

# MINNESOTA

## Advance Directive

### Planning for Important Healthcare Decisions

Courtesy of CaringInfo

[www.caringinfo.org](http://www.caringinfo.org)

800-658-8898

CaringInfo, a program of the National Hospice and Palliative Care Organization (NHPCO), is a national consumer engagement initiative to improve care and the experience of caregiving during serious illness and at the end of life. As part of that effort, CaringInfo provides detailed guidance for completing advance directive forms in all 50 states, the District of Columbia, and Puerto Rico.

This package includes:

- 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.

#### **BEFORE YOU BEGIN**

Check to be sure that you have the materials for each state in which you may receive healthcare. Because documents are state-specific, having a state-specific document for each state where you may spend significant time can be beneficial. A new advance directive is not necessary for ordinary travel into other states. The advance directives in this package will be legally binding only if the person completing them is a competent adult who is 18 years of age or older, or an emancipated minor.

#### **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, scan, or take a photo of the form and give it to the person you have appointed to make decisions on your behalf, your family, friends, healthcare providers, and/or faith leaders so that the form is available in the event of an emergency.

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5. You may also want to save a copy of your form in your electronic healthcare record, or 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 ADVANCE HEALTH CARE DIRECTIVE**

This packet contains a legal document, a **Minnesota Advance 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.

Your Minnesota Advance Directive has three parts. Part I, **Appointment of Health Care Agent**, lets you name someone to make decisions about your healthcare if you can no longer speak for yourself. Part II, **Health Care Instructions**, functions as your living will. Part III contains the signature and witness provisions so that your document will be effective. Depending on your advance planning needs, you may complete either or both of the first two parts. However, **you must complete Part III.**

### **How do I make my Minnesota advance health care directive legal?**

You must sign and date your advance directive or direct an adult to do so for you if you are unable to sign it yourself. Your signature must be either:

- witnessed before a notary public
- or two adult (18 years old and above) witnesses.

Your two adult witnesses cannot be the person you have appointed as an agent, if you have appointed an agent.

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

The person notarizing your healthcare directive may be an employee of a healthcare 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 healthcare 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 healthcare decisions for you.

Unless they are related to you by blood, marriage, registered domestic partnership or adoption or you say otherwise in your Directive, your agent **cannot** be:

- your supervising healthcare provider on the date you sign your directive,
- an employee of your healthcare provider on the date you sign your directive

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

### **Should I add personal instructions to my advance directive?**

Yes! One of the most important reasons to execute an advance directive is to have your voice heard. When you name an agent and clearly communicate to them what you want and don't want, they are in the strongest position to advocate for you. Because the future is unpredictable, be careful that you do not unintentionally restrict your agent's power to act in your best interest. Be especially careful with the words "always" and "never." In any event, be sure to talk with your agent and others about your future healthcare and describe what you consider to be an acceptable "quality of life."

### **When does my agent's authority become effective?**

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 healthcare decision at issue. If you are still capable of making some, but not all, healthcare decisions, your agent is only authorized 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 healthcare decisions. You retain the primary authority for your healthcare decisions as long as you are able to make your wishes known.

### **Agent Limitations**

Your agent will be bound by the current laws of Minnesota as they regard pregnancy and termination of pregnancies.

### **What if I change my mind?**

You may revoke your healthcare directive using anyone 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.

Unless you specify otherwise in the additional instructions section on page 3 of the directive, if you designate your spouse or domestic partner as your agent, that designation will automatically be revoked by divorce, annulment, or termination of your marriage or domestic partnership.

## **Mental Health Issues**

These forms do not *expressly* address mental illness, although you can state your wishes and grant authority to your agent regarding mental health issues. The National Resource Center on Psychiatric Advance Directives maintains a website (<https://nrc-pad.org/>) with links to each state's psychiatric advance directive forms. If you would like to make more detailed advance care plans regarding mental illness, you could talk to your physician and an attorney about a durable power of attorney tailored to your needs.

## **What other important facts should I know?**

Be aware that your advance directive will not be effective in the event of a medical emergency, except to identify your agent. Ambulance and hospital emergency department personnel are required to provide cardiopulmonary resuscitation (CPR) unless you have a separate physician's order, which are typically called "prehospital medical care directives" or "do not resuscitate orders." DNR forms may be obtained from your state health department or department of aging (<https://www.hhs.gov/aging/state-resources/index.html>). Another form of orders regarding CPR and other treatments are state-specific POLST (portable orders for life sustaining treatment) (<https://polst.org/form-patients/>). Both a POLST and a DNR form MUST be signed by a healthcare provider and MUST be presented to the emergency responders when they arrive. These directives instruct ambulance and hospital emergency personnel not to attempt CPR (or to stop it if it has begun) if your heart or breathing should stop.

**MINNESOTA HEALTH CARE DIRECTIVE – PAGE 1 OF 12**

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

PRINT THE NAME,

RELATIONSHIP,  
ADDRESS AND  
TELEPHONE  
NUMBER OF  
YOUR AGENT

\_\_\_\_\_ 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.

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

**MINNESOTA HEALTH CARE DIRECTIVE - PAGE 3 OF 12**

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.)

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



**MINNESOTA HEALTH CARE DIRECTIVE - PAGE 5 OF 12**

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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

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

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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

**MINNESOTA HEALTH CARE DIRECTIVE - PAGE 7 OF 12**

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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



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

**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