MISSISSIPPI LEGISLATURE REGULAR SESSION 2015

By: Representative Dixon To: Judiciary A

HOUSE BILL NO. 708

AN ACT TO AMEND SECTION 87-3-1, MISSISSIPPI CODE OF 1972, TO REQUIRE THAT ALL POWERS OF ATTORNEY BE FILED IN CHANCERY COURT AND COPIES BE MADE AVAILABLE ON THE OFFICIAL MISSISSIPPI WEBSITE; TO AMEND SECTIONS 87-3-17, 41-41-205, 41-41-207 AND 41-41-209, MISSISSIPPI CODE OF 1972, IN CONFORMITY WITH THE PROVISIONS OF THIS ACT; AND FOR RELATED PURPOSES.

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF MISSISSIPPI:

SECTION 1. Section 87-3-1, Mississippi Code of 1972, is amended as follows:

87-3-1. All letters of attorney intended to be used in this state *** * *** shall be acknowledged or proved as conveyances of land are required to be under 89-3-3, and, when so acknowledged or proved, *** * *** shall be recorded in *** * *** the chancery court of the county in which the principal resides; and copies thereof, duly certified, shall be admitted in evidence, without accounting for the nonproduction of the original. Copies of all letters of attorney shall be made available on the official website of the State of Mississippi until the letter of attorney is revoked.

SECTION 2. Section 87-3-17, Mississippi Code of 1972, is amended as follows:

87-3-17. Any writing revoking letters of attorney * * * shall, when acknowledged or proved as conveyances of land are required to be acknowledged or proved under 89-3-3, be recorded in like manner, and with like effect from the time of being filed for record, in the * * * chancery court in which the letters revoked were recorded.

SECTION 3. Section 41-41-205, Mississippi Code of 1972, is amended as follows:

41-41-205. (1) An adult or emancipated minor may give an individual instruction. The instruction may be oral or written. The instruction may be limited to take effect only if a specified condition arises.

(2) An adult or emancipated minor may execute a power of attorney for health care, which may authorize the agent to make any health-care decision the principal could have made while having capacity. The power remains in effect notwithstanding the principal's later incapacity and may include individual instructions. Unless related to the principal by blood, marriage, or adoption, an agent may not be an owner, operator, or employee of a residential long-term health-care institution at which the principal is receiving care. The power must be in writing, contain the date of its execution, be signed by the principal, and be witnessed by one (1) of the following methods:

(a) Be signed by at least two (2) individuals each of whom witnessed either the signing of the instrument by the

principal or the principal's acknowledgement of the signature or of the instrument, each witness making the following declaration in substance: "I declare under penalty of perjury pursuant to Section 97-9-61, Mississippi Code of 1972, that the principal is personally known to me, that the principal signed or acknowledged this power of attorney in my presence, that the principal appears to be of sound mind and under no duress, fraud or undue influence, that I am not the person appointed as agent by this document, and that I am not a health-care provider, nor an employee of a health-care provider or facility." In addition, the declaration of at least one (1) of the witnesses must include the following: "I am not related to the principal by blood, marriage or adoption, and to the best of my knowledge, I am not entitled to any part of the estate of the principal upon the death of the principal under a will now existing or by operation of law."

(b) Be acknowledged before a notary public at any place within this state, the notary public certifying to the substance of the following:

"State of _____

County of _____

On this _____ day of _____, in the year ____, before me, _____ (insert name of notary public) appeared _____, personally known to me (or proved to me on the basis of satisfactory evidence) to be the person whose name is subscribed to this instrument, and acknowledged that he or she

executed it. I declare under the penalty of perjury that the person whose name is subscribed to this instrument appears to be of sound mind and under no duress, fraud or undue influence.

Notary Seal

_____

(Signature of Notary Public)"

(3) None of the following may be used as witness for a power of attorney for health care:

(a) A health-care provider;

(b) An employee of a health-care provider or facility; or

(c) The agent.

(4) At least one (1) of the individuals used as a witness for a power of attorney for health care shall be someone who is neither:

(a) A relative of the principal by blood, marriage or adoption; nor

(b) An individual who would be entitled to any portion of the estate of the principal upon his or her death under any will or codicil thereto of the principal existing at the time of execution of the power of attorney for health care or by operation of law then existing.

(5) Unless otherwise specified in a power of attorney for health care, the authority of an agent becomes effective only upon a determination that the principal lacks capacity, and ceases to

be effective upon a determination that the principal has recovered capacity.

(6) Unless otherwise specified in a written advance health-care directive, a determination that an individual lacks or has recovered capacity, or that another condition exists that affects an individual instruction or the authority of an agent, must be made by the primary physician.

(7) An agent shall make a health-care decision in accordance with the principal's individual instructions, if any, and other wishes to the extent known to the agent. Otherwise, the agent shall make the decision in accordance with the agent's determination of the principal's best interest. In determining the principal's best interest, the agent shall consider the principal's personal values to the extent known to the agent.

(8) A health-care decision made by an agent for a principal is effective without judicial approval.

(9) A written advance health-care directive may include the individual's nomination of a guardian of the person.

(10) An advance health-care directive is valid for purposes of this chapter if it complies with Sections 41-41-201 through 41-41-229, regardless of when or where executed or communicated.

(11) Each acknowledged power of attorney for health care shall be filed in chancery court and made available on the official State of Mississippi website as required by Section 87-3-1.

SECTION 4. Section 41-41-207, Mississippi Code of 1972, is amended as follows:

41-41-207. (1) An individual may revoke the designation of an agent only by a signed writing or by personally informing the supervising health-care provider.

(2) An individual may revoke all or part of an advance health-care directive, other than the designation of an agent, at any time and in any manner that communicates an intent to revoke.

(3) A health-care provider, agent, guardian, or surrogate who is informed of a revocation shall promptly communicate the fact of the revocation to the supervising health-care provider and to any health-care institution at which the patient is receiving care.

(4) A decree of annulment, divorce, dissolution of marriage, or legal separation revokes a previous designation of a spouse as agent unless otherwise specified in the decree or in a power of attorney for health care.

(5) An advance health-care directive that conflicts with an earlier advance health-care directive revokes the earlier directive to the extent of the conflict.

(6) An individual shall inform the chancery court in which the power of attorney for health care or advance health-care directive was filed after the power of attorney or advance health-care directive is revoked; however, failure to inform the applicable chancery court shall have no effect on the validity of

the revocation made under this section. After the power of attorney for health care or advance health-care directive is revoked, it shall be removed from the official State of Mississippi website.

SECTION 5. Section 41-41-209, Mississippi Code of 1972, is amended as follows:

41-41-209. The following form may be used to create an advance health care directive. Sections 41-41-201 through 41-41-207 and 41-41-211 through 41-41-229 govern the effect of this or any other writing used to create an advanced health care directive. An individual may complete or modify all or any part of the following form:

ADVANCE HEALTH CARE DIRECTIVE

Explanation

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

Part 1 of this form is a power of attorney for health care. Part 1 lets you name another individual as agent to make health care decisions for you if you become incapable of making your own decisions or if you want someone else to make those decisions for

you now even though you are still capable. You may name an alternate agent to act for you if your first choice is not willing, able or reasonably available to make decisions for you. Unless related to you, your agent may not be an owner, operator, or employee of a residential long-term health care institution at which you are receiving care.

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

(a) Consent or refuse consent to any care, treatment, service, or procedure to maintain, diagnose, or otherwise affect a physical or mental condition;

(b) Select or discharge health care providers and institutions;

(c) Approve or disapprove diagnostic tests, surgical procedures, programs of medication, and orders not to resuscitate; and

(d) Direct the provision, withholding, or withdrawal of artificial nutrition and hydration and all other forms of health care.

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

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

Part 4 of this form lets you authorize the donation of your organs at your death, and declares that this decision will supersede any decision by a member of your family.

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

Any acknowledged advance health-care directive shall be filed in chancery court and made available on the official State of Mississippi website as required by Section 87-3-1.

You have the right to revoke this advance health care directive or replace this form at any time.

PART 1

POWER OF ATTORNEY FOR HEALTH CARE

(1) DESIGNATION OF AGENT: I designate the following individual as my agent to make health care decisions for me:

_____

(name of individual you choose as agent)

_____

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

_____

(home phone) (work phone)

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

_____

(name of individual you choose as first alternate agent)

_____

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

_____

(home phone) (work phone)

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

_____

(name of individual you choose as second alternate agent)

_____

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

_____

(home phone) (work phone)

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

_____

_____

_____

(Add additional sheets if needed.)

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

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

interest. In determining my best interest, my agent shall consider my personal values to the extent known to my agent.

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

PART 2

INSTRUCTIONS FOR HEALTH CARE

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

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

[ ] (a) Choice Not To Prolong Life

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

[ ] (b) Choice To Prolong Life

I want my life to be prolonged as long as possible within the limits of generally accepted health care standards.

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

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

_____

_____

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

_____

_____

(Add additional sheets if needed.)

PART 3

PRIMARY PHYSICIAN

(OPTIONAL)

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

_____

(name of physician)

_____

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

_____

(phone)

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

_____

(name of physician)

_____

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

_____

(phone)

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

(12) SIGNATURES: Sign and date the form here:

_____ _____

(date) (sign your name)

_____ _____

(address) (print your name)

_____

(city) (state)

PART 4

CERTIFICATE OF AUTHORIZATION FOR ORGAN DONATION

(OPTIONAL)

I, the undersigned, this _____day of _____, 20__, desire that my _____ organ(s) be made available after my demise for:

(a) Any licensed hospital, surgeon or physician, for medical education, research, advancement of medical science, therapy or transplantation to individuals;

(b) Any accredited medical school, college or university engaged in medical education or research, for therapy, educational research or medical science purposes or any accredited school of mortuary science;

(c) Any person operating a bank or storage facility for blood, arteries, eyes, pituitaries, or other human parts, for use in medical education, research, therapy or transplantation to individuals;

(d) The donee specified below, for therapy or transplantation needed by him or her, do donate my _____ for that purpose to _____ (name) at _____ (address).

I authorize a licensed physician or surgeon to remove and preserve for use my _____ for that purpose.

I specifically provide that this declaration shall supersede and take precedence over any decision by my family to the contrary.

Witnessed this _____ day of _____, 20__.

_____

(donor)

_____

(address)

_____

(telephone)

_____

(witness)

_____

(witness)

(13) WITNESSES: This power of attorney will not be valid for making health care decisions unless it is either (a) signed by two (2) qualified adult witnesses who are personally known to you and who are present when you sign or acknowledge your signature; or (b) acknowledged before a notary public in the state.

ALTERNATIVE NO. 1

Witness

I declare under penalty of perjury pursuant to Section 97-9-61, Mississippi Code of 1972, that the principal is personally known to me, that the principal signed or acknowledged this power of attorney in my presence, that the principal appears

to be of sound mind and under no duress, fraud or undue influence, that I am not the person appointed as agent by this document, and that I am not a health care provider, nor an employee of a health care provider or facility. I am not related to the principal by blood, marriage or adoption, and to the best of my knowledge, I am not entitled to any part of the estate of the principal upon the death of the principal under a will now existing or by operation of law.

_____ _____

(date) (signature of witness)

_____ _____

(address) (printed name of witness)

_____

(city) (state)

Witness

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

_____ _____

(date) (signature of witness)

_____ _____

(address) (printed name of witness)

_____

(city) (state)

ALTERNATIVE NO. 2

State of _____

County of _____

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

Notary Seal

_____

(Signature of Notary Public)

SECTION 6. This act shall take effect and be in force from and after July 1, 2015.

~ OFFICIAL ~

ST: Powers of attorney; all power of attorney must be filed in Chancery Court and copies must be available on the official state website.