

# **SOUTH DAKOTA Advance Directive Planning for Important Health Care Decisions**

*CaringInfo*  
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[www.caringinfo.org](http://www.caringinfo.org)  
800-658-8898

CaringInfo, 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.

## **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:

- L**earn about options for end-of-life services and care
- I**mplement plans to ensure wishes are honored
- V**oice decisions to family, friends and health care providers
- E**ngage in personal or community efforts to improve end-of-life care

**Note:** The following is not a substitute for legal advice. While CaringInfo updates the following information and form to keep them up-to-date, changes in the underlying law can affect how the form will operate in the event you lose the ability to make decisions for yourself. If you have any questions about how the form will help ensure your wishes are carried out, or if your wishes do not seem to fit with the form, you may wish to talk to your health care provider or an attorney with experience in drafting advance directives. **If you have other questions regarding these documents, we recommend contacting your state attorney general's office.**

## Using these Materials

### BEFORE YOU BEGIN

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

1. You may want to photocopy or print a second set of these forms before you start so you will have a clean copy if you need to start over.
2. When you begin to fill out the forms, refer to the gray instruction bars — they will guide you through the process.
3. 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.
4. 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, health care providers, and/or faith leaders so that the form is available in the event of an emergency.
5. South Dakota does not maintain an Advance Directive Registry. However you may record a durable power of attorney for health care (Part I of this form) at your county's register of deeds. Be aware that, if you do record your advance directive, you will also need to record any revocation you make.
6. You may also want to save a copy of your form in an online personal health records application, program, or service that allows you to share your medical documents with your physicians, family, and others who you want to take an active role in your advance care planning.

## INTRODUCTION TO YOUR SOUTH DAKOTA ADVANCE DIRECTIVE

This packet contains a legal document, a **South Dakota Advance 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. You may complete Part I, Part II, or both, depending on your advance-planning needs. You must complete Part III.

**Part I** contains a **South Dakota Durable Power of Attorney for Health Care**. This part lets you name someone, your “agent,” to make decisions about your medical care—including decisions about life-sustaining procedures—if you can no longer speak for yourself. The durable power of attorney for health care is especially useful because it appoints someone to speak for you any time you are unable to make your own medical decisions, not only at the end of life.

Your durable power of attorney for health care goes into effect when your doctor determines in good faith that you are no longer able to make or communicate your health care decisions.

**Part II** contains a **South Dakota Declaration**, which is your state’s living will. Your declaration lets you state your wishes about health care in the event that you can no longer make your own health care decisions and you are terminally ill.

Your living will go into effect when your doctor determines that you are no longer able to participate in your medical decisions, you are terminally ill—which includes permanent unconsciousness—and your death is imminent.

**Part III** contains the signature and witnessing provisions so that your document will be effective.

Following the advance directive is a **South Dakota Organ Donation Form**.

This document does not expressly address mental illness. If you would like to make advance care plans regarding mental illness, you should talk to your physician and an attorney about an advance directive tailored to your needs.

*Note: This document will be legally binding only if the person completing it is an individual of sound mind who is 18 years or older.*

## **COMPLETING YOUR SOUTH DAKOTA ADVANCE DIRECTIVE**

### **How do I make my South Dakota Advance Directive legal?**

If you complete part II, the directive, you must sign or have someone sign for you at your direction your document in the presence of two adult witnesses. Although not required, you may also have your document notarized.

While there are no legal requirements for witnessing your signature if you only complete Part I, your durable power of attorney for health care, you should have it witnessed in the manner required for Part II to be sure that your wishes are honored in the event someone challenges your document.

### **Whom should I appoint as my agent?**

Your agent—also called an “attorney-in-fact”—is the person you appoint to make decisions about your health care if you become unable to make those decisions yourself. Your agent may 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 health care decisions for you.

You can appoint a second person as your alternate agent. The alternate will step in if the first person you name as an agent is unable, unwilling, or unavailable to act for you.

### **Should I add personal instructions to my South Dakota Durable Power of Attorney for Health Care?**

One of the strongest reasons for naming an agent is to have someone who can respond flexibly as your health care situation changes and deal with situations that you did not foresee. If you add instructions to this document it may help your agent carry out your wishes, but be careful that you do not unintentionally restrict your agent’s power to act in your best interest. In any event, be sure to talk with your agent about your future medical care and describe what you consider to be an acceptable “quality of life.”

### **What if I change my mind?**

You can revoke Part I, your durable power of attorney for health care, at any time and in any manner that expresses your intent, such as executing a written revocation, destroying all copies of your document, or stating your revocation orally. It is important that you notify your agent of your revocation, as he or she will not be held liable for acting as your agent if he or she is unaware of your revocation. If you recorded your durable power of attorney for health care with the register of deeds, you must also record any revocation with the register of deeds.

You can revoke Part II, your declaration, at any time and in any manner that expresses your intent, such as executing a written revocation, destroying all copies of your document, or stating your revocation orally. Your revocation becomes effective on communication to your health care provider.

**What other important facts should I know?**

Your agent cannot withhold or withdraw comfort care.

Artificial nutrition and hydration will not be withheld or withdrawn unless you specifically state that you want it withheld or withdrawn in your advance directive or you expressly authorize your agent to direct the withholding of artificial nutrition or hydration.

Life-sustaining treatment and artificial nutrition and hydration will not be withheld from you if you are pregnant, unless it is reasonably medically certain that such treatment will not permit the development and live birth of the unborn child, or will be physically harmful to you, or will prolong severe pain which cannot be alleviated by medication.

**SOUTH DAKOTA ADVANCE DIRECTIVE – PAGE 1 OF 5**

**PART I**

PRINT YOUR NAME AND ADDRESS

**PART I. DURABLE POWER OF ATTORNEY FOR HEALTH CARE**

I, \_\_\_\_\_, of  
(name of principal)

\_\_\_\_\_  
(address)

hereby appoint \_\_\_\_\_, of  
(name of agent)

\_\_\_\_\_  
(address and telephone number of agent)

As my attorney-in-fact ("agent") to consent to, to reject, or to withdraw consent for medical procedures, treatment, or intervention.

2) In the event the person I appoint above is unable, unwilling or unavailable to act as my health care agent, I hereby appoint as my successor agent:

\_\_\_\_\_, of  
(name of successor agent)

\_\_\_\_\_  
(address and telephone number of successor agent)

3) I have discussed my wishes with my agent and my successor agent, and authorize him/her to make all and any health care decisions for me, including decisions to withhold or withdraw any form of life support. I expressly authorize my agent (and successor agent) to make decisions for me regarding the withholding or withdrawal of artificial nutrition and hydration in all medical circumstances.

4) This power of attorney becomes effective when I can no longer make my own medical decisions, and is not affected by physical disability or mental incompetence. The determination of whether I can make my own medical decisions is to be made by my agent, or if he or she is unable, unwilling or unavailable to act, by my successor agent, unless the attending physician determines that I have decisional capacity.

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

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



PART II

**PART II. DECLARATION**

Notice

This is an important legal document. A living will directs the medical treatment you are to receive in the event you are in a terminal condition and are unable to participate in your own medical decisions. This living will may state what kind of treatment you want or do not want to receive.

NOTICE

Prepare this document carefully. If you use this form, read it completely. You may want to seek professional help to make sure the form does what you intend and is completed without mistakes.

This document will remain valid and in effect until and unless you revoke it. Review this document periodically to make sure it continues to reflect your wishes. You may amend or revoke this document at any time by notifying your physician and other health care providers. You should give copies of this document to your family, your physician and your health care facility. This form is entirely optional. If you choose to use this form, please note that the form provides signature lines for you, the two witnesses whom you have selected and a notary public.



**SOUTH DAKOTA ADVANCE DIRECTIVE - PAGE 4 OF 5**

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PRINT YOUR NAME

TO MY FAMILY, HEALTH CARE PROVIDER, AND ALL THOSE CONCERNED WITH MY CARE:

I, \_\_\_\_\_,  
direct that you follow my wishes for care if I am in a terminal condition, my death is imminent, and I am unable to communicate my decisions about my medical care.

With respect to any life-sustaining treatment, I direct the following:

LIFE-SUSTAINING  
TREATMENT  
CHOICES

*(Initial only one of the following optional options. If you do not agree with either of the following options, space is provided below for you to write your own instructions).*

INITIAL ONLY ONE

\_\_\_\_\_ If my death is imminent, I choose not to prolong my life. If life sustaining treatment has been started, stop it, but keep me comfortable and control my pain.

\_\_\_\_\_ Even if my death is imminent, I choose to prolong my life.

\_\_\_\_\_ I choose neither of the above options, and here are my instructions should I become terminally ill and my death is imminent:

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With respect to artificial nutrition and hydration, I direct the following

ARTIFICIAL  
NUTRITION AND  
HYDRATION  
CHOICES

*(Artificial nutrition and hydration means food and water provided by means of a tube inserted into the stomach or intestine or needle into a vein.)*

(initial only one):

INITIAL ONLY ONE

\_\_\_\_\_ If my death is imminent, I do not want artificial nutrition and hydration. If it has been started, stop it.

\_\_\_\_\_ Even if my death is imminent, I want artificial nutrition and hydration.

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Palliative Care  
Organization 2022  
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**SOUTH DAKOTA ADVANCE DIRECTIVE - PAGE 5 OF 5**

**PART III**

SIGN, DATE, AND PRINT YOUR NAME AND ADDRESS

IF YOU COMPLETED PART II, YOU MUST HAVE YOUR SIGNATURE WITNESSED

IN ANY EVENT IT IS A GOOD IDEA TO HAVE YOUR SIGNATURE WITNESSED, EVEN IF YOU HAVE COMPLETED ONLY PART I

YOUR WITNESSES MUST SIGN, DATE, AND PRINT THEIR NAMES AND ADDRESSES HERE

THIS OPTIONAL SECTION IS TO BE COMPLETED BY A NOTARY PUBLIC

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**PART III. EXECUTION**

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

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

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

**WITNESSES**

The declarant voluntarily signed this document in my presence.

Witness Signature: \_\_\_\_\_ Date: \_\_\_\_\_

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

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

Witness Signature: \_\_\_\_\_ Date: \_\_\_\_\_

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

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

**NOTARY (OPTIONAL)**

On this the \_\_\_\_\_ day of \_\_\_\_\_, \_\_\_\_\_, the declarant, \_\_\_\_\_, and witnesses \_\_\_\_\_ and \_\_\_\_\_,

personally appeared before the undersigned officer and signed the foregoing instrument in my presence.

Dated this \_\_\_\_\_ day of \_\_\_\_\_, \_\_\_\_\_.

\_\_\_\_\_  
Notary Public

My Commission expires: \_\_\_\_\_

*Courtesy of CaringInfo*  
1731 King St., Suite 100, Alexandria, VA 22314  
www.caringinfo.org, 800-658-8898

ORGAN DONATION  
(OPTIONAL)

INITIAL THE  
OPTION THAT  
REFLECTS YOUR  
WISHES

ADD NAME OR  
INSTITUTION (IF  
ANY)

PRINT YOUR NAME,  
SIGN, AND DATE  
THE DOCUMENT

YOUR  
WITNESSES  
MUST SIGN AND  
PRINT THEIR  
ADDRESSES

AT LEAST ONE  
WITNESS MUST BE  
A DISINTERESTED  
PARTY

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Organization 2022  
Revised.

## SOUTH DAKOTA ORGAN DONATION FORM - PAGE 1 OF 1

Initial the line next to the statement below that best reflects your wishes. You do not have to initial any of the statements. If you do not initial any of the statements, your attorney for health care, proxy, or other agent, or your family, may have the authority to make a gift of all or part of your body under South Dakota law.

\_\_\_\_\_ I do not want to make an organ or tissue donation and I do not want my attorney for health care, proxy, or other agent or family to do so.

\_\_\_\_\_ I have already signed a written agreement or donor card regarding organ and tissue donation with the following individual or institution:

Name of individual/institution: \_\_\_\_\_

\_\_\_\_\_ Pursuant to South Dakota law, I hereby give, effective on my death:

\_\_\_\_\_ Any needed organ or parts.

\_\_\_\_\_ The following part or organs listed below:

\_\_\_\_\_

For (initial one):

\_\_\_\_\_ Any legally authorized purpose.

\_\_\_\_\_ Transplant or therapeutic purposes only.

Declarant name: \_\_\_\_\_

Declarant signature: \_\_\_\_\_, Date: \_\_\_\_\_

The declarant voluntarily signed or directed another person to sign this writing in my presence.

Witness \_\_\_\_\_, Date \_\_\_\_\_

Address \_\_\_\_\_

\_\_\_\_\_

I am a disinterested party with regard to the declarant and his or her donation and estate. The declarant voluntarily signed or directed another person to sign this writing in my presence.

Witness \_\_\_\_\_, Date \_\_\_\_\_

Address \_\_\_\_\_

\_\_\_\_\_

*Courtesy of CaringInfo*  
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## **You Have Filled Out Your Health Care Directive, Now What?**

1. Your *South Dakota Advance 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, doctor(s), family, close friends, clergy, and anyone else who might become involved in your health care. 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(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. South Dakota does not maintain an Advance Directive Registry. However you may record a durable power of attorney for health care (Part I of this form) at your county's register of deeds. Be aware that, if you do record your advance directive, you will also need to record any revocation you make as well.
5. You may also want to save a copy of your form in an online personal health records application, program, or service that allows you to share your medical documents with your physicians, family, and others who you want to take an active role in your advance care planning.
6. If you want to make changes to your documents after they have been signed and witnessed, you must complete a new document.
7. Remember, you can always revoke your South Dakota document.
8. Be aware that your South Dakota document will not be effective in the event of a medical emergency. Ambulance and hospital emergency department personnel are required to provide cardiopulmonary resuscitation (CPR) unless they are given a separate directive that states otherwise. These directives called "prehospital medical care directives" or "do not resuscitate orders" are designed for people whose poor health gives them little chance of benefiting from CPR. These directives instruct ambulance and hospital emergency personnel not to attempt CPR if your heart or breathing should stop.

Currently not all states have laws authorizing these orders. We suggest you speak to your physician if you are interested in obtaining one. **CaringInfo does not distribute these forms.**

## Congratulations!

You've downloaded **your free, state specific advance directive.**

You are taking important steps to make sure your wishes are known. Please consider helping us keep this resource free.

Your generous support to the National Hospice Foundation allows us to continue to provide FREE resources, tools, and information to educate and empower individuals to access advance care planning, caregiving, hospice and grief services.

**Please show your support for our mission and consider making a tax-deductible gift to the National Hospice Foundation today.**

Since 1992, the National Hospice Foundation has been dedicated to creating FREE resources for individuals and families facing a life-limiting illness, raising awareness for the need for hospice and palliative care, and providing ongoing professional education and skills development to hospice and palliative care professionals across the nation. To learn more, please visit [www.NationalHospiceFoundation.org](http://www.NationalHospiceFoundation.org)

You may wonder if a gift of \$35, \$50 or \$100 to the National Hospice Foundation would make a difference, but it is only because of the generosity of others like you that these FREE resources are made available.

Please consider supporting our mission by returning a **generous tax-deductible donation.** Every gift makes a difference! Your gift strengthens the Foundation's ability to provide FREE caregiver and family resources.

**Cut along the dotted line and use the coupon below to return a check contribution of the most generous amount you can send. Thank you.**


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YES! I want to support the important work of the National Hospice Foundation.

<b>\$35</b>	helps us provide webinars to hospice professionals
<b>\$50</b>	helps us provide free advance directives
<b>\$100</b>	helps us maintain our free InfoLine
\$_____	to support the mission of the National Hospice Foundation.

Return to:  
National Hospice Foundation  
PO Box 824401  
Philadelphia, PA 19182-4401

2022AD



OR donate online today: [www.NationalHospiceFoundation.org/donate](http://www.NationalHospiceFoundation.org/donate)