



SOUTH COUNTRY

HEALTH ALLIANCE

Bringing Wellness Home

HEALTH CARE DIRECTIVES

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.



South Country Health Alliance Member Services 1-866-567-7242 (toll free) • TTY 1-877-824-5611

Attention. If you want free help translating this information, call the above number.

ملاحظة: إذا أردت مساعدة مجانية في ترجمة هذه المعلومات، فاتصل على الرقم الموجود أعلاه.

កំណត់សំគាល់ បើអ្នកចង់បានជំនួយបកប្រែព័ត៌មាននេះដោយមិនគិតថ្លៃ សូមទូរស័ព្ទ ទៅលេខនៅខាងលើ។

Pažnja. Ako vam je potrebna besplatna pomoć za prevod ove informacije, nazovite gornji broj.

Ceeb toom. Yog koj xav tau kev pab txhais cov xov no dawb, thov hu rau tus xov tooj saud.

ໂປຼດຊາບ. ຖ້າຫາກທ່ານຕ້ອງການການຊ່ວຍເຫຼືອໃນການເປາຍຂໍ້ຄວາມດັ່ງກ່າວນີ້ພຣີ, ຈົ່ງໂທຫາຕາມເລກໂທທີ່ຢູ່ຂ້າງເທິງນີ້.

Hubaddhu. Yoo akka odeeffannoon kun sii hiikamu gargaarsa tolaa feeta ta'e, lakkoofsa armaa olii bilbili.

Внимание. Если вам нужна бесплатная помощь в переводе этой информации, позвоните по указанному выше телефону.

Ogow. Haddii aad dooneyso in laga kaalmeeyo tarjama dda macluumaadkani oo lacag la'aan ah, wac lambarka kore.

Atención. Si desea recibir asistencia gratuita para traducir esta información, llame al número que aparece más arriba.

Chú Ý. Nếu quý vị cần dịch thông tin này miễn phí, xin gọi số nêu trên.

This information is available in other forms to people with disabilities by calling **1-866-567-7242** (toll free) or **1-877-824-5611** (TTY for the hearing impaired), or 711, or through the Minnesota Relay at 1-800-627-3529 (TTY, Voice, ASCII, Hearing Carry Over), or 1-877-627-3848 (speech to speech relay service).

LB5-0001 (4-09)

Minnesota Law

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. The information that follows tells about health care directives and how to prepare them. It does not give every detail of the law.

Why Have a Health Care Directive?

A Health Care Directive is a way for you to specify your wishes about health care treatment options. It is a way of making your voice heard when you no longer can speak. A Health Care Directive provides a way for you to communicate your wishes to family, friends and health care professionals, and to avoid confusion later on. It allows you to appoint a person called an “agent” in writing who then communicates your health care wishes if you can’t because of illness or injury. Health care decisions could include:

- The use of breathing machines
- If you want to be resuscitated if breathing or heartbeat stops
- Tube feeding
- Organ or tissue donation
- Pain medications and other comfort treatments

What Happens if I Don’t Have a Health Care Directive?

You will still receive medical treatment if you don’t have a written directive. Health care providers will listen to what people close to you say about your treatment preferences, but the best way to be sure your wishes are followed is to have a Health Care Directive.

Where Do I Find a Health Care Directive form?

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 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. For example, you may include:

- The person you trust as your agent to make health care decisions for you. You can name alternative agents in case the first agent is unavailable, or joint agents
- 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 and 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 instance:

- 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 the naming of the 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. If you want to change it, you must write a new Health Care Directive meeting the requirements

as stated on the previous page (page i). You may cancel your directive by any of the following:

- A written statement saying you want to cancel it
- Destroying ALL copies of it
- Telling at least two other people you want to cancel it

What If My Health Care Provider Refuses to Follow My Health Care Directive?

Your health care provider generally will 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 directives, including living wills, durable health care powers of attorney 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 followed 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 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. But 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 people copies of it. You may wish to inform family members, your health care agent or agents, and your health care providers that you have a Health Care Directive. You should give them a copy. It's a good idea to review and update your directive as your needs change. Keep it in a safe place where it is easily found.

What if I believe a Health Care Provider Has Not Followed Health Care Directive Requirements?

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

What if I believe SCHA Has Not Followed Health Care Directive Requirements?

Complaints of this type can be filed with the Minnesota Health Information Clearinghouse at 651-201-5178 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.

You may also contact:

- **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**

Your attorney may also have Health Care Directive forms.

Minnesota Health Care Directive

Purpose of Form	<p>PART 1. Allows you to appoint another person (called an agent) to make health care decisions if a doctor decides you are unable to do so.</p> <p>PART 2. Allows you to give written instructions about what you want.</p> <p>PART 3. Requires you and others to sign and date to make this legal.</p>
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My Personal Information	<p>My Name: _____</p> <p>Address: _____</p> <p>_____</p> <p>Home phone: () _____</p> <p>Work phone: () _____</p> <p>Date of birth: _____</p> <p>Social Security No: _____</p>
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I revoke all living wills, Durable Powers of Attorney for Health Care, or other written advance health care directives I have signed in the past.

PART 1. Naming An Agent

Agent duties:	<p>My health care agent can:</p> <ul style="list-style-type: none">◆ Make health care decisions for me if I am unable to make and communicate decisions for myself.◆ Make decisions based on any instructions in Part II of this document or in other documents.◆ Make decisions based on what he or she knows about my wishes.◆ Act in my best interests if instructions are not available.
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Agent roles:	<p>When naming my health care agent, I must choose one of the following. <i>Initial the line in front of the statement you WANT.</i></p>
<u>Act Alone</u>	<p>_____ I appoint one person to serve as my primary health care agent to make decisions for me if I am unable to make or communicate these decisions for myself. My primary agent may act alone. If my primary agent is not able, willing, or available, each alternate agent I name may act alone, in the order listed.</p>
<u>Act Together</u>	<p>_____ I appoint two or more persons to act together as my health care agent. My primary agent and alternate agents must act together and be in agreement when making decisions. If they are not all readily available, or if they disagree, a majority of the agents who are readily available may make decisions for me.</p>

My primary health care agent	I appoint: Agent's name: _____ Address: _____ _____ Home phone: () _____ Work phone: () _____
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My first alternate health care agent	I appoint: Agent's name: _____ Address: _____ _____ Home phone: () _____ Work phone: () _____
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My second alternate health care agent	I appoint: Agent's name: _____ Address: _____ _____ Home phone: () _____ Work phone: () _____
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(If needed) Reasons for naming health care provider	I have named as my agent a health care provider, or employee of a health care provider, who is currently or might be providing direct care to me when decisions are needed. That person is not related to me by blood, marriage, registered domestic partnership, or adoption. My reasons for wanting to appoint that person as my agent are: _____ _____ _____ _____
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Powers of my agent	If I am unable to decide or speak for myself, my agent has the power to: <ul style="list-style-type: none"> ◆ Consent to, refuse, or withdraw any health care, treatment, service, or procedure. ◆ Stop or not start health care which is keeping or might keep me alive. ◆ Choose my health care providers. ◆ Choose where I live when I need health care and what personal security measures are needed to keep me safe. ◆ Obtain copies of my medical records and allow others to see them.
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Additional powers of my agent	<p><i>If I WANT my agent to have any of the following powers, I must initial the line in front of the statement.</i></p> <p>I also authorize my agent to:</p> <p>_____ Make health care decisions for me even if I am able to decide or speak for myself.</p> <p>_____ Carry out my wishes regarding a funeral, burial, or what will happen to my body when I die.</p> <p>_____ Make decisions about mental health treatment including electroconvulsive therapy and antipsychotic medication, including neuroleptics.</p> <p>_____ In the event I am pregnant, determine whether to attempt to continue my pregnancy to delivery based upon my agent's understanding of my values, preferences, or instructions.</p> <p>_____ Continue as my health care agent even if a dissolution, annulment, or termination of our marriage or domestic partnership is in process or has been completed.</p>
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Limiting the powers of my agent	<p>I wish to limit the powers of my health care agent in the following way(s):</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>If more space is needed, attach another sheet of paper to this document.</p>
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PART 2. Health Care Instructions*

- ◆ I give the following instructions about my health care (my values and beliefs, what I do and do not want, views about medical treatments or situations):

- ◆ I am attaching additional instructions (pages 5–8) concerning my health care values and preferences.
Initial one line: _____ Yes _____ No
- ◆ I authorize donation of organs, tissue, or other body parts after my death.
Initial one line: _____ Yes _____ No

*You may want to fill out pages 5 through 8 prior to filling in this section.

PART 3. Making This Document Legal

My signature/ mark and date	I agree with everything in this document and have made this document willingly: My signature: _____ Date: _____ <p style="text-align: center;">(month / day / year)</p>
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Notary Public OR Witnesses

Notary Public NOTE: Must not be named as agent or alternate agent.	STATE OF MINNESOTA County of _____ This document was signed or acknowledged before me this _____ <p style="text-align: right;">(day)</p> of _____, _____ by the above named principal. <p style="text-align: center;">(month) (year)</p> _____ Signature of Notary Public
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Two Witnesses NOTE: Only one witness can be a direct care provider or employee of a provider on the day this is signed.	This document was signed or acknowledged in my presence. I am not an agent or alternate agent in this document. Witness Signature: _____ Address: _____ _____ Date: _____ <p style="text-align: center;">(month / day / year)</p> Witness Signature: _____ Address: _____ _____ Date: _____ <p style="text-align: center;">(month / day / year)</p>
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Additional Health Care Instructions Worksheet

My Health Care Goals

Having a sense of what is important to you can help your decision makers make health care decisions under different and complex circumstances. Read each statement below and on a scale of “0” to “4,” rate how important each of the health care goals are to you. In this case, “0” means “Not Important At All” and “4” means “Extremely Important.” Remember reasonable medical care should always include maintaining a person’s comfort, hygiene, and human dignity.

Health Care Goals	Not Important 0	1	Somewhat Important 2	3	Extremely Important 4
How Important Is Pain Control?					
◆ Being as comfortable and free from pain as possible					
◆ Having pain controlled, even if my ability to think clearly is reduced					
◆ Having pain controlled, even if it shortens my life					
How Important Is the Use of Life Prolonging Treatment When:					
◆ I have a reasonable chance of recovering both physically and mentally (50/50+)					
◆ I have some physical limitations but can socially relate to those I care about					
◆ I can live a longer life no matter what my physical or mental health					
◆ I have little or no chance of doing everyday activities I enjoy					
◆ I am not able to socially relate to those I care about					
◆ I have a terminal illness and treatment will only prolong when I die					
◆ I have severe and permanent brain injury and there is little chance of regaining consciousness					
◆ I have severe dementia or confusion and my condition will only get worse					
Importance of Finances and Health Care					
◆ Having my wishes followed regardless of whether or not my finances are exhausted					
◆ Not being a financial burden to those around me					
◆ Not having my health care costs affect the financial situations of those I care about					

I also want my decision makers to know the following things are important to me when receiving health care:

My Medical Treatment Preferences

It is helpful for others to know if and why you have strong feelings about certain medical treatments. Some of the more difficult medical decisions are about treatments used to prolong life, such as those listed below. Most medical treatments can be tried for a while and then stopped if they do not help. Discuss these medical treatments with a health care professional to make sure you understand what they might mean for you given your current as well as future health conditions.

Medical Procedure	What It Is Used and Its Effects	My Feelings About This Procedure
<p>Ventilator/Respirator A breathing machine</p> <p>A Do Not Intubate (DNI) order is put on your medical record when you do not want this procedure</p>	<p>When you cannot breathe on your own</p> <p>You cannot talk or eat by mouth on this machine</p>	
<p>Nutrition support and hydration</p>	<p>When you cannot eat or drink by mouth, feeding solutions can provide enough nutrition to support life indefinitely</p> <p>Feeding solutions can be put through a tube in your stomach, nose, intestine, or veins</p>	
<p>Cardiopulmonary Resuscitation (CPR)</p> <p>A Do Not Resuscitate (DNR) order is put on your medical record when you do not want this procedure.</p>	<p>Actions to make your heart and lungs start if they stop including pounding on your chest, electric shocks, medications, and a tube in your throat</p>	<p><input type="checkbox"/> I do not want CPR attempted if my heart or breathing stops, but rather, want to permit a natural death.</p> <p><input type="checkbox"/> I want CPR attempted unless my doctor determines any of the following:</p> <ul style="list-style-type: none"> ◆ I have an incurable illness or injury and am dying; or ◆ I have no reasonable chance of survival if my heart or breathing stops, or ◆ I have little chance of long-term survival if my heart or breathing stops and the process of resuscitation would cause significant suffering <p><input type="checkbox"/> I want CPR if my heart or breathing stops.</p>
<p>Dialysis</p>	<p>A mechanical means of cleaning the blood when kidneys are not working</p>	

My feelings or concerns about other medical treatments include: _____

If I am pregnant, my feelings about medical treatment would include: _____

My Religious and Spiritual Beliefs

Religious or spiritual beliefs and traditions influence how people feel about certain medical treatments, what quality of life means to them, and how they wish to be treated when they are dying or when they have died.

My decision makers should know the following about how my religious or spiritual beliefs should affect my health care: _____

My religion/spirituality is: _____

My congregation/spiritual community (name, city, state): _____

I wish to have my (priest/pastor/rabbi/shaman/spiritual leader) consulted. ____ Yes ____ No

If yes, the person to be contacted is: _____

Feelings About Quality and Length of Life

If I reach a point where I can no longer make decisions for myself and it is reasonably certain that I will not recover my ability to know who I am:

- I want to stop or withhold all treatments that are prolonging my life. This includes but is not limited to tube feedings, IV (intravenous fluids, respirator/ventilator (breathing machine), cardiopulmonary resuscitation (CPR), and antibiotics.
- I do want all appropriate treatments recommended by my doctor, until my doctor and agent agree that such treatments are harmful or no longer helpful.

Comments or directions to health care providers:

My Preferences for Care When Dying

If a choice is possible and reasonable when I am dying, I would prefer to receive care:

_____ At home _____

_____ At a hospital. Which one? _____

_____ At a nursing home. Which one? _____

_____ Through hospice services/care. Which one? _____

_____ From other health care providers. Which ones? _____

Other wishes I have about my care if I am dying _____

My Wishes About Donating Organs, Tissues, or Other Body Parts

Initial the lines that apply to you:

_____ I DO wish to donate organs, tissue, or other body parts when I die.

_____ Any needed organs, tissue, or other body parts

_____ Only the following listed organs, tissue, or body parts _____

Limitations or special wishes I have include: _____

_____ I DO NOT wish to donate organs, tissue, or other body parts when I die.

Additional Health Care Instructions

My decision makers should also know these things about me to help them make decisions about my health care:

I agree that these are my health care instructions and have completed this willingly.

My signature: _____

Date completed: _____
(month / day / year)

◆ This worksheet is an attachment to my Health Care Directive:

Initial one line: _____ Yes _____ No