

**MINNESOTA**  
**Advance Directive**  
**Planning for Important Health Care Decisions**

*Caring Connections*  
*1731 King St., Suite 100, Alexandria, VA 22314*  
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*800/658-8898*

**CARING CONNECTIONS**

Caring Connections, a program of the National Hospice and Palliative Care Organization (NHPCO), is a national consumer engagement initiative to improve care at the end of life.

**It's About How You LIVE**

*It's About How You LIVE* is a national community engagement campaign encouraging individuals to make informed decisions about end-of-life care and services. The campaign encourages people to:

- L**earn about options for end-of-life services and care
- I**mplement plans to ensure wishes are honored
- V**oice decisions to family, friends and health care providers
- E**ngage in personal or community efforts to improve end-of-life care

**Note:** The following is not a substitute for legal advice. While Caring Connections updates the following information and form to keep them up-to-date, changes in the underlying law can affect how the form will operate in the event you lose the ability to make decisions for yourself. If you have any questions about how the form will help ensure your wishes are carried out, or if your wishes do not seem to fit with the form, you may wish to talk to your health care provider or an attorney with experience in drafting advance directives.

## Using these Materials

### BEFORE YOU BEGIN

1. Check to be sure that you have the materials for each state in which you may receive health care.
2. These materials include:
  - Instructions for preparing your advance directive, please read all the instructions.
  - Your state-specific advance directive forms, which are the pages with the gray instruction bar on the left side.

### ACTION STEPS

1. You may want to photocopy or print a second set of these forms before you start so you will have a clean copy if you need to start over.
2. When you begin to fill out the forms, refer to the gray instruction bars — they will guide you through the process.
3. Talk with your family, friends, and physicians about your advance directive. Be sure the person you appoint to make decisions on your behalf understands your wishes.
4. Once the form is completed and signed, photocopy the form and give it to the person you have appointed to make decisions on your behalf, your family, friends, health care providers and/or faith leaders so that the form is available in the event of an emergency.
5. You may also want to save a copy of your form in an online personal health records application, program, or service that allows you to share your medical documents with your physicians, family, and others who you want to take an active role in your advance care planning.

## Introduction to Your Minnesota Health Care Directive

This packet contains a legal document, the Minnesota Health Care Directive, that protects your right to refuse medical treatment you do not want, or to request treatment you do want, in the event you lose the ability to make decisions yourself. You may complete Part I, Part II, or both, depending on your advance planning needs. You must complete Part III.

**Part I, Appointment of Health Care Agent**, lets you name someone to make decisions about your health care—including decisions about life support—if you can no longer speak for yourself, or immediately, if you specify this in the document. The appointment of health care agent is especially useful because it appoints someone to speak for you any time you cannot make your own medical decisions, not only at the end of life.

Unless you specify that your agent's powers go into effect immediately in the additional instructions section on page 3 of the form, your agent's authority goes into effect when your doctor determines that you are no longer able to make or communicate the health care decision at issue. If you are still capable of making some, but not all, health care decisions, your agent is only authorized to make those decisions that you are incapable of making.

**Part II, Health Care Instructions**, functions as your living will. It lets you state your wishes about health care in the event that you can no longer make your own health care decisions. If you are still capable of making some, but not all, health care decisions, your instructions apply only to make those decisions that you are incapable of making.

Your health care instructions go into effect when your doctor determines that you are no longer able to make or communicate your health care decisions.

**Part III** contains the signature and witness provisions so that your document will be effective.

This form does not expressly address mental illness. If you would like to make advance care plans regarding mental illness, you should talk to your physician and an attorney about a durable power of attorney or other directive tailored to your needs.

*Note: This documents will be legally binding only if the person completing it is a competent adult who is 18 years of age or older.*

## Completing Your Minnesota Health Care Directive

### How do I make my Health Care Directive legal?

In order to make your health care directive legally binding you have two options:

1. Sign your document in the presence of two witnesses, who must also sign the document. Neither of your witnesses can be:
  - under the age of 18, or
  - the person you appointed as your agent or alternate agent,

In addition, at least one of your witnesses must be someone who is not your health care provider or an employee of your health care provider.

### OR

2. Sign your document in the presence of a notary public. The person notarizing your health care directive may be an employee of a health care provider providing you with direct care but cannot be the person you appointed as your agent or alternate agent.

### Whom should I appoint as my agent?

Your agent is the person you appoint to make decisions about your health care if you become unable to make those decisions yourself. Your agent may be a family member or a close friend whom you trust to make serious decisions. The person you name as your agent should clearly understand your wishes and be willing to accept the responsibility of making health care decisions for you.

You can appoint a second person as your alternate agent. The alternate will step in if the first person you name as an agent is unable, unwilling, or unavailable to act for you.

You **cannot** appoint the following persons as your agent unless they are related to you by blood, marriage, registered domestic partnership, or adoption, unless you specifically say otherwise in your Directive:

- a health care provider providing care to you on the date you sign your directive;
- an employee of your health care provider on the date you sign your directive.

### Should I add personal instructions to my Appointment of Health Care Agent?

One of the strongest reasons for naming an agent is to have someone who can respond flexibly as your health care situation changes and deal with situations that you did not foresee. If you add instructions to this document it may help your agent carry out your wishes, but be careful that you do not unintentionally restrict your agent's power to act in your best interest. In any event, be sure to talk with your agent about your future medical care and describe what you consider to be an acceptable "quality of life."

## **What if I Change My Mind?**

You may revoke your health care directive using any one of the following methods:

- sign a new directive that is inconsistent with your prior directive;
- cancel, deface, obliterate, burn, tear or otherwise destroy your directive, or direct another person in your presence to destroy the directive, with the intent to revoke the directive in whole or in part,
- sign a written and dated statement indicating that you wish to revoke your Directive, in whole or in part, or
- verbally express your intent to revoke your Directive, in whole or in part, in the presence of two witnesses who do not have to be present at the same time.

If you appoint your spouse or domestic partner as your health care agent, that appointment will automatically be revoked in the event proceedings are commenced for dissolution, annulment, or termination of your marriage or registered partnership, unless you specifically say otherwise in your directive in the additional instructions section on page 3.

PRINT YOUR NAME

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

PART I: 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/OR

Part II: 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.

PART I

**PART I: APPOINTMENT OF 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 know I can change my agent or alternate agent at any time and I know I do not have to appoint an agent or an alternate agent.

*Note: If you appoint an agent, you should discuss this health care directive with your agent and give your agent a copy. If you do not wish to appoint an agent, you may leave Part I blank and go to Part II.*

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:

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

PRINT THE NAME,  
RELATIONSHIP,  
ADDRESS AND  
TELEPHONE  
NUMBER OF  
YOUR AGENT

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(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.

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). 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.

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.

PRINT THE NAME, RELATIONSHIP, ADDRESS AND TELEPHONE NUMBER OF YOUR ALTERNATE AGENT

SEE THE NEXT PAGE IF YOU WANT TO LIMIT ANY OF THESE POWERS

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ADD PERSONAL INSTRUCTIONS (ONLY IF YOU WANT TO LIMIT THE POWER OF YOUR AGENT)

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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(Attach additional pages if needed.)

INITIAL THESE STATEMENTS IF YOU WANT YOUR AGENT'S POWER TO INCLUDE THESE DECISIONS

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 my body or body part(s), including organs, tissues, and eyes, when I die.

\_\_\_\_\_ (2) To decide what will happen with my body when I die (burial, cremation).

ADD OTHER INSTRUCTIONS, IF ANY, REGARDING YOUR ADVANCE CARE PLANS

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

THESE INSTRUCTIONS CAN FURTHER ADDRESS YOUR HEALTH CARE PLANS, SUCH AS YOUR WISHES REGARDING HOSPICE TREATMENT, BUT CAN ALSO ADDRESS OTHER ADVANCE PLANNING ISSUES, SUCH AS YOUR BURIAL WISHES

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ATTACH ADDITIONAL PAGES IF NEEDED

(Attach additional pages if needed.)

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PART II

**PART II: HEALTH CARE INSTRUCTIONS**

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

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: (Attach additional pages if needed.)

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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ADD PERSONAL INSTRUCTIONS, IF ANY

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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: (Attach additional pages if needed.)

*(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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ADD PERSONAL INSTRUCTIONS, IF ANY

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**MINNESOTA HEALTH CARE DIRECTIVE - PAGE 6 OF 12**

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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ADD PERSONAL  
INSTRUCTIONS,  
IF ANY

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*There are other things that I want or do not want for my health care, if possible: (Attach additional pages if needed.)*

Who I would like to be my doctor:

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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, etc.):

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ADD PERSONAL  
INSTRUCTIONS,  
IF ANY

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PART III

**Part III: Execution**

This advance health-care directive will not be valid for making health-care decisions unless it is EITHER:

(A) Signed by two witnesses. Your witnesses must be at least 18 years of age, and cannot be your health care agent or alternate health care agent. At least one of your witnesses must be someone who is not your health care provider or an employee of your health care provider. (Use Alternative 1, below, if you decide to have your signature witnessed.)

**OR**

(B) Acknowledged before a notary public in the state. Your notary public cannot be your health care agent, alternate health care agent, or your health care provider. Your notary may be an employee of your health care provider. (Use Alternative 2, below, if you decide to have your signature notarized.)

YOU MAY EITHER  
HAVE YOUR FORM  
WITNESSED OR  
NOTARIZED

**ALTERNATIVE NO. 1 (Sign with Two Witnesses)**

I am thinking clearly, I agree with everything that is written in this document, and I have made this document willingly.

My Signature: \_\_\_\_\_

My Printed Name: \_\_\_\_\_

Date signed: \_\_\_\_\_

Date of birth: \_\_\_\_\_

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.

**WITNESS ONE:**

(i) 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.

(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.

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

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

\_\_\_\_\_  
(Printed Name of Witness One) (Date)

Address: \_\_\_\_\_

\_\_\_\_\_

SIGN AND DATE YOUR DOCUMENT HERE

IF YOU CANNOT SIGN YOUR OWN DOCUMENT, YOU CAN ASK SOMEONE TO DO IT FOR YOU

WITNESS #1 MUST DATE THE DOCUMENT AND PRINT YOUR NAME HERE

HAVE THE WITNESS SIGN AND DATE AND PRINT ADDRESS HERE

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**ALTERNATIVE NO. 1 (Sign with Two Witnesses, continued)**

**WITNESS TWO:**

(i) 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.

(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) I am not a health care provider or an employee of a health care provider giving direct care to the person listed above in (i).

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

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

\_\_\_\_\_  
(Printed Name of Witness Two) (Date)

Address: \_\_\_\_\_

\_\_\_\_\_

WITNESS #2 MUST DATE THE DOCUMENT AND PRINT YOUR NAME HERE

WITNESS #2 MAY NOT BE A HEALTH CARE PROVIDER OR AN EMPLOYEE OF A HEALTH CARE PROVIDER GIVING YOU DIRECT CARE

HAVE THE WITNESS SIGN AND DATE AND PRINT ADDRESS HERE



**ALTERNATIVE NO. 2 (Sign before a Notary)**

I am thinking clearly, I agree with everything that is written in this document, and I have made this document willingly.

My Signature: \_\_\_\_\_

My Printed Name: \_\_\_\_\_

Date signed: \_\_\_\_\_

Date of birth: \_\_\_\_\_

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.

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)

SIGN AND DATE  
YOUR DOCUMENT  
HERE

IF YOU CANNOT  
SIGN YOUR OWN  
DOCUMENT, YOU  
CAN ASK SOMEONE  
TO DO IT FOR YOU

THIS PORTION  
MUST BE FILLED  
OUT BY A NOTARY  
PUBLIC

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## **You Have Filled Out Your Health Care Directive, Now What?**

1. Your Minnesota Health Care Directive is an important legal document. Keep the original signed document in a secure but accessible place. Do not put the original document in a safe deposit box or any other security box that would keep others from having access to it.
2. Give photocopies of the signed original to your agent and alternate agent, doctor(s), family, close friends, clergy, and anyone else who might become involved in your health care. If you enter a nursing home or hospital, have photocopies of your document placed in your medical records.
3. Be sure to talk to your agent(s), doctor(s), clergy, family, and friends about your wishes concerning medical treatment. Discuss your wishes with them often, particularly if your medical condition changes.
4. You may also want to save a copy of your form in an online personal health records application, program, or service that allows you to share your medical documents with your physicians, family, and others who you want to take an active role in your advance care planning.
5. If you want to make changes to your documents after they have been signed and witnessed, you must complete a new document.
6. Remember, you can always revoke your Minnesota document.
7. Be aware that your Minnesota document will not be effective in the event of a medical emergency. Ambulance and hospital emergency department personnel are required to provide cardiopulmonary resuscitation (CPR) unless they are given a separate directive that states otherwise. These directives called "prehospital medical care directives" or "do not resuscitate orders" are designed for people whose poor health gives them little chance of benefiting from CPR. These directives instruct ambulance and hospital emergency personnel not to attempt CPR if your heart or breathing should stop.

Currently not all states have laws authorizing these orders. We suggest you speak to your physician if you are interested in obtaining one. **Caring Connections does not distribute these forms.**