overdoses.1 The individual and societal costs resulting from this public health crisis, including but not limited to death, are enormous.2 The drug overdose crisis is multifaceted and has evolved beyond prescription opioids. In recent years illicit opioids, largely driven by fentanyl and its analogues, have become key contributors to the overdose crisis. Other controlled substances, including benzodiazepines and stimulants (particularly methamphetamine), are also being used in combination with opioids. While FDA's previous strategies have largely focused on opioid use and overdoses, the evolving nature of this crisis calls for a new approach.

In October 2021, the U.S. Department of Health and Human Services announced an Overdose Prevention Strategy, which supports the National Drug Control Strategy. The Office of the Assistant Secretary for Planning and Evaluation led the broad interagency effort to develop the HHS Strategy with support from FDA and other HHS agencies. HHS' Strategy reflects the evolving nature of the overdose crisis and features four priority areas: primary prevention; harm reduction; evidence-based treatment; and recovery support. The HHS Strategy is also guided by four cross-cutting principles: equity; data and evidence; coordination, collaboration, and integration; and stigma reduction.

Deriving from the HHS Strategy, FDA has identified specific Overdose Prevention Priorities to provide a framework and focus for FDA's actions to address the crisis and sustain long-term recovery outcomes. FDA's priorities build upon existing initiatives and incorporate a greater focus on the evolving crisis. Priority areas one through three in the HHS Strategy correspond with FDA's priorities one through three. FDA's fourth priority reflects our critical role to regulate drug supply safety. The FDA Framework is guided by the same four cross-cutting principles as the HHS Strategy.

FDA's four priorities are:

1. **Supporting primary prevention** by eliminating unnecessary initial prescription drug exposure and inappropriate prolonged prescribing;
2. **Encouraging harm reduction** through innovation and education;
3. **Advancing development of evidence-based treatments** for substance use disorders; and
4. **Protecting the public from unapproved, diverted, or counterfeit drugs presenting overdose risks.**

1 Provisional Drug Overdose Death Counts
2 The High Price of the Opioid Crisis, 2021

Supporting Primary Prevention

To eliminate unnecessary initial exposure and inappropriate prolonged prescribing of substances with abuse potential, FDA is:

- Promoting appropriate prescribing of medications with abuse potential, including opioids, stimulants, and benzodiazepines
- Exploring the need for potential new authorities for opioid approval standards
- Supporting development of alternative, non-addictive therapies and technologies
- Evaluating innovative packaging and disposal solutions of medications with abuse potential

USG Partners: HHS, CDC, CMS, NIH, SAMHSA

Encouraging Harm Reduction

To reduce morbidity and mortality associated with overdoses, FDA is:

- Expanding availability and access to overdose reversal products, including naloxone, by supporting accelerated review of products and exploring over-the-counter access
- Supporting development of novel overdose reversal products
- Supporting development and authorization of fentanyl test strips to test human specimens at the point of care

USG Partners: HHS, CDC, CMS, IHS, NIH, SAMHSA

Advancing Evidence-Based Treatments

To expand therapy options, availability, and access, FDA is:

- Expanding availability and access to evidence-based treatments for substance use disorders
- Facilitating development of treatments for substance use disorders, with focus on stimulant use disorder
- Facilitating opportunities to incorporate stakeholder engagement into treatment development

USG Partners: HHS, CDC, CMS, DEA, IHS, NIH, SAMHSA, VA

Protecting the Public from Unapproved, Diverted, or Counterfeit Drugs Presenting Overdose Risks

To enhance the security of the U.S. drug supply chain, FDA is:

- Preventing and reducing counterfeit and illegal online sales
- Instituting enhanced targeting and screening methods at International Mail Facilities, Express Couriers, and Ports of Entry
- Taking compliance and enforcement actions against unapproved, diverted, or counterfeit drug products

USG Partners: CBP, DEA, DOJ, FBI, HSI, and USPIS

Acronyms

CBP - U.S. Customs and Border Protection

CDC - Centers for Disease Control and Prevention

CMS - Centers for Medicare & Medicaid Services

DEA - Drug Enforcement Administration

DOJ - U.S. Department of Justice

FBI - Federal Bureau of Investigation

FDA - Food and Drug Administration

HHS - U.S. Department of Health and Human Services

HSI - U.S. Department of Homeland Security Investigations

IHS - Indian Health Service

NIH - National Institutes of Health

USPIS -U.S. Postal Inspection Service

SAMHSA - Substance Abuse and Mental Health Services Administration

VA - U.S. Department of Veterans Affairs

For more information please visit our website.

www.fda.gov

Missouri Opioid Treatment Programs (OTP) Demographic and Personnel Information

Center for Life Solutions
Cheryl Gardine, Chief Executive Officer
9144 Pershall Rd.
Hazelwood, MO 63042
(314) 731-0100
Cheryl@centerforlifesolutions.org
MO Accreditation/Certification Expires: June 2020

Behavioral Health Group - Seven clinics in MO:
Behavioral Health Group, LP
Administrative Office
5950 Sherry Lane, Suite 750
Dallas, Texas 75225
Joint Commission Accredited
MO Certification Expires: September 2021

Regional Director, Southern Missouri
Pam.Barrett@bhgrecovery.com

Regional Director, Regional Director, Northern Missouri and Kansas
Michelle.McGraw@bhgrecovery.com

Columbia Treatment Center
Melissa Thomas, Clinic Coordinator
1301 Vandiver, Suite Y
Columbia, MO 65202
(573) 449-8338
Melissa.Thomas@bhgrecovery.com

DRD Kansas City Medical Center
Cammy Testerman, Clinic Coordinator
723 East 18th Street
Kansas City, MO 64108
(816) 283-3877
Cammy.Testerman@bhgrecovery.com

Springfield Treatment Center
Megan Holly-Michalski, Clinic Coordinator
404 East Battlefield
Springfield, MO 65807
(417) 865-8045
megan.hollymichalski@bhgrecovery.com

Springfield North Treatment Center
Chauntay Bunch, Clinic Coordinator
2545 West Kearney St.
Springfield, MO 65803
(417) 210-6025
Chauntay.Bunch@bhgrecovery.com

Joplin Treatment Center
Daniel Bingham, Clinic Coordinator
2919 East 4th Street
Joplin, MO 64801
(417)-782-7933
Daniel.Bingham@bhgrecovery.com

Poplar Bluff Treatment Center
Pam Barrett, **Interim** Clinic Coordinator
624 South Westwood Blvd.
Poplar Bluff, MO 63901
(573)-772-7937
Pam.Barrett@bhgrecovery.com

West Plains Treatment Center
Tess Miley, Clinic Coordinator
1639 Bruce Smith Parkway
West Plains, MO 65775
(417) 257-1833
Tess.Miley@bhgrecovery.com

ReDiscover – Two Clinics in MO

Full MO Accreditation/Certification
Expires: November 2019

Rediscover: Treatment Options Program (TOP)

Hank Dietz, Program Manager
88 Blue Ridge Blvd.
Kansas City, MO 63138
(816)-384-0700
mdietz@rediscovermh.org

Rediscover: Transitions

Dee Ann Shelton, Program Director
1000 E. 24th St.
Kansas City, MO 64108
(816) 384-0700
dshelton@rediscovermh.org

Colonial Management Group, LP/New Seasons - (Four sites in MO)

MO Accreditation/certification expires: May 2021

James Williams, Regional Director (Missouri clinics)
(407) 885-2036
james.williams@cmglp.com

Metro Treatment of Missouri – St. Louis

John Mullins, Program Director
9733 St. Charles Rock Road
Breckenridge Hills, MO 63114
(314) 423-7030
John.Mullins@cmglp.com

Cape Girardeau Metro Treatment Center

Angelica O'Neill, Program Director
Cape Girardeau Metro Treatment Center
760 South Kingshighway, Suite F
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angelica.oneill@cmglp.com.

St. Joseph Metro Treatment Center

Janice Chandler, Program Director
St. Joseph Metro Treatment Center
3935 Sherman Ave.
St. Joseph, MO
(816) 233-7300
Janice.chandler@cmglp.com

New Season/St. Charles Treatment Center

Jennifer Brassard, Program Director
2027 Campus Drive
St. Charles, MO 63301
636-321-7600
jennifer.brassard@cmglp.com

Westend Clinic

Wardell Carter, Executive Director
5736 West Florissant
St. Louis, MO 63120
(314) 381-0560
Westendclinic45@yahoo.com
MO Accreditation/Certification expires April 2020