



## Health Care Directives

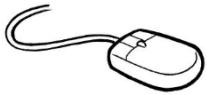
### What is a Health Care Directive?

A Health Care Directive is a document that lets you leave instructions about your health care and name a “Health Care Agent.” A Health Care Agent is someone you choose who can make decisions about your health care when your doctor determines you can’t make decisions yourself.

You may name an Agent without leaving instructions about your care OR you may leave instructions without naming an agent. You can

There is a sample Health Care Directive form attached to this fact sheet.

Or you can [create a Health Care Directive online](http://www.LawHelpMN.org/formhelper) at [www.LawHelpMN.org/formhelper](http://www.LawHelpMN.org/formhelper).



- Click on “Health Care and Other Powers”
- Click on “Health Care Directive”

This is a step-by-step interview that lets you print out a completed form when done.



### What must a Health Care Directive include?

- It must be in writing.
- It must be dated and state your name.
- It must be signed in front of a Notary Public **OR** witnessed by 2 people.
- It must name someone to make decisions for you (Health Care Agent) and/or give health care instructions.

## **Who can be a Health Care Agent?**

Your Health Care Agent must be 18 or older. Pick someone you know well who will follow your wishes, act in your best interest and who will be available to your health care providers. Anyone can be your Agent except a health care provider or employee of a provider giving you care, **unless** you are related to that person by blood, marriage, registered domestic partnership or adoption.

You may also say in the Health Care Directive why you want that person to be your Agent.

**It is very important to talk to the person you name as your Agent to be sure they are willing to make your health care decisions when it may become necessary. You also want to make sure they know what your wishes are for your health care.**

## **Can more than one person be my Health Care Agent?**

You may name one or more Agents or alternates. If you do, you should also say if the Agents have to decide things together or if they may make decisions independently.

## **What powers will my Health Care Agent have?**

Unless you limit your Agent's powers, your Agent will automatically be able to:

1. Consent to, refuse or withdraw medical or health care treatment on your behalf. This includes intrusive mental health treatment.
2. Stop or not start care which is keeping you or may keep you alive.
3. Choose your health care providers.
4. Choose where you will get your health care.
5. Decide if you will live in your home, or a hospice, or a nursing home.
6. Review your medical records and have the same rights that you would have to give your medical records to other people.
7. Visit you when you are a patient at a health care facility.



If you want to limit these powers, you must say so in the Directive.

## Are there other things I can give my Agent permission to do?

Yes. You may give the Agent permission to do other things if you specifically say so in the Health Care Directive:

1. To decide if you want to donate any parts of your body, including organs, tissues, and eyes when I die.
2. Say what you want done with your body after your death (cremation, burial).
3. You can also give your Agent permission to make your health care decisions even if you could still make decisions yourself.

## When can the Health Care Agent take over decisions?

The Agent takes over decisions when:

- Your doctor thinks that you cannot make your own decisions, or
- When the Health Care Directive says the Agent can take over.



## What is the job of the Health Care Agent?

The Agent should make health care decisions **as if they were you**. They make sure the Health Care Directive is followed and should get legal help if it is not.

## Can I cancel the Health Care Directive?

Yes. You can cancel all or part of the Directive by:

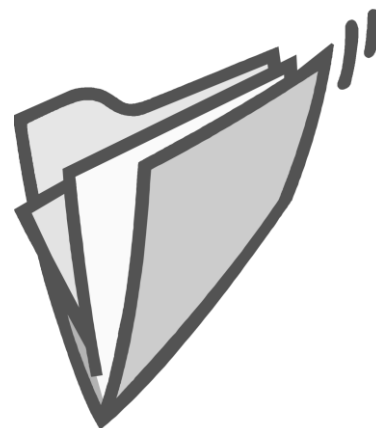
- Destroying the document.
- Telling another person to destroy it.
- Making a written and dated statement saying that you want to cancel all or part of the Directive. If you are just cancelling part of it, say what part of the Directive you want to cancel.
- Verbally stating that you want to cancel the Health Care Directive before two witnesses. They do not have to be present at the same time.
- Making a new Health Care Directive.

## Where should I keep the Health Care Directive?

Keep it with personal papers in a safe place where others can find it, not in a safe deposit box. Give signed copies to doctors, family, close friends, the Agent you named to make decisions for you, and the person you named as an alternate agent. Ask to have it put in your file at your doctor's office and the hospital, home care agency, hospice or nursing home.

## Are my old "Living Will" or "Durable Health Care Power Of Attorney" papers valid?

Only if they were signed before August 1, 1998. If you update or make new papers, you must use the new Health Care Directive, not a "Living Will" or a "Durable Health Care Power of Attorney." It is a good idea to update your forms, and this may be the time to do it!



You may use the form at the end of this fact sheet. The last 2 pages are a Health Care Directive worksheet. You do not have to do the worksheet part, but it can help you decide about health care needs and can be added to the rest of your form if you want.

Find more fact sheets at [www.lawhelpmn.org/LASMfactsheets](http://www.lawhelpmn.org/LASMfactsheets)

Find your local legal aid office at [www.lawhelpmn.org/resource/legal-aid-offices](http://www.lawhelpmn.org/resource/legal-aid-offices)

*Fact Sheets are legal information NOT legal advice. See a lawyer for advice.  
Don't use this fact sheet if it is more than 1 year old. Ask us for updates, a fact sheet list, or alternate formats.*

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# Minnesota Health Care Directive

I, \_\_\_\_\_, understand this document allows me to do **ONE OR BOTH** of the following:

**1. (Part 1 of form):** 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 (if any) in part 2 of this document, 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

**2. (Part 2 of form):** 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 helping with my health care and my family, in the event I can't make decisions for myself.

## PART 1: Naming a 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 can change my agent or alternate agent at any time.
- I do not have to appoint an agent or an alternate agent.

NOTE: If you appoint an agent, talk about this health care directive with them, and give them a copy. If you don't want to appoint an agent, leave Part 1 blank and go to Part 2.

### Appointment of Health Care Agent

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

\_\_\_\_\_

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: \_\_\_\_\_

\_\_\_\_\_

**(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. This person is called my alternate health care agent.

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). But I can limit these powers if I want to.
- 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.

If 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.

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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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 any parts of my body, 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:

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## **PART 2: Health Care Instructions**

**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).

NOTE: Complete this Part 2 if you wish to give health care instructions. If you appointed an agent in Part 1, completing Part 2 is optional but would be very helpful to your agent. However, if you chose not to appoint an agent in Part 1, you **MUST** complete some or all of Part 2 if you wish to make a valid health care directive.

### **These Are My Beliefs and Values About My Health Care**

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

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

My goals for my health care:

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My fears about my health care:

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My spiritual or religious beliefs and traditions:

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

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

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### **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:

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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:

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

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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:

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**There are other things that I want or do not want for my health care, if possible:**

Who I would like my doctor to be:

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Where I would like to live to receive health care:

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

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

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

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Any other things:

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### PART 3: Making the Document Legal

This document must be signed by me. It also must either be verified by:

- 1) a notary public (Option 1 below)
- OR
- 2) witnessed by two witnesses (Option 2 below)

It must be dated when it is verified or witnessed.

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: \_\_\_\_\_

My address: \_\_\_\_\_

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)*

#### 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)*

## 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 One:

1. 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.

2. I am at least 18 years of age

3. I am not named as a health care agent or alternate health care agent in this document.

4. 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 box: \_\_\_\_\_

I certify that the information in 1 through 4 is true and correct.

\_\_\_\_\_  
*(Signature of Witness One)*

Address of witness one:

\_\_\_\_\_  
\_\_\_\_\_

**Witness Two:**

1. 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.

2. I am at least 18 years of age

3. I am not named as a health care agent or alternate health care agent in this document.

4. 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 box:

I certify that the information in 1 through 4 is true and correct.

\_\_\_\_\_  
(Signature of Witness Two)

Address of witness two:

\_\_\_\_\_  
\_\_\_\_\_

**REMINDER:**

- Keep this document with your personal papers in a safe place (not in a safe deposit box).
- Give signed copies to your doctors, family, close friends, health care agent, and alternate health care agent.
- Make sure your 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.