

# The Minnesota Health Care Directive

- ◆ A Suggested Form
- ◆ Suggestions For Completing
  - Selecting a health care agent
  - Sorting out preferences and wishes

The right to control your health care decisions

**St. Luke's**  
Hospital & Regional Trauma Center

**SMDC**  
St. Mary's/Duluth Clinic  
Health System

 **Miller-Dwan  
Medical Center**

UNIVERSITY OF MINNESOTA

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S E R V I C E

## Where To Keep Copies Of Your Health Care Directive

- Give copies of your health care directive to family, friends, and health care providers so that your preferences will be known when needed. Copies of the form are valid. Copies should be placed:
  - ✓ In your medical record where you receive care. Ask your physician to make sure your health care directive is on file.
  - ✓ With health care providers (such as physicians, hospitals, home care, hospice). Start a discussion with your physician and share your preferences. Are your care providers willing and able to carry out your wishes?
  - ✓ With named health care agents and alternate agents. Help your decision makers understand their responsibilities and powers.
  - ✓ With family members and close friends. Inform those important to you that you have completed a health care directive, where it is, and who you have chosen as your decision makers.
- DO NOT keep your health care directive in a safe deposit box where it would not be available in an emergency.
- Indicate you have a health care directive on your Minnesota driver's license or other sources of identification in your wallet or billfold.

### Common Terms

**Advance Directive:** A written tool used to guide health care decisions when an individual is unable to do so because of incapacity. Most people are familiar with the terms "living will" or "Durable Power of Attorney for Health Care" as types of advance directives.

**Health Care Directive:** As of August 1, 1998, Minnesota law was changed to make it easier and less confusing to complete an advance directive. The new advance directive is called a "health care directive." It combines the general purposes of the living will and durable power of attorney for health care.

**Health care agent:** One or more persons legally authorized to make health care decisions for another who is not able to communicate.

#### **Beware! Don't Confuse A Health Care Directive With Other Estate Planning Tools!**

**A Will:** A legal document written to have control over what happens to one's property and assets when one dies. Does not involve health care decisions.

**A Power of Attorney:** A legal document in which one person gives another the authority to make specific financial decisions. Unless specifically written to do so, will not cover health care decisions.

## **Suggestions For Completing A Minnesota Health Care Directive Why Plan Ahead?**

- **Medical decision making is a patient's right.** Adults have the right to control their own medical care by consenting to or refusing medical treatment. Patients have the right to understand their health problems, potential care options, and what effect accepting or rejecting various treatments might have on their quality of life.
- **A person's right to control his or her health care decisions does not end if they become incapable.** There are times when health care decisions may need to be made when an individual is no longer able to decide or communicate his or her preferences. Adults of all ages are at risk as a result of an injury or illness.
- **Putting your wishes in writing is the best way to help make sure your wishes will be known and followed by family, friends, health care providers, and others.**
- **A Health Care Directive** is a tool which allows you to:
  - Appoint another person (called an agent) to make health care decisions for you if you become unable to make or communicate decisions for yourself (Part I), or
  - Leave written instructions so that others can make decisions based on your wishes and preferences (Part II), or
  - Do both—appoint a health care agent and leave instructions.

You are encouraged, but not required, to complete both Part I and Part II of the Health Care Directive form. Knowing who you want to make decisions for you and providing instructions to your decision makers helps reduce future questions and conflicts.

### **Part I: Naming An Agent**

#### **Review the Agent's Duties**

When naming a health care agent, select someone who is at least 18 years of age and, when possible, someone whom:

- You trust;
- Has similar beliefs and values about medical care and death or dying OR is willing to carry out your wishes even if they are different from his or her own;
- Is not easily intimidated by family members, friends, or health care providers;
- Will be an advocate for your interests;
- Can cope with making difficult life and death decisions including making decisions which would allow you to die;
- Can make decisions under stress.

## **Talk with Your Health Care Agent**

Before naming an agent or alternate agent, talk with each person to be sure he or she is willing to:

- Serve as your health care agent
- Take time to understand and talk about your wishes
- Follow your instructions or act in your best interest

## **Decide If Agents Will Act Alone or Act Together**

Act Alone. If you want the individuals you name to act alone when making health care decisions:

- Initial the first statement (page 1)
- Name your primary health care agent (page 2)
- You are encouraged to name at least two alternate agents to speak for you if the agent you name is unable, unwilling, or unavailable when needed (page 2)

Act Together. Individuals may want to name a spouse, adult children, or other family or friends to consult with each other and agree on what health care decisions should be made. If you want to name two or more individuals to act together:

- Initial the second statement (page 1)
- List the names using the spaces provided for primary agent and alternate agents (page 2). Attach additional pages if more than three individuals are named.

Keep in mind that a group of people may find it difficult to be available, to agree, or to understand or carry out a patient's preferences or wishes.

- If you appoint two or more persons as your health care agent, you need to say how you want decisions made, and offer suggestions on what should be done if there are disagreements. Additional instructions beyond the statement you checked on page 1 can be attached.

## **IF Naming A Health Care Provider. . .**

You cannot appoint a health care provider or employee of a provider giving direct care to you when you complete this form or when decisions need to be made unless:

- You are related to that person by blood, marriage, adoption, or registered domestic partnership
- You state why you want that person to serve as your health care agent (complete section on page two)

## **Powers of Agent**

- Minnesota law allows your agent to make the same types of health care decisions that you would be able to make.
- In addition, you may want to give your agent power over some related health care decisions. Initial the line in front of each statement if you want your agent to have the power explained. Your health care agent is NOT automatically given these powers.
  - ✓ Minnesota law has changed. You are now able to have your agent make decisions for you even when you are able to make and communicate your own health care decisions. You can do this if you would prefer to have someone else make your health care decisions. If you want to do this initial the appropriate box in the “additional powers of my agent” section.
  - ✓ Minnesota law assumes if you name your spouse or registered domestic partner as an agent you would NOT want that individual to continue as your health care agent if a dissolution, annulment, or termination of the relationship is in process or has been completed.
- You may limit the powers you want your agent to have. Use the space provided (page 3). You should carefully consider the effect of limiting your agent’s powers on their ability to make informed decisions regarding your care.

## **Part II: Leave Health Care Instructions**

**Why Leave Instructions? If you did not appoint an agent in Part I, you MUST leave some instructions in Part II for your health care directive to be valid.**

- Leaving instructions helps make sure decisions are based on your values, preferences, and wishes. While making health care decisions is never easy, knowing what a person does or does not want helps decision makers feel as if they are making the “right” decisions.

### **How to Leave Instructions**

DO leave instructions which help others understand your health care goals, fears, concerns, and what you want as well as do not want. It is impossible to predict what specific types of health care decisions might be needed.

You may:

- Fill in the space provided (page 3), or
- Write out your wishes on a piece of paper, or
- Use and attach the worksheet provided.

DO NOT leave instructions asking for illegal practices in Minnesota:

- Assisted suicide, mercy killing, or euthanasia
- Health care treatment that is outside of reasonable medical practice

## Completing the Instructions Worksheet

The worksheet leads you through specific questions about your health care values and preferences including:

- What is most important for others to consider
  - Feelings about specific medical treatments
  - How your religious or spiritual beliefs should influence your care
  - Your beliefs about quality and length of life
  - Wishes for care when dying
  - Your preferences regarding organ and tissue donation.
- You do not have to complete all of the questions or blanks on the worksheet. Complete only those you feel will help others understand your personal wishes.
  - Do not be surprised if you find some of the questions hard to answer at first. Take time to think about and complete the worksheet. Try out your answers by talking with family and friends. Gather more information from clergy, a religious or spiritual adviser, or health care providers until you feel comfortable with your answers. Remember that there are no right or wrong answers. What is right for someone else may not be for you.

## Part III: Making The Document Legal

- You must sign and date your health care directive. A signature can be any mark you choose (such as an “X”). If you are unable to write, the document can be signed for you by someone you ask.
- Before signing: Talk with the agent and alternate agents to make sure they are willing to serve.
- Check to make sure you have completed either Part I, Part II, or both Parts I and II.
- Have the document witnessed by a notary public or two individuals. Neither of the witnesses or the Notary Public can be named as your agent or alternate agents. Only one of the witnesses can be someone who is a direct care provider or employee of a provider on the day this form is signed.

These materials were developed by a group of professionals with expertise in law, health care, life and death health care decision making, and plain language materials development with the leadership of Marlene S. Stum, PhD, University of Minnesota Extension Service. (August, 1998)

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# Minnesota Health Care Directive

## Purpose of form

Part I. Allows you to appoint another person (called an agent) to make health care decisions if a doctor decides you are unable to do so.  
Part II. Allows you to give written instructions about what you want.  
Part III. Requires you and others to sign and date to make this legal.

## My personal information

My name: \_\_\_\_\_  
Address: \_\_\_\_\_  
\_\_\_\_\_  
Home phone: (    ) \_\_\_\_\_  
Work phone: (    ) \_\_\_\_\_  
Date of birth: \_\_\_\_\_  
Social security #: \_\_\_\_\_

- I revoke all living wills, Durable Powers of Attorney for Health Care, or other written advance health care directives I have signed in the past.

## PART 1: Naming An Agent

### Agent duties

My health care agent can:

- Make health care decisions for me if I am unable to make and communicate decisions for myself.
- Make decisions based on any instructions in Part II of this document or in other documents.
- Make decisions based on what he or she knows about my wishes.
- Act in my best interests if instructions are not available.

### Agent roles

• When naming my health care agent, I must choose one of the following. *Check the line in front of the statement you WANT.*

Act alone    \_\_\_\_\_ I appoint one person to serve as my primary health care agent to make decisions for me if I am unable to make or communicate these decisions for myself. My primary agent may act alone. If my primary agent is not able, willing, or available, each alternate agent I name may act alone, in the order listed.

Act together    \_\_\_\_\_ I appoint two or more persons to act together as my health care agent. My primary agent and alternate agents must act together and be in agreement when making decisions. If they are not all readily available, or if they disagree, a majority of the agents who are readily available may make decisions for me.

**My primary health care agent**

I appoint:  
Agent's name: \_\_\_\_\_  
Address: \_\_\_\_\_  
\_\_\_\_\_  
Home phone: (    ) \_\_\_\_\_  
Work phone: (    ) \_\_\_\_\_

**My first alternate health care agent**

Agent's name: \_\_\_\_\_  
Address: \_\_\_\_\_  
\_\_\_\_\_  
Home phone: (    ) \_\_\_\_\_  
Work phone: (    ) \_\_\_\_\_

**My second alternate health care agent**

Agent's name: \_\_\_\_\_  
Address: \_\_\_\_\_  
\_\_\_\_\_  
Home phone: (    ) \_\_\_\_\_  
Work phone: (    ) \_\_\_\_\_

**(If needed) Reasons for naming health care provider**

I have named as my agent a health care provider, or employee of a health care provider, who is currently or might be providing direct care to me when decisions are needed. That person is not related to me by blood, marriage, registered domestic partnership, or adoption. My reasons for wanting to appoint that person as my agent are: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Powers of my agent**

If I am unable to decide or speak for myself, my agent has the power to:

- Consent to, refuse, or withdraw any health care, treatment, service, or procedure
- Stop or not start health care which is keeping or might keep me alive
- Choose my health care providers
- Choose where I live when I need health care and what personal security measures are needed to keep me safe.
- Obtain copies of my medical records and allow others to see them.

**Additional powers of my agent**

*If I WANT my agent to have any of these additional powers, I must check the line in front of the statement.*

I also authorize my agent to:

- Make health care decisions for me even if I am able to decide or speak for myself.
- Carry out my wishes regarding a funeral, burial, or what will happen to my body when I die.
- Make decisions about mental health treatment including electroconvulsive therapy and antipsychotic medication, including neuroleptics.
- In the event I am pregnant, determine whether to attempt to continue my pregnancy to delivery based upon my agent's understanding of my values, preferences, or instructions.
- 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.

The above checked statements represent my wishes \_\_\_\_\_.

(Initial Here)

**Limiting the powers of my agent**

I wish to limit the powers of my health care agent in the following way(s): \_\_\_\_\_

\_\_\_\_\_

**PART II: Health Care Instructions**

- I give the following instructions about my health care (my values and beliefs, what I do and do not want, views about medical treatments or situations) \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_
- I am attaching additional instructions concerning my health care values and preferences. *Check one line:* \_\_\_\_\_ Yes \_\_\_\_\_ No
- I authorize donation of organs, tissue, or other body parts after my death. *Check one line:* \_\_\_\_\_ Yes \_\_\_\_\_ No

### PART III: Making This Document Legal

**My signature/  
mark and  
date**

I agree with everything in this document and have made this document willingly:

My signature: \_\_\_\_\_

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

(day / month / year)

### Notary Public OR Witnesses

**Notary Public**

NOTE: Must not be named as agent or alternate agent.

STATE OF MINNESOTA

County of \_\_\_\_\_

This document was signed or acknowledged before me this \_\_\_\_\_ (day)

of \_\_\_\_\_, \_\_\_\_\_ by the above named principal.  
(month) (year)

\_\_\_\_\_  
Signature of Notary Public

**Two  
Witnesses**

NOTE: Only one witness can be a direct care provider or employee of a provider on the day this is signed.

This document was signed or acknowledged in my presence. I am not an agent or alternate agent in this document.

Witness Signature: \_\_\_\_\_

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

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

(month / day / year)

Witness Signature: \_\_\_\_\_

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

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

(month / day / year)

# Health Care Instructions Worksheet

## Part II Of Minnesota Health Care Directive

### MY HEALTH CARE GOALS

Having a sense of what is important to you can help your decisionmakers make health care decisions under different and complex circumstances. Read each statement below and on a scale of “0” to “4,” rate how important each of the health care goals are to you. In this case, “4” means “Extremely Important and “0” means “Not Important At All.” Remember reasonable medical care should always include maintaining a person’s comfort, hygiene, and human dignity.

HEALTH CARE GOALS	Not Important  0	1	Somewhat Important  2	3	Extremely Important  4
<b>How Important Is Pain Control?</b>					
• Being as comfortable and free from pain as possible					
• Having pain controlled, even if my ability to think clearly is reduced					
• Having pain controlled, even if it shortens my life					
<b>How Important Is the Use of Life Prolonging Treatment When:</b>					
• I have a reasonable chance of recovering both physically and mentally (50/50+)					
• I have some physical limitations but can socially relate to those I care about					
• I can live a longer life no matter what my physical or mental health					
• I have little or no chance of doing everyday activities I enjoy					
• I am not able to socially relate to those I care about					
• I have a terminal illness and treatment will only prolong when I die					
• I have severe and permanent brain injury and there is little chance of regaining consciousness					
• I have severe dementia or confusion and my condition will only get worse					
<b>Importance of Finances and Health Care</b>					
• Having my wishes followed regardless of whether or not my finances are exhausted					
• Not being a financial burden to those around me					
• Not having my health care costs affect the financial situations of those I care about					

I also want my decisionmakers to know the following things are important to me when receiving health care: \_\_\_\_\_  
 \_\_\_\_\_

## My Medical Treatment Preferences

It is helpful for others to know if and why you have strong feelings about certain medical treatments. Some of the more difficult medical decisions are about treatments used to prolong life, such as those listed below. Most medical treatments can be tried for a while and then stopped if they do not help. Discuss these medical treatments with a health care professional to make sure you understand what they might mean for you given your current as well as future health conditions.

Medical Procedure	When It Is Used and Its Effects	My Feelings About This Procedure
Ventilator/Respirator A breathing machine	When you cannot breathe on your own  You cannot talk or eat by mouth on this machine	
Nutrition support and hydration	When you cannot eat or drink by mouth, feeding solutions can provide enough nutrition to support life indefinitely.  Feeding solutions can be put through a tube in your stomach, nose, intestine, or veins.	
Cardiopulmonary Resuscitation (CPR)	Actions to make your heart and lungs start if they stop including pounding on your chest, electric shocks, medications, and a tube in your throat.	
A Do Not Resuscitate (DNR) order	You do not want the actions of pounding on your chest, electric shocks and tube in your throat.	
Dialysis	A mechanical means of cleaning the blood when kidneys are not working.	

My feelings or concerns about other medical treatments include: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

If I am pregnant, my feelings about medical treatment would include: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

### **My Religious and Spiritual Beliefs**

Religious or spiritual beliefs and traditions influence how people feel about certain medical treatments, what quality of life means to them, and how they wish to be treated when they are dying or when they have died.

My decision makers should know the following about how my religious or spiritual beliefs should affect my health care: \_\_\_\_\_

\_\_\_\_\_

My religion/spirituality/ is: \_\_\_\_\_

My congregation/spiritual community (name, city, state): \_\_\_\_\_

\_\_\_\_\_

I wish to have my (priest/pastor/rabbi/shaman/spiritual leader) consulted. \_\_\_\_\_ Yes \_\_\_\_\_ No

If yes, the person to be contacted is: \_\_\_\_\_

### **Feelings About Quality and Length of Life**

I have the following beliefs about whether life should be preserved as long as possible: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

The following kinds of mental or physical conditions would make me think that medical treatment should no longer be used to keep me alive: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

### My Preferences for Care When Dying

If a choice is possible and reasonable when I am dying, I would prefer to receive care:

- \_\_\_\_\_ At home \_\_\_\_\_
- \_\_\_\_\_ At a hospital. Which one? \_\_\_\_\_
- \_\_\_\_\_ At a nursing home. Which one? \_\_\_\_\_
- \_\_\_\_\_ Through hospice services/care. Which one? \_\_\_\_\_
- \_\_\_\_\_ From other health care providers. Which ones? \_\_\_\_\_

Other wishes I have about my care if I am dying \_\_\_\_\_  
\_\_\_\_\_

### My Wishes About Donating Organs, Tissues, or Other Body Parts

*Initial the lines that apply to you:*

- \_\_\_\_\_ I DO wish to donate organs, tissue, or other body parts when I die
  - \_\_\_\_\_ Any needed organs, tissue, or other body parts
  - \_\_\_\_\_ Only the following listed organs, tissue, or body parts \_\_\_\_\_
  - \_\_\_\_\_

Limitations or special wishes I have include: \_\_\_\_\_  
\_\_\_\_\_

- \_\_\_\_\_ I DO NOT wish to donate organs, tissue, or other body parts when I die

### Additional Health Care Instructions

My decision makers should also know these things about me to help them make decisions about my health care:

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

I agree that these are my health care instructions and have completed this willingly.

My signature: \_\_\_\_\_

Date completed: \_\_\_\_\_  
(month / day / year)

- This worksheet is an attachment to my Health Care Directive:

*Initial one box:* \_\_\_\_\_ Yes \_\_\_\_\_ No

## HEALTH CARE DIRECTIVE PLANNING RECORD

Keep a master list of who has copies of your health care directive. It will be easier to make sure everyone is kept up-to-date if and when changes are made. Copies of my Health Care Directive have been given to:

_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

## REVIEW AND UPDATE YOUR HEALTH CARE DIRECTIVE

- You can change or revoke your Health Care Directive as long as you are able to make and communicate your own health care decisions. Your most recently dated advance directive should be followed.

MY MOST RECENT HEALTH CARE DIRECTIVE WAS COMPLETED ON \_\_\_\_\_  
(month/day/year)

- It is not uncommon for individuals to change their opinions about who they want as agent or about specific health care instructions. Review your Health Care Directive on a regular basis, especially when there are changes in:
  - ✓ Your health status
  - ✓ Your state of residence given differences in state laws
  - ✓ The availability of individuals named as health care agent or alternate agents
- If you completed an advance directive prior to August 1, 1998 (when state laws changed), review your written wishes and make sure they are still accurate/effective.

These materials were developed by a group of professionals with expertise in law, health care, life and death health care decision making, and plain language materials development with the leadership of Marlene S. Stum, PhD, University of Minnesota Extension Service (August, 1998). Users are encouraged to copy these materials keeping the content, format, and credits intact. For a master copy or to provide feedback, call 612-625-4270 or e-mail [mstum@che2.che.umn.edu](mailto:mstum@che2.che.umn.edu). The University of Minnesota is an equal opportunity educator and employer.

# Making Informed Life And Death Health Care Decisions

## Did you know...

- ◆ Minnesota advance directive laws changed as of August 1, 1998. A new planning tool, called a Health Care Directive, makes it easier and less confusing to put your wishes in writing (see inside).
- ◆ Once a health care directive is written, it can be changed or revoked as long as you have capacity.
- ◆ It is just as important for an individual who wants to initiate or continue medical treatment to leave written instructions as it is for individuals who have other preferences.
- ◆ A health care directive does not require an attorney to complete. A suggested form and suggestions for completing are included inside to help you put your wishes in writing.
- ◆ It is illegal for a health care provider to require you to complete an advance directive. Health care providers are required to tell you about advance directive laws in Minnesota and note whether or not you have an advance directive in your medical file.
- ◆ Laws regarding advance directives are not the same in all fifty states in the U.S. If you spend a great deal of time in another state, or move to another state, be sure you understand the laws.