South Country
HEALTH ALLIANCE

Health Care Directive

Informing others about your wishes for your health care

Minnesota law allows you to inform others of your health care wishes. You have the right to state your wishes or appoint an agent in writing so that others will know what you want if you can't tell them because of illness or injury.

Information in this booklet tells about health care directives and how to prepare them. Please note the content of this document does not give every detail of the law.

1-866-567-7242, TTY 1-800-627-3529 or 711

Attention. If you need free help interpreting this document, call the above number.

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ملاحظة: إذا أردت مساعدة مجانية لترجمة هذه الوثيقة، اتصل على الرقم أعلاه.

သတိ။ ဤစာရွက်စာတမ်းအားအခမဲ့ဘာသာပြန်ပေးခြင်း အကူအညီလိုအပ်ပါက၊ အထက်ပါဖုန်းနံပါတ်ကိုခေါ်ဆိုပါ။

កំណត់សំគាល់ ។ បើអ្នកត្រូវការជំនួយក្នុងការបកប្រែឯកសារនេះដោយឥតគិតថ្លៃ សូមហៅទូរស័ព្ទតាមលេខខាងលើ ។

請注意，如果您需要免費協助傳譯這份文件，請撥打上面的電話號碼。

Attention. Si vous avez besoin d’une aide gratuite pour interpréter le présent document, veuillez appeler au numéro ci-dessus.

Thov ua twb zoo nyeem. Yog hais tias koj xav tau kev pab txhais lus rau tsab ntaub ntawv no pub dawb, ces hu rau tus najnpawb xov tooj saum toj no.

ဟ်သူဉ်ဟ်သးဘဉ်တကွ၊်. ဖဲနမ့၊်လိဉ်ဘဉ်တ၊်မၤစၢၤကလီလၢတ၊်ကကျိးထံဝဲဒဉ်လံာ် တီလံာ်မီတခါအံၤန့ဉ်,ကိးဘဉ် လီတဲစိနီ၊်ဂ်၊်လၢထးအံၤန့ဉ်တကွ၊်.

알려드립니다. 이 문서에 대한 이해를 돕기 위해 무료로 제공되는 도움을 받으시려면 위의 전화번호로 연락하십시오.

ໂປຣດຊາບ. ຖ້າຫາກ ທ່ານຕ້ອງການການຊ່ວຍເຫຼືອໃນການແປເອກະສານນີ້ຟຣີ, ຈົ່ງ ໂທຣໄປທີ່ໝາຍເລກຂ້າງເທິງນີ້.

Hubachiisa. Dokumentiin kun tola akka siif hiikamu gargaarsa hoo feete, lakkoobsa gubbatti kenname bilbili.

Внимание: если вам нужна бесплатная помощь в устном переводе данного документа, позвоните по указанному выше телефону.

Digniin. Haddii aad u baahantahay caawimaad lacag-la’aan ah ee tarjumaadda (afcelinta) qoraalkan, lambarka kore wac.

Atención. Si desea recibir asistencia gratuita para interpretar este documento, llame al número indicado arriba.

Chú ý. Nếu quý vị cần được giúp đỡ dịch tài liệu này miễn phí, xin gọi số bên trên.

Health Care Directive Questions and Answers

What is a health care directive?

A health care directive is a written document that informs others of your wishes about your health care. It allows you to name a person ("agent") to decide for you if you are unable to make that decision. Health care directives are not just for the elderly. Anyone 18 years or older who wants to direct their medical care for the future should complete a health care directive.

Why should I have a health care directive?

A health care directive is a way for you to specify your wishes about health care treatment if you are unable to make decisions for yourself. It lets you communicate your wishes to provide guidance to your family, friends, and health care professionals. You can appoint a person called an "agent" who will communicate your health care wishes if you can't because of illness or injury. Health care decisions include:

- The use of breathing machines
- Resuscitation if breathing or heartbeat stops
- Tube feeding
- Organ or tissue donation
- Pain medications and other comfort treatments

What if I don't have a health care directive?

Health care providers will listen to what people close to you say about your treatment preferences. The best way to be sure your wishes are followed is to have a health care directive, but you will still receive medical treatment if you don't.

Where can I find a health care directive form? What information is required?

There is a health care directive form beginning on page 1 of this document. You don't have to use this form, but your health care directive must meet the following requirements to be legal:

- Be in writing and dated
- State your name
- Be signed by you, or someone you authorize to sign for you, when you can understand and communicate your health care wishes
- Have your signature verified by a notary public or two witnesses
- Include the appointment of an agent to make health care decisions for you and/or instructions about the health care choices you wish to make

Before you prepare or revise your health care directive, you should discuss your health care wishes with your doctor or other health care provider.

What can I put in a health care directive?

You have many choices of what to put in your health care directive. Here are some examples:

- The person you trust as your agent to make health care decisions for you. You can name joint agents or alternative agents in case the first agent is unavailable
- Your goals, values, and preferences about health care
- The types of medical treatment you would want or not want
- How you want your agent or agents to decide
- Where you want to receive care
- Instructions about artificial nutrition/hydration
- Mental health treatments that use electroshock therapy or neuroleptic medications
- Instructions if you are pregnant
- Donation of organs, tissues, and eyes
- Funeral arrangements
- Who you would like as your guardian or conservator if there is a court action

You may be as specific or as general as you wish. You can choose which issues or treatments to deal with in your health care directive.

Are there any limits to what I can put in my health care directive?

There are some limits about what you can put in your health care directive. For example:

- Your agent must be at least 18 years of age.
- Your agent cannot be your health care provider, unless the health care provider is a family member or you give reasons for naming a provider as an agent in your directive.
- You cannot request health care treatment that is outside of reasonable medical practice.
- You cannot request assisted suicide.

How long does a health care directive last? Can I change it?

Your health care directive lasts until you cancel or change it. As long as the changes meet the health care directive requirements above, you may do any of the following:

- Completing a written statement saying you want to cancel it; or
- Destroying *all* copies of it; or
- Telling at least two other people you want to cancel it; or
- Writing a new health care directive

What if my health care provider refuses to follow my health care directive?

Your health care provider will generally follow your health care directive or any instructions from your agent, as long as the health care follows reasonable medical practice. But you or your agent cannot request treatment that will not help you or which the provider cannot provide. If the provider cannot follow your agent's directions about life-sustaining treatment, the provider must inform the agent. The provider must also document the notice in your medical record. The provider must allow the agency to arrange to transfer you to another provider who will follow the agent's directions.

What if I've already prepared a health care document? Is it still good?

Before August 1, 1998, Minnesota law provided for several other types of health care documents, including living wills, durable powers of attorney for health care, and mental health declarations.

The law changed so people can use one form for all their health care instructions.

Forms created before August 1, 1998, are still legal if they follow the law in effect when written. They are also legal if they meet the requirements of the new law (described above). You may want to review any existing documents to make sure they say what you want and meet all requirements.

I prepared my health care directive in another state. Is it still good?

Health care directives prepared in other states are legal if they meet the requirements of the other state's laws or the Minnesota requirements. However, requests for assisted suicide will not be followed.

What should I do with my health care directive after I have signed it?

You should inform others of your health care directive and give copies to your family members, agent(s), and health care providers. Review and update your directive as your needs change. Keep it in a safe place where it is easily found. Some suggest keeping a copy in your freezer for emergency personnel to locate.

South Country Policies for health care directives

Members have the right to make decisions about their medical care. Members have the right to implement a living will, durable power of attorney for health care, or other advance health care directives. If a member has implemented a health care directive, there will be no condition on treatment or other discrimination by South Country or the provider. South Country has written contracts with providers that require providers to document whether or not a member patient has implemented a health care directive, and to follow the advance health care directives as specified in the member's health care directive document.

What if I believe a health care provider or South Country has not followed health care directive requirements?

Complaints of this type can be filed with the Office of Health Facility Complaints at 1-651-201-4200 (Metro area) or toll-free at 1-800-369-7994.

File health plan complaints with the Department of Health, Clearing House at 1-651-201-5178 (Metro area) or toll-free at 1-800-657-3793.

How to obtain additional information and forms

If you want more information about health care directives or additional forms, contact Member Services at 1-866-567-7242 (TTY users call 1-800-627-3529 or 711).

You may also contact the following:

- **Minnesota Board on Aging's Senior LinkAge Line®, 1-800-333-2433**
- **Disability LinkAge Line, 1-866-333-2466**
- **Veterans Linkage Line, 1-888-546-5838**

Another resource is the Minnesota based Light the Legacy website: **www.lightthelegacy.org** for support in advance care planning. Click on "Download forms" under "Healthcare Directive" to locate forms in a variety of languages.

Your attorney may also have health care directive forms.

Health Care Directive

Introduction

I have completed this Health Care Directive with much thought. This document gives my treatment choices and preferences, and/or appoints a Health Care Agent to speak for me if I cannot communicate or make my own health care decisions. My Health Care Agent, if named, is able to make medical decisions for me, including the decision to refuse treatments that I do not want.

NOTE: *This document does not apply to intrusive mental health treatments, defined as electroconvulsive therapy or neuroleptic medications.*

Any advance directive document created before this is no longer legal or valid.

My name: _____

My date of birth: _____

My address: _____

My telephone numbers: (home) _____(cell) _____

☐ My initials here indicate a professional medical interpreter helped me complete this document.

Part 1: My Health Care Agent

If I cannot communicate my wishes and health care decisions due to illness or injury, or if my health care team determines that I cannot make my own health care decisions, I choose the following person to communicate my wishes and make my health care decisions. My Health Care Agent must:

- Follow my health care instructions in this document.
- Follow any other health care instructions I have given to him or her.
- Make decisions in my best interest.

My Primary (main) Health Care Agent is:

Name: _____Relationship: _____

Telephone numbers: (H)_____(C)_____ (W)_____

Full address: _____

If I cancel my primary agent's authority, or if my primary agent is not willing, able, or reasonably available to make health care decisions for me, I choose an alternate Health Care Agent.

My Alternate Health Care Agent is:

Name: _____Relationship: _____

Telephone numbers: (H)_____(C)_____ (W)_____

Full address: _____

I understand my Health Care Agent (primary or alternate) cannot be a health care provider or employee of a health care provider giving me direct care to me unless I:

- Am related to that person by blood or marriage, registered domestic partnership, or adoption
- Provide a clear reason why I want that person to serve as my agent:

_____

_____

_____

Powers of my Health Care Agent:
My Health Care Agent automatically has all the following powers when I am unable to communicate for myself:

A. Agree to, refuse, or cancel decisions about my health care. This includes tests, medications, surgery, taking out or not putting in tube feedings, and other decisions related to treatments. If treatment has already begun, my agent can continue it or stop it based on my instructions.
B. Interpret any instruction in this document based on his or her understanding of my wishes, values and beliefs.
C. Review and release my medical records and personal files as needed for my health care, as stated in the Health Insurance Portability and Accountability Act of 1996 (HIPAA), and the Minnesota Health Records Act.
D. Arrange for my health care and treatment in Minnesota or other state or location he or she thinks is appropriate.
E. Decide which health care providers and organizations provide my health care.
F. Make decisions about organ and tissue donation and autopsy according to my instructions in Part 2 of this document.

Comments or limits on the above:

Additional powers of my Health Care Agent:
My initials below indicate I also authorize my Health Care Agent to:

☐ Make decisions about the care of my body after death.

☐ Continue as my Health Care Agent even if our marriage or domestic partnership is legally ending or has been ended.

☐ Make health care decisions for me even if I am able to decide or speak for myself, if I so choose.

☐ In the event I am pregnant, decide whether to try to continue my pregnancy to delivery based upon my agent's understanding of my values, preferences and/or instructions.

Part 2: My Health Care Instructions

My choices and preferences for health care are as follows. I ask my Health Care Agent to communicate these choices, and my health care team to honor them, if I cannot communicate or make my own choices. **I have initialed a box below for the option I prefer for each situation.**

NOTE: *You do not need to write instructions about treatments to extend your life, but it is helpful to do so. If you do not have written instructions, your agent will make decisions based on your spoken wishes, or in your best interest if your wishes are unknown.*

1. Cardiopulmonary Resuscitation: A Decision for the Present

This decision refers to a treatment choice I am making today based on my current health. Item 3 below **(Treatments to Prolong My Life: A Decision for the Future)** indicates treatment choices I want if my health changes in the future and I cannot communicate for myself.

CPR is a treatment used to attempt to restore heart rhythm and breathing when they have stopped. CPR may include chest compressions (forceful pushing on the chest to make the blood circulate), medications, electrical shocks, a breathing tube, and hospitalization. I understand that CPR can save a life but does not always work. I also understand that CPR does not work as well for people who have chronic (long-term) diseases or impaired functioning, or both. I understand that recovery from CPR can be painful and difficult.

Therefore:

☐ I want CPR attempted if my heart or breathing stops.

or

☐ I want CPR attempted if my heart or breathing stops based on my current state of health. However, in the future if my health has changed; for example:

- I have an incurable illness or injury and am dying
- I have no reasonable chance of survival if my heart or breathing stops
- I have little chance of long-term survival if my heart or breathing stops and CPR would cause significant suffering

then my agent or I (if I am able) should discuss CPR with my health care team. My choices in **Section 2: Treatment Preferences and Section 3: Treatments to Prolong My Life** below should be considered when making this decision.

or

☐ I do not want CPR attempted if my heart or breathing stops. I want to allow a natural death. I understand if I choose this option I should see my health care provider about writing a Do Not Resuscitate (DNR) order.

2. Treatment Choices: My Health Condition

My treatment choices for my specific health condition(s) are written here. With any treatment choice, I understand I will continue to receive pain and comfort medicines, as well as food and liquids by mouth if I am able to swallow.

My initials here indicate additional documents are attached: ☐

3. Treatments to Prolong My Life: A Decision for the Future

If I can no longer make decisions for myself, and my health care team and agent believe I will not recover my ability to know who I am, I want:

NOTE: With either choice, I understand I will continue to receive pain and comfort medicines, as well as food and liquids by mouth if I am able to swallow.

☐ To **stop or withhold all treatments** that extend my life. This includes but is not limited to tube feedings, IV (intravenous) fluids, respirator/ventilator (breathing machine), cardiopulmonary resuscitation (CPR), and antibiotics.

or

☐ **All treatments recommended** by my health care team. This includes but is not limited to tube feedings, IV (intravenous) fluids, respirator/ventilator (breathing machine), cardiopulmonary resuscitation (CPR), and antibiotics. I want treatments to continue until my health care team and agent agree such treatments are harmful or no longer helpful.

Comments or directions to my health care team:

4. Organ donation

☐ I want to donate my eyes, tissues and/or organs, if able. My Health Care Agent, according to Minnesota Law, may start and continue treatments or interventions needed to maintain my organs, tissues and eyes until donation has been completed. My specific wishes (if any) are:

or

☐ I do not want to donate my eyes, tissues and/or organs.

or

☐ My Health Care Agent can decide.

5. Autopsy

☐ My Health Care Agent may request an autopsy if the autopsy can help others understand the cause of my death or help with future health care decisions.

or

☐ I do not want an autopsy unless required by law.

6. Comments or directions to my health care team:

You may use this space to write any additional instructions or messages to your health care team which have not been covered in this directive, or to elaborate on a point for clarification. You may also leave this space blank.

My initials here indicate additional documents are attached: ☐

Part 3: My Hopes and Wishes (Optional)

I want my loved ones to know my following thoughts and feelings:

The things that make life most worth living to me are:

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

My thoughts about specific medical treatments, if any:

My thoughts and feelings about how and where I would like to die:

If I am nearing my death, I want my loved ones to know that I would appreciate the following for comfort and support (rituals, prayers, music, etc.):

Religious affiliation: I am of the _____ faith, and am a member of _____ faith community in (city) _____.
Please notify them of my death and arrange for them to provide my funeral/memorial/burial. I would like my funeral to include, if possible, the following (people, music, rituals, etc.):

Other wishes and instructions:

My initials here indicate additional documents are attached: ☐

Part 4: Legal Authority

NOTE: *Under Minnesota law, 2 witnesses **or** a notary public must verify your signature and the date. Your witnesses or notary public cannot be named as your primary or alternate Health Care Agent.*

I have made this document willingly. I am thinking clearly. This document states my wishes about my future health care decisions:

Signature:_____ **Date:**_____

If I cannot sign my name, I ask the following person to sign for me:

_____ _____

Printed Name **Signature** *(of person asked to sign)*

Statement of Witnesses:
This document was signed or verified in my presence. I certify that I am at least 18 years of age, and I am not appointed as a primary or alternate Health Care Agent in this document.

If I am a health care provider or an employee of a health care provider giving direct care to the person listed above, I must initial this line: _____. One witness cannot be a provider or an employee of the provider giving direct care on the date this document is signed.

Witness 1:	**Witness 2:**
Signature _____	Signature _____
Date: _____	Date: _____
Print name	Print name
_____	_____
Address (optional)	Address (optional)
_____	_____
_____	_____

Or

Notary Public:

In the state of Minnesota, County of _____.

In my presence on _____ (date), _____ (name) acknowledged his or her signature on this document or that he or she authorized the person signing this document to sign on his or her behalf. I am not named as a Health Care Agent in this document.

Signature of notary: *Notary stamp:*

My commission expires (date):

This is the directive of (name): _____ ***Date Completed:***_____

Clear Form

Part 5: Next Steps

Now that I have completed my Health Care Directive, I will also:

- Tell my primary and alternate Health Care Agents and make sure they feel able to do this important job for me in the future.
- Give my primary and alternate Health Care Agents a copy of this completed Health Care Directive.
- Talk to the rest of my family and close friends who might be involved if I have a serious illness or injury, making sure they know who my Health Care Agent is, and what my wishes are.
- Give a copy of this completed Health Care Directive to my doctor and other health care providers, and make sure they understood and will follow my wishes.
- Keep a copy of my Health Care Directive where it can be easily found.
- Take a copy of my Health Care Directive any time I am admitted to a health care facility, and ask that it be placed in my medical record.
- **Review my health care wishes every time I have a physical exam or whenever any of the "Five D's" occur:**

Decade	when I start each new decade of my life.
Death	whenever I experience the death of a loved one.
Divorce	when I experience a divorce or other major family change.
Diagnosis	when I am diagnosed with a serious health condition.
Decline	when I experience a significant decline or deterioration of an existing health condition, especially when I am unable to live on my own.

Copies of this document have been given to:

Primary (main) Health Care Agent (listed on page 1 of this document)

Name: _____ Telephone: _____

Alternate Health Care Agent (listed on page 1 of this document)

Name: _____ Telephone: _____

Health Care Provider/Clinic

Name: _____ Telephone: _____

Name: _____ Telephone: _____

Name: _____ Telephone: _____

If my wishes change, I will fill out a new Health Care Directive. I will give copies of the new document to everyone who has copies of my previous Health Care Directive. I will tell them to destroy the previous version.