MINNESOTA HEALTH CARE LIVING WILL

NOTICE: This is an important legal document. Before signing this document, you should know these important facts:

(a) This document gives your health care providers or your designated proxy the power and guidance to make health care decisions according to your wishes when you are in a terminal condition and cannot do so. This document may include what kind of treatment you want or do not want and under what circumstances you want these decisions to be made. You may state where you want or do not want to receive any treatment.

(b) If you name a proxy in this document and that person agrees to serve as your proxy, that person has a duty to act consistently with your wishes. If the proxy does not know your wishes, the proxy has the duty to act in your best interests. If you do not name a proxy, your health care providers have a duty to act consistently with your instructions or tell you that they are unwilling to do so.

(c) This document will remain valid and in effect until and unless you amend or revoke it. Review this document periodically to make sure it continues to reflect your preferences. You may amend or revoke the living will at any time by notifying your health care providers.

(d) Your named proxy has the same right as you have to examine your medical records and to consent to their disclosure for purposes related to your health care or insurance unless you limit this right in this document.

(e) If there is anything in this document that you do not understand, you should ask for professional help to have it explained to you.

TO MY FAMILY, DOCTORS, AND ALL THOSE CONCERNED WITH MY CARE:

I, ____, born on _________________, being an adult of sound mind, willfully and voluntarily make this statement as a directive to be followed if I am in a terminal condition and become unable to participate in decisions regarding my health care. I understand that my health care providers are legally bound to act consistently with my wishes, within the limits of reasonable medical practice and other applicable law. I also understand that I have the right to make medical and health care decisions for myself as long as I am able to do so and to revoke this living will at any time.

(1) The following are my feelings and wishes regarding my health care (you may state the circumstances under which this living will applies): _____________________________

____

(2) I particularly want to have all appropriate health care that will help in the following ways (you may give instructions for care you do want): _____________________________

____

AMERICA LIVING WILL REGISTRY

(3) I particularly do not want the following (you may list specific treatment you do not want in certain circumstances): ____

____

(4) I particularly want to have the following kinds of life-sustaining treatment if I am diagnosed to have a terminal condition (you may list the specific types of life-sustaining treatment that you do want if you have a terminal condition): ________________________

____

(5) I particularly do not want the following kinds of life-sustaining treatment if I am diagnosed to have a terminal condition (you may list the specific types of life-sustaining treatment that you do not want if you have a terminal condition): ____________________

____

(6) I recognize that if I reject artificially administered sustenance, then I may die of dehydration or malnutrition rather than from my illness or injury. The following are my feelings and wishes regarding artificially administered sustenance should I have a terminal condition (you may indicate whether you wish to receive food and fluids given to you in some other way than by mouth if you have a terminal condition): ____________

____

(7) Thoughts I feel are relevant to my instructions. (You may, but need not, give your religious beliefs, philosophy, or other personal values that you feel are important. You may also state preferences concerning the location of your care.) ____________________

____

(8) Proxy Designation. (If you wish, you may name someone to see that your wishes are carried out, but you do not have to do this. You may also name a proxy without including specific instructions regarding your care. If you name a proxy, you should discuss your wishes with that person.)

If I become unable to communicate my instructions, I designate the following person(s) to act on my behalf consistently with my instructions, if any, as stated in this document. Unless I write instructions that limit my proxy's authority, my proxy has full power and authority to make health care decisions for me. If a guardian or conservator of the person is to be appointed for me, I nominate my proxy named in this document to act as guardian or conservator of my person.

Name: ____

Address: ____

____

Phone Number: ____

Relationship: (If any) _______________________________________

If the person I have named above refuses or is unable or unavailable to act on my behalf, or if I revoke that person's authority to act as my proxy, I authorize the following person to do so:

Name: ____

Address: ____

____

Phone Number: ____

Relationship: (If any) _______________________________________

I understand that I have the right to revoke the appointment of the persons named above to act on my behalf at any time by communicating that decision to the proxy or my health care provider.

(9) Organ Donation After Death. (If you wish, you may indicate whether you want to be an organ donor upon your death.) Initial the statement which expresses your wish:

________ In the event of my death, I would like to donate my organs. I understand that to become an organ donor, I must be declared brain dead. My organ function may be maintained artificially on a breathing machine, (i.e., artificial ventilation), so that my organs can be removed.
Limitations or special wishes: (If any) ____

____

I understand that, upon my death, my next of kin may be asked permission for donation. Therefore, it is in my best interests to inform my next of kin about my decision ahead of time and ask them to honor my request.

I (have) (have not) agreed in another document or on another form to donate some or all of my organs when I die.
________ I do not wish to become an organ donor upon my death.

DATE: ________________________________

SIGNED: ______________________________

STATE OF MINNESOTA

COUNTY OF ____________

Subscribed, sworn to, and acknowledged before me by ___________________________
on this __________ day of _________________________, 20_____.

____
NOTARY PUBLIC

OR

(Sign and date here in the presence of two adult witnesses, neither of whom is entitled to any part of your estate under a will or by operation of law, and neither of whom is your proxy.)
I certify that the declarant voluntarily signed this living will in my presence and that the declarant is personally known to me. I am not named as a proxy by the living will, and to the best of my knowledge, I am not entitled to any part of the estate of the declarant under a will or by operation of law.

Witness ________________________ Address ________________________

Witness ________________________ Address ________________________

Reminder: Register this document with America Living Will Registry. Keep the signed original with your personal papers. Give signed copies to your doctors, family, and proxy.

AMERICA LIVING WILL REGISTRY

MINNESOTA HEALTH CARE DIRECTIVE

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: 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: ____

(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.
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:

____

____

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:

____

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:
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.
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: ____
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: ____

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: ____

____

PART 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 witnesses (Option 2). 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: ____________________________

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:

(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) 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.

____
(Signature of Witness One)

Address: __________________________________

____

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) 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.

____
(Signature of Witness Two)

Address: __________________________________

____