Provided by Lewis Kannegieter Law, Ltd.

Minnesota Health Care Directive

Instructions for Completing the Form

Having a Health Care Directive is imperative for all adults. A Health Care Directive allows you to appoint an agent to speak for you if you are unable to do so yourself **and/or** provide instructions for the medical care you wish to receive. If you have not done so already, please request our book ***Why Every Adult Must Have A Health Care Directive*** for valuable information on Health Care Directives and advance care planning.

Attached you will find a free Minnesota Health Care Directive form. This form is designed to be completed on your own, by following the instructions below. If you do need assistance in preparing your Health Care Directive, or if it is time to complete your estate plan, please contact me at **(763) 244-2949** or jennifer@lewisklaw.com**.**

Instructions

Introduction

1. Provide your full legal name under "Minnesota Health Care Directive Of"
2. Complete your personal information, including full name, birth date, address, and number.
3. Remember, you **must** either name a Health Care Agent **OR** provide Health Care Instructions. You can also do **both**.

Naming Health Care Agents

4. If you are choosing to appoint Health Care Agents, provide the name, address, and phone number of your primary (first choice) agent.
5. If you wish to appoint alternate agents, who can act if the primary agent is unable to, provide the name, address, and phone number for each alternate agent.
6. If you have named more than one agent to serve as primary agents, first alternate agents, or second alternate agents, decide whether you want the agents to act alone or jointly, and mark the appropriate line.
7. *Note:* If you have named a health care provider or employee of a health care provider who is not related to you, you **must** provide your reason.

Powers of Your Health Care Agents

8. The next section explains the powers your Health Care Agent(s) will have. The first set of powers are automatically granted.
9. The second set of powers are optional. If you want your Health Care Agent to have any of these powers, check the box next to that power.
10. You can also provide additional powers, or limit the powers granted by filling in the blanks at the bottom of page 3.

Health Care Instructions

11. If you wish to provide Health Care Instructions, you may do so by answering the questions on page 4 and 5.
12. If you wish to provide an additional page of instructions, initial the line at the bottom of page 5.
13. **Remember:** You do not have to answer all of the questions, and if you have appointed an agent you do not need to answer any of them. If you have not appointed an agent, you **must** provide instructions.

Making It Legal

14. Take the completed but unsigned Health Care Directive to either a notary public **or** two witnesses.
15. The witnesses **must** be over the age of 18 and **must not** be appointed as an agent in the document. Only one witness can be a health care provider or employee of a health care provider.
16. In front of the notary public or witnesses, initial the bottom of each and every page. Date and sign page 6. If you are unable to sign for yourself, you can ask another person to sign for you, and print their own name on page 6.
17. If you are using a notary public, the notary public should then complete the section for the notary, date, stamp, and sign page 6. If you are using witnesses they should provide their printed name and address, and date and sign page 7.
18. After your Health Care Directive is complete and signed, make copies to distribute to your Health Care Agents, your family, and your doctors. Keep a list of everyone who has a copy. Keep the original in a safe place.

Encourage your loved ones to do the same!

Request our book and additional Health Care Directive Forms at www.LewisKLaw.com/mnhcd

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MINNESOTA HEALTH CARE DIRECTIVE OF

_____

Introduction: I have considered my treatment options and personal preferences and have prepared this document in the event that I cannot communicate for myself or make my own health care decisions. I understand this document allows me to name a health care agent to make health care decisions for me if I am unable to decide for myself **AND/OR** provide health care instructions to guide others in my care decisions.

THIS HEALTH CARE DIRECTIVE SHALL REVOKE ALL PRIOR HEALTH CARE DIRECTIVES, LIVING WILLS, DURABLE POWERS OF ATTORNEY FOR HEALTH CARE, OR OTHER WRITTEN ADVANCE CARE DIRECTIVES.

MY PERSONAL INFORMATION:

Name: _____

Birth Date: _____

Address: _____

Phone Number: _____

PART 1: NAMING A HEALTH CARE AGENT

My Health Care Agent shall have the power to make health care decisions for me, and act on my behalf if I am unable to communicate for myself. My agent must follow my instructions as found in this document and any other instructions given to my agent. My agent must make decisions that are consistent with my wishes and are in my best interests.

APPOINTMENT OF AGENT(S)

Primary Health Care Agent: If I am unable to communicate for myself, I appoint the following person(s) as my health care agent:

Name: _____

Address: _____

Phone Number: _____

First Alternate Health Care Agent: If my primary health care agent (named above) is unable or unwilling to serve, I appoint the following person(s) as my health care agent:

Name: _____

Address: _____

Phone Number: _____

Second Alternate Health Care Agent: If my primary and first alternate health care agents (named above) are unable or unwilling to serve, I appoint the following person(s) as my health care agent:

Name: _____

Address: _____

Phone Number: _____

If I have named more than one agent, it is my desire that the agents:

____ **Act Alone:** Only one agent is needed to act

____ **Act Jointly:** **ALL** agents must act together and agree on treatment

If I have named a health care provider or employee of a health care provider who is not related to me as a health care agent, I have done so for the following reason: _____

Powers of My Health Care Agent:

If I am unable to speak for myself, my Health Care Agent has the power to:

- ✓ Make any health care decision for me, when, in the judgment of my attending physician, I lack decision-making capacity. This includes the power to give, refuse, or withdraw consent to any care, treatment, service, or procedure. My agent has the power to stop or not start care that is keeping me alive or might keep me alive. This shall include all types of mental health treatment.
- ✓ Choose my health care providers and care facilities.
- ✓ Choose where I live when I need health care and determine what personal security measures are needed for my safety.
- ✓ Review my medical records and have the same rights that I would have to allow other people access to my medical records. My Health Care Agent shall be treated as my personal representative for purposes of the Health Insurance Portability and Accountability Act of 1996 (HIPAA). I waive all medical privilege in favor of any agent and personal representative I appoint under this document.

Additional Powers of My Health Care Agent:

(If I want my Health Care Agent to have any of the following powers, I will check the box in front of each statement below.)

I also authorize my Health Care Agent to:

- □ Make health care decisions for me even if I am able to decide or speak for myself, if I so choose.
- □ Arrange for and make decisions about the care of my body after death and carry out my wishes regarding a burial, cremation, funeral, or memorial service.
- □ In the event I am pregnant, determine whether to continue my pregnancy to delivery based upon my agent's understanding of my values and preferences.
- □ In the event of a court proceeding for a guardian to have authority concerning life-sustaining procedures or other health care for me, I nominate, pursuant to Minnesota Statutes, my Health Care Agent(s) named in this document to be appointed by the court as my guardian.

□ If I have named a spouse or domestic partner, to 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.

Additional powers or restrictions for my Health Care Agent: _____

_____

_____

_____

_____

_____

PART 2: HEALTH CARE INSTRUCTIONS

My instructions and preferences for my health care are as follows. I ask my agent and doctors to honor them in case I am unable to communicate them myself.

General Preferences: I have the following general preferences for my health care:

_____

_____

_____

_____

_____

_____

Specific Instructions: I have the following instructions for my health care:

_____

_____

_____

_____

Location for Care: I have the following preferences for where I receive care:

_____

_____

_____

_____

Is Life Worth Living? I have the following beliefs about when life would no longer be worth living and what is most important to me:

_____

_____

_____

_____

_____

_____

_____

_____

Additional Thoughts: I have the following thoughts and feelings about health care, end-of-life care, and death:

_____

_____

_____

_____

_____

_____

_____

Terminal Condition Instructions: I have the following instructions if I am in a terminal condition:

□ I **do want** all appropriate treatments and procedures as reasonably recommended by my doctor until my doctor and agent decide such treatments are harmful or no longer helpful.

□ I **do <u>NOT</u> want** treatments and procedures that will not substantially improve my condition or help me recover, but will only postpone the moment of my death.

□ If it is reasonably certain I will not recover my ability to know who I am, I wish to be allowed to die naturally and not be kept alive by artificial means or heroic measures.

□ Other instructions for terminal condition: _____

_____

_____

_____

Organ Donation: I have the following wishes regarding organ donation after death.

□ I **DO NOT** wish to donate my organs, tissue, eyes, and/or other body parts

□ I **DO** wish to donate my organs, tissue, eyes, and/or other body parts when I die.

- □ I wish to donate anything and everything that could be used
- □ I wish to donate everything EXCEPT _____
- □ I ONLY wish to donate: _____

□ I wish the donation to be made to _____

□ I do not want my donated organs to be used for _____

My Body After Death: After my death, I want:

- □ To be cremated
- □ To be buried
- □ To donate my body to: _____
- □ For my agent to decide
- □ Other instructions for my body after death: _____

_____

_____

_____

Additional Instructions Attached. If I have attached additional instructions concerning my health care values and preferences, I have initialed here: _____

PART 3: LEGALLY REQUIRED SIGNATURES

*Under Minnesota law, to be a valid legal document this Health Care Directive must be signed and dated in the presence of two witness **OR** a notary public.*

I have made this document willingly. I am thinking clearly and I agree with everything that is written in this document. This document accurately reflects my wishes and preferences for future medical care.

Date: _____, 20__ _____
Signature

If I cannot sign my name, I ask the following person to sign for me:
Printed name of person asked to sign: _____
Signature of person asked to sign: _____

Notary Public

STATE OF MINNESOTA)
) ss.
COUNTY OF _____)

Subscribed, sworn to, and acknowledged before me by _____ on this ____ day of _____ 20_____. I am not named as a health care agent or alternate health care agent in this document.

_____
Notary Stamp or Seal Notary Public

Two Witnesses (If document is not notarized)

I personally witnessed the signing of this document. I am not an agent or alternate agent appointed in this agreement.

First Witness:

_____ _____

Date *Signature*

Printed Name: _____

Address: _____

If I am a health care provider or an employee of a health care provider providing care to the person named above, I must initial here: _____

I personally witnessed the signing of this document. I am not an agent or alternate agent appointed in this agreement.

Second Witness:

_____ _____

Date *Signature*

Printed Name: _____

Address: _____

If I am a health care provider or an employee of a health care provider providing care to the person named above, I must initial here: _____

REMINDER: Keep this document with your personal papers in a safe place (not in a safe deposit box). Give signed copies to your health care providers, family, health care agent, and alternate health care agent. Keep a list of the copies you give out. 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.