MINNESOTA
Advance Directive
Planning for Important Healthcare Decisions

Caring Connections
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CARING CONNECTIONS

Caring Connections, a program of the National Hospice and Palliative Care Organization (NHPCO), is a national consumer engagement initiative to improve care at the end of life.

Caring Connections tracks and monitors all state and federal legislation and significant court cases related to end-of-life care to ensure that our advance directives are up to date.

It's About How You LIVE

It's About How You LIVE is a national community engagement campaign encouraging individuals to make informed decisions about end-of-life care and services. The campaign encourages people to:

Learn about options for end-of-life services and care
Implement plans to ensure wishes are honored
Voice decisions to family, friends and healthcare providers
Engage in personal or community efforts to improve end-of-life care

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Using these Materials

BEFORE YOU BEGIN

1. Check to be sure that you have the materials for each state in which you may receive healthcare.

2. These materials include:
   - Instructions for preparing your advance directive, please read all the instructions.
   - Your state-specific advance directive forms, which are the pages with the gray instruction bar on the left side.

ACTION STEPS

3. You may want to photocopy these forms before you start so you will have a clean copy if you need to start over.

4. When you begin to fill out the forms, refer to the gray instruction bars - they will guide you through the process.

5. Talk with your family, friends, and physicians about your advance directive. Be sure the person you appoint to make decisions on your behalf understands your wishes.

6. Once the form is completed and signed, photocopy the form and give it to the person you have appointed to make decisions on your behalf, your family, friends, healthcare providers and/or faith leaders so that the form is available in the event of an emergency.

Introduction to Your Minnesota Healthcare Directive

This packet contains a legal document, the Minnesota Healthcare Directive, that protects your right to refuse medical treatment you do not want, or to request treatment you do want, in the event you lose the ability to make decisions yourself.

1. Part I, **Appointment of Healthcare Agent**, lets you name someone to make decisions about your healthcare—including decisions about life support—if you can no longer speak for yourself, or immediately, if you specify this in the document. The Appointment of Healthcare Agent is especially useful because it appoints someone to speak for you any time you cannot make your own medical decisions, not only at the end of life.

2. Part II, **Healthcare Instructions**, functions as your living will. It lets you state your wishes about medical care in the event that you can no longer make your own medical decisions.

   Note: These documents will be legally binding only if the person completing them is a competent adult who is 18 years of age or older.

How do I make my Healthcare Directive legal?
In order to make your Healthcare Directive legally binding you have two options:

1. Sign your document in the presence of two witnesses, who must also sign the document. Neither of your witnesses can be:
   - under the age of 18, or
   - the person you appointed as your agent or alternate agent,

In addition, one of your witnesses cannot be:
   - your healthcare provider, or an employee of your healthcare provider.

OR

2. Sign your document in the presence of a notary public. The person notarizing your healthcare directive may be an employee of a healthcare provider providing you with direct care but cannot be the person you appointed as your agent or alternate agent.

Completing Part I: Appointment of Healthcare Agent

Whom should I appoint as my agent?

A healthcare agent is the person you appoint to make decisions about your healthcare if you become unable to make these decisions yourself. Your agent can be a family member or a close friend whom you trust to make serious decisions. The person you name as your agent should clearly understand your wishes and be willing to accept the responsibility of making medical decisions for you.

You **cannot** appoint the following persons as your agent unless they are related to you by blood, marriage, registered domestic partnership, or adoption, unless you specifically say otherwise in your Directive:

- your healthcare provider on the date you sign your healthcare directive or on the date your healthcare agent must make decisions for you;
- an employee of your healthcare provider on the date you sign your healthcare directive or on the date your healthcare agent must make decisions for you.

If you appoint your spouse or domestic partner as your healthcare agent, that appointment will automatically be revoked in the event proceedings are commenced for dissolution, annulment or termination of your marriage or registered partnership, unless you specifically say otherwise in your Directive.

You can appoint a second person as your alternative agent. An alternative agent may act on your behalf if the person you name as agent is unable, unwilling or unavailable to act for you.

Should I add personal instructions to my Appointment of Healthcare Agent?

You can use the space provided to limit your agent's authority. One of the strongest reasons for naming a healthcare agent is to have someone who can respond flexibly as your medical condition changes and can deal with situations that you did not foresee. Unless the form you sign limits the authority of your agent, your agent may make all healthcare decisions for you including:

- the power to give, refuse, or withdraw consent to any care, treatment, service, or procedures. This includes deciding whether to stop or not start healthcare that is keeping you or might keep you alive, and deciding about intrusive mental health treatment;
- choosing your healthcare providers;
- deciding where you live and receive care and support when those choices relate to your healthcare needs;
- the right to review your medical records and have the same rights that you would have to give your records to other people.

Completing Part I: Appointment of Healthcare Agent (continued)

Under Minnesota law, your healthcare agent has a legal duty to act in good faith on your behalf. This means that your agent must act consistently with any instructions included in your Directive or other information you make known unless your agent has actual knowledge of the modification or revocation of the information expressed. When these sources do not provide adequate guidance, your agent must act in your best interests, considering your overall general health condition and prognosis and your personal values to the extent they are known to your agent. We urge you to talk with your healthcare agent about your future medical care and describe what you consider to be an acceptable "quality of life."

If you want to record your wishes about specific treatments or conditions, you can use Part II of this document, Healthcare Instructions.

Completing Part II: Healthcare Instructions

Are there personal instructions I should add to my Healthcare Instructions?

If you have appointed an agent, it is a good idea to write a statement such as, "Any questions about how to interpret or when to apply my Healthcare Instructions are to be decided by my agent."

If you are a woman of childbearing age and would like your Minnesota Healthcare Instructions to be honored even if you are pregnant, then you must state this in the Healthcare Instructions.

It is important to learn about the kinds of life-sustaining treatment you might receive. Consult your doctor.

IMPORTANT FACTS

In general, your directive becomes effective and your healthcare agent may make healthcare decisions for you when:

- your attending physician determines that you lack the capacity to make decisions for yourself because (you are unable to understand significant benefits, risks, and alternatives to proposed healthcare and to make and communicate a healthcare decision; or),
- you specifically in your Directive that it is to become effective upon certain conditions or circumstances, are met.

A Directive is NOT effective for a healthcare decision when your attending physician determines that you have or recover decision-making capacity, or your conditions for effectiveness have not been met.

You may revoke your Healthcare Directive using any one of the following methods:

- sign a new Directive that is inconsistent with your prior directive;
- cancel, deface, obliterate, burn, tear or otherwise destroy your Directive, or direct another person in your presence to destroy the Directive, with the intent to revoke the Directive in whole or in part;
- sign a written and dated statement indicating that you wish to revoke your Directive, in whole or in part,
  or;
- verbally express your intent to revoke your Directive, in whole or in part, in the presence of two witnesses who do not have to be present at the same time.

INSTRUCTIONS

MINNESOTA HEALTH CARE DIRECTIVE – PAGE 1 OF 8

PRINT YOUR NAME

I, ____,
understand this document allows me to do ONE or BOTH of the following:

PART I: Name another person (called the health care agent) to make health care decisions for me if I am unable to decide or speak for myself. My health care agent must make health care decisions for me based on the instructions I provide in this document (Part II), if any, the wishes I have made known to him or her, or must act in my best interest if I have not made my health care wishes known.

AND/OR

Part II: Give health care instructions to guide others making health care decisions for me. If I have named a health care agent, these instructions are to be used by the agent. These instructions may also be used by my health care providers, others assisting with my health care and my family, in the event I cannot make decisions for myself.

PART I: APPOINTMENT OF HEALTH CARE AGENT THIS IS WHO I WANT TO MAKE HEALTH CARE DECISIONS FOR ME IF I AM UNABLE TO DECIDE OR SPEAK FOR MYSELF

(I know I can change my agent or alternate agent at any time and I know I do not have to appoint an agent or an alternate agent.)

Note: If you appoint an agent, you should discuss this health care directive with your agent and give your agent a copy. If you do not wish to appoint an agent, you may leave Part I blank and go to Part II.

When I am unable to decide or speak for myself, I trust and appoint

PRINT THE NAME, RELATIONSHIP, ADDRESS AND TELEPHONE NUMBER OF YOUR AGENT

____ to make health care decisions for me. This person is called my health care agent.

Relationship of my health care agent to me: ______________________

Telephone number of my health care agent: ______________________

Address of my health care agent:

____

____

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PRINT THE NAME, RELATIONSHIP, ADDRESS AND TELEPHONE NUMBER OF YOUR ALTERNATE AGENT

(OPTIONAL)
APPOINTMENT OF ALTERNATE HEALTH CARE AGENT:

If my health care agent is not reasonably available, I trust and appoint

____ to be my health care agent instead.

Relationship of my alternate health care agent to me: _______________

Telephone number of my alternate health care agent: _______________

Address of my alternate health care agent:

_ _

_ _

THIS IS WHAT I WANT MY HEALTH CARE AGENT TO BE ABLE TO DO IF I AM UNABLE TO DECIDE OR SPEAK FOR MYSELF

(I know I can change these choices)

My health care agent is automatically given the powers listed below in (A) through (D). My health care agent must follow my health care instructions in this document or any other instructions I have given to my agent. If I have not given health care instructions, then my agent must act in my best interest.

Whenever I am unable to decide or speak for myself, my health care agent has the power to:
(A) Make any health care decision for me. This includes the power to give, refuse, or withdraw consent to any care, treatment, service, or procedures. This includes deciding whether to stop or not start health care that is keeping me or might keep me alive, and deciding about intrusive mental health treatment.
(B) Choose my health care providers.
(C) Choose where I live and receive care and support when those choices relate to my health care needs.
(D) Review my medical records and have the same rights that I would have to give my medical records to other people.

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

If I DO NOT want my health care agent to have a power listed above in (A) through (D) OR if I want to LIMIT any power in (A) through (D), I MUST say that here:

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INITIAL THESE STATEMENTS IF YOU WANT YOUR AGENT'S POWER TO INCLUDE THESE DECISIONS

ADD PERSONAL INSTRUCTIONS (IF ANY)

My health care agent is NOT automatically given the powers listed below in (1) and (2). If I WANT my agent to have any of the powers in (1) and (2), I must INITIAL the line in front of the power; then my agent WILL HAVE that power.

________ (1) To decide whether to donate my body or body part(s), including organs, tissues, and eyes, when I die.

________ (2) To decide what will happen with my body when I die (burial, cremation).

If I want to say anything more about my health care agent's powers or limits on the powers, I can say it here:

PART II: HEALTH CARE INSTRUCTIONS

Note: Complete this Part II if you wish to give health care instructions. If you appointed an agent in Part I, completing this Part II is optional but would be very helpful to your agent. However, if you chose not to appoint an agent in Part I, you MUST complete some or all of this Part II if you wish to make a valid health care directive.

These are instructions for my health care when I am unable to decide or speak for myself. These instructions must be followed (so long as they address my needs).

THESE ARE MY BELIEFS AND VALUES ABOUT MY HEALTH CARE

(I know I can change these choices or leave any of them blank.)

ADD PERSONAL INSTRUCTIONS (IF ANY)

I want you to know these things about me to help you make decisions about my health care:

My goals for my health care:

My fears about my health care:

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My spiritual or religious beliefs and traditions:

My beliefs about when life would be no longer worth living:

My thoughts about how my medical condition might affect my family:

THIS IS WHAT I WANT AND DO NOT WANT FOR MY HEALTH CARE

(I know I can change these choices or leave any of them blank.)

Many medical treatments may be used to try to improve my medical condition or to prolong my life. Examples include artificial breathing by a machine connected to a tube in the lungs, artificial feeding or fluids through tubes, attempts to start a stopped heart, surgeries, dialysis, antibiotics, and blood transfusions. Most medical treatments can be tried for a while and then stopped if they do not help. I have these views about my health care in these situations:

(Note: You can discuss general feelings, specific treatments, or leave any of them blank.)

If I had a reasonable chance of recovery, and were temporarily unable to decide or speak for myself, I would want:

If I were dying and unable to decide or speak for myself, I would want:

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If I were permanently unconscious and unable to decide or speak for myself, I would want:

If I were completely dependent on others for my care and unable to decide or speak for myself, I would want:

In all circumstances, my doctors will try to keep me comfortable and reduce my pain. This is how I feel about pain relief if it would affect my alertness or if it could shorten my life:

There are other things that I want or do not want for my health care, if possible:
Who I would like to be my doctor:

Where I would like to live to receive health care:

Where I would like to die and other wishes I have about dying:

My wishes about donating parts of my body when I die:

My wishes about what happens to my body when I die (cremation, burial):

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ADD OTHER PERSONAL INSTRUCTIONS (IF ANY)

Any other things:

PART III: MAKING THE DOCUMENT LEGAL

This document must be signed by me. It also must either be verified by a notary public (Option 1) OR witnessed by two witnesses (option 2). It must be dated when it is verified or witnessed.

SIGN AND DATE THE DOCUMENT PRINT YOUR DATE OF BIRTH AND ADDRESS

I am thinking clearly, I agree with everything that is written in this document, and I have made this document willingly.

My Signature ______________________________

Date signed: ____________________

Date of birth: ____________________

Address: ____

_ _

ONLY COMPLETE THIS SECTION IF YOU WERE UNABLE TO SIGN & SOMEONE ELSE SIGNED FOR YOU

If I cannot sign my name, I can ask someone to sign this document for me.

_ _

Signature of the person who I asked to sign this document for me.

_ _

Printed name of the person who I asked to sign this document for me.

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WITNESSING PROCEDURE

EITHER A NOTARY PUBLIC MUST FILL OUT THIS SECTION

OPTION 1: NOTARY PUBLIC

In my presence on ________________________________ (date),

________________________________ (name) acknowledged his/her signature on this document or acknowledged that he/she authorized the person signing this document to sign on his/her behalf. I am not named as a health care agent or alternate health care agent in this document.

____
(Signature of Notary) (Notary Stamp)

OR

OPTION 2: TWO WITNESSES

Two witnesses must sign. Only one of the two witnesses can be a health care provider or an employee of a health care provider giving direct care to me on the day I sign this document.

WITNESS #1 HAVE YOUR WITNESS SIGN & DATE THE DOCUMENT AND THEN PRINT THEIR ADDRESS

WITNESS ONE:

(i) In my presence on ________________________________ (date),

________________________________ (name) acknowledged his/her signature on this document or acknowledged that he/she authorized the person signing this document to sign on his/her behalf.

(ii) I am at least 18 years of age.
(iii) I am not named as a health care agent or an alternate health care agent in this document.
(iv) If I am a health care provider or an employee of a health care provider giving direct care to the person listed above in (i), I must initial this box: [ ]

I certify that the information in (i) through (iv) is true and correct.

________________________________ ________________________________
(Signature of Witness One) (Date)

Address: ________________________________

_ _

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WITNESS #2
HAVE YOUR WITNESS SIGN & DATE THE DOCUMENT AND THEN PRINT THEIR ADDRESS

WITNESS TWO:

(i) In my presence on ____
(date)

____ (name)
acknowledged his/her signature on this document or acknowledged that he/she authorized the person signing this document to sign on his/her behalf.

(ii) I am at least 18 years of age.
(iii) I am not named as a health care agent or an alternate health care agent in this document.
(iv) If I am a health care provider or an employee of a health care provider giving direct care to the person listed above in (i), I must initial this box: [ ]

I certify that the information in (i) through (iv) is true and correct.

____ ____________________
(Signature of Witness Two) (Date)

Address: ____

____

Reminder: Keep this document with your personal papers in a safe place (not in a safe deposit box). Give photocopies of the signed original to your doctors, family, close friends, health care agent, and alternate health care agent. Make sure you doctor is willing to follow your wishes. This document should be part of your medical record at your physician's office and at the hospital, home care agency, hospice, or nursing facility where you receive your care.

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Courtesy of Caring Connections
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You Have Filled Out Your Advance Directive, Now What?

1. Your Minnesota Healthcare Directive is an important legal document. Keep the original signed document in a secure but accessible place. Do not put the original document in a safe deposit box or any other security box that would keep others from having access to it.

2. Give photocopies of the signed original to your agent and alternate agent(s), doctor(s), family, close friends, clergy and anyone else who might become involved in your healthcare. If you enter a nursing home or hospital, have photocopies of your document placed in your medical records.

3. Be sure to talk to your agent and alternate agent(s), doctor(s), clergy, family and friends about your wishes concerning medical treatment. Discuss your wishes with them often, particularly if your medical condition changes.

4. If you want to make changes to your document after it has been signed and witnessed, you should complete a new document.

5. Remember, you can always revoke one or both sections of your Minnesota Healthcare Directive.

6. Be aware that your Minnesota documents will not be effective in the event of a medical emergency. Ambulance personnel are required to provide cardiopulmonary resuscitation (CPR) unless they are given a separate order that states otherwise. These orders, commonly called "non-hospital do-not-resuscitate orders," are designed for people whose poor health gives them little chance of benefiting from CPR. These orders must be signed by your physician and instruct ambulance personnel not to attempt CPR if your heart or breathing should stop.

   Currently not all states have laws authorizing non-hospital do-not-resuscitate orders. We suggest you speak to your physician for more information. **Caring Connections does not distribute these forms**.