DOWNLOAD COVERSHEET:

This is a standard advance directive for your state, made available to you as a courtesy by Lifecare Directives, LLC. You should be aware that extensive research has demonstrated that there are significant drawbacks to using a very brief state-standard document. As one researcher has noted, "the development of statutory forms occurs in the legislative arena, [so] their content is the result of a political rather than a 'scientific' process." Because of "political compromise, ...many of the forms ultimately passed by the legislatures are not optimal from a consumer perspective" (see: Hoffmann, Diane E; Zimmerman, S; Tompkins, C. The dangers of directives, or the false security of forms. *Journal of Law, Medicine & Ethics*. 1996;24(1) (Spring):5-17).

American Bar Association concurs, noting that "The statutory advance directive is not necessarily the exclusive, or even the best, pathway for individuals to follow," and suggesting that revised and enhanced documents "may be especially helpful as a...replacement for statutory forms where restrictions in a statutory directive prevents the individual from fully expressing his or her wishes" (see: American Bar Association. (1991). *Patient Self Determination Act State Law Guide*. Government printing office, Washington, DC).

Lifecare Directives staff have reviewed more than 6,000 medical, legal, academic, and news media articles on advance directives, as well as reviewing hundreds of document forms. They have also conducted formal research with scores of medical, legal, and academic processionals along with more than 1,000 lay public participants. From this process, more than 30 additional key living will and medical power of attorney enhancements have been identified that should be included in any living will (or "health care instruction" or "declaration") and medical power of attorney (or "proxy") forms that you may use.

Please consider obtaining the *Lifecare Advance Healthcare Directive* to obtain these important additions and benefits. To better understand the important enhancements available through this combined living will and medical power of attorney, you may wish to obtain the booklet, "*Should I Use a Shorter Standard Directive?*" available through Lifecare Directives, LLC.

If you have any other questions about this document or other Lifecare resources, please do not hesitate to contact our staff who will make every effort to fully respond your inquiries and address any questions you may have. We can be reached at the following:

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~ Lifecare Directives ~

Statutory Advance Directive

For Minnesota Residents

Standard State Statutory
Advance Directive for
Health Care Choices

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Important Notice:

An advance directive is not a substitute for medical, legal or other necessary advice or direction. This document should not be construed as offering counseling, medical, legal, financial, or estate planning or advice, nor any other similar guidance or direction. Such counsel should be obtained from qualified, certified, and licensed professionals in your locale who are experienced in the specific areas of concern. Completion of this document constitutes acceptance of its content both in whole and in part, as well as a determination of its utility for the purposes indicated. Lifecare Directives, LLC, and all involved in this document's design, publication, and distribution assume no liability for its use, including that which may arise from omissions, technical inaccuracies, and typographical errors. Diligent efforts notwithstanding, this document is not warrantied to be in compliance with state and local laws. All warranties, including those of merchantability, fitness for a particular purpose, and non-infringement are expressly disclaimed. The utilizer agrees to seek appropriate outside review prior to completion. The utilizer and all heirs, assigns, designees, devisees, representatives, and all others involved, agree to assume all liability for its use and any subsequent outcomes, and to release and hold harmless all involved in its design, publication, advertising and distribution. The utilizer also agrees that any physician, health care provider, agent, proxy, surrogate, representative, mediator, court officer, and all others relying on the document's content are similarly free of all liability, when they act in good faith and with due diligence to follow the recorded wishes and directions.

Statutory Advance Directive For Minnesota Residents

_____ _____

Print Full Name *Date of Birth*

Your right *(when age 18 or older): To Document Your Personal Wishes, and to have these wishes followed ~~*

The Minnesota state legislature has provided statutes governing the structure and use of both a living will and a Power of Attorney for Health Care for use by the public. Collectively, these documents are known as "advance directives." As the content of these documents is designed by your state government, each should be in compliance with relevant statutes and laws.

There is an introduction to each that summarizes the scope and purpose of the documents, as well as providing further directions for completion. Read each carefully to ensure that your advance directives are fully and properly filled out.

Understanding Your Directive

To make the *best* choices for your medical care, your physician needs to know *your* wishes. In fact, the law requires doctors to seek your permission before giving you *any* treatment. However, if you are ever unable to make decisions due to severe illness or injury, this may not be possible. Completing this Directive will help your family and physicians know who should speak for you, and understand what you want if you cannot make this known yourself. This document allows you to do one or both of the following:

SECTION I: 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.

AND/OR,

SECTION II: 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

SECTION III: Making the document legal by required witnessing or notarization.

SECTION I:

HEALTH CARE INSTRUCTION

(MSA Ch.145C: §145C.01 to §145C.16)

The following is a suggested form of a health care directive and is not a required form.

Intent to Complete:

I have chosen *not* to complete a Health Care Instruction at this time, but I *do* want to appoint a Health Care Agent (*sign here and skip now to page 6*):

Signature: _____ Date: _____

OR:

I, _____, being of sound mind, and acting willingly and without duress, fraud or undue influence, herein direct that the instructions provided in Section I of this document represent my Health Care Instruction and treatment wishes. It is my intent that these instructions be used to guide to any agent, attorney-in-fact, proxy, surrogate, representative, court-appointed guardian or conservator, medical professional, or family member, as well as any other person or entity providing or overseeing my care, or making medical decisions in my behalf. These instructions shall be binding upon all involved to the fullest extent allowed by law.

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).

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: _____

_____

_____

_____

_____

_____

My fears about my health care: _____

_____

_____

_____

_____

_____

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. Therefore, I have the following views about my health care in these situations:

(Note: *You can discuss your general feelings and thoughts about 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: _____

_____
_____
_____
_____
_____
_____

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:

Name: _____
Facility/Office: _____
Address: _____
Phone: (_____) _____-_____

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): _____

Any other things important to me: _____

SECTION II:
APPOINTMENT OF HEALTH CARE AGENT

(Pursuant to §145C.01 to §145C.16)

Naming Who I Want to Make Health Care Decisions for Me
If I Am Unable to Decide or Speak for Myself

Intent to Complete:

_____ I do not want to choose a health care agent at this time (or I have no one appropriate to the task). However, I instruct that Section I of this document be recognized (by statutory law, case law, common law, and/or federal law as a declaration of my wishes within this Health Care Directive (*initial upper left space, and proceed to sign on page 8*);

OR,

I, _____, being of sound mind, and acting willingly and without duress, fraud or undue influence, herein direct that the instructions provided in Section I of this document represent my Health Care Instruction and treatment wishes. It is my intent that these instructions be used to guide to any agent, attorney-in-fact, proxy, surrogate, representative, court-appointed guardian or conservator, medical professional, or family member, as well as any other person or entity providing or overseeing my care, or making medical decisions in my behalf. These instructions shall be binding upon all involved to the fullest extent allowed by law. NOTE: If you appoint an agent, you should discuss this health care directive with your agent and give your agent a copy.

When I am unable to decide or speak for myself, then I:

Full Legal Name: _____
Date of Birth: _____
Street Address: _____
City: _____ County: _____
State: _____ Zip Code: _____

~~ do fully trust and appoint:

Name of Agent: _____
Relationship to me: _____
Address: _____
Telephone: Home:_____ Work:_____
Cell Phone or Pager: _____ E-mail: _____

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

Appointment of Alternate Health Care Agent (*optional*):

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

Name of Alternate: _____

Relationship to me: _____

Address: _____

Telephone: Home:_____ Work:_____

Cell Phone or Pager: _____ E-mail: _____

~~ to be my health care agent instead.

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 <u>not</u> given health care instructions applicable to a presenting situation, 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.

Limitations to Agent Authority:

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 write that here:

_____

_____

_____

Specific Additional Authorities:

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, donation, etc).

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

_____

_____

_____

SECTION 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 qualified witnesses (Option 2). It must be dated when it is verified or witnessed. I want it known that I am thinking clearly, that 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: _____

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

Signature Assistance: *Have the following completed, only if you (the "principal") are physically unable to sign*: The principal's name, above (and/or elsewhere within this document), was signed at his/her direction and in the presence of the principal and two witnesses, by the person whose signature and name appear below:

Signature of Assistant: _____
Printed Name:_____ Date: _____
Address: _____
Telephone: Home: _____ Work: _____

WITNESSING REQUIREMENTS

Option 1: Notary Public

On this_____day of _____, in the year_____, before me (*insert officer name/title*): _____, personally appeared (*insert name of Principal here*):_____, personally known to me or proved to me on the basis of satisfactory evidence to be the person(s) whose name(s) is/are subscribed to this/these instrument(s) and acknowledged to me that he/she executed the same in his/her authorized capacity, and that by his/her signature on the instrument(s), executed the instrument(s).

WITNESS my hand and official seal.

_____ **Notary Seal:**
Signature of Notary Public

_____
Date Commission Expires

Option 2: Two Qualified 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:

(i) On this_____day of _____, in the year_____, the Principal (*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 (A), I must initial this box: [_____]

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

1st Witness: _____
(Signature)

_____ _____
(Name Printed) (Date)

_____
(Residence Address)

Witness Two:

(i) On this_____day of _____, in the year_____, the Principal (*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 (A), I must initial this box: [_____]

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

1st Witness: _____
(Signature)

_____ _____
(Name Printed) (Date)

_____
(Residence Address)

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.

For additional copies of this directive, or other related materials, please contact Lifecare Directives, LLC, at:

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