

*Advance Directive and Durable Power of Attorney*  
Health Care Directive

State of Minnesota

The Rest of Your Life recommends that you review completed documents with an attorney, especially if there are mitigating circumstances surrounding your Advance Directive or Durable Power of Attorney.

### **Advance Directives Electronic Forms**

The ROYL is a leader in offering electronic Advance Directive documents for digital signatures. Electronic Advance Directive Forms are secure and accessible anytime from any device that allows for Internet access.

### **Why do an Advance Directive?**

Anyone 18 years of age or older should have an Advance Directive. This document allows for the care you have designated to be respected and followed through in the event you cannot speak for yourself. It allows for you to name someone to speak on your behalf, but most importantly it removes the stress, anxiety and guilt from decisions that your loved ones would otherwise have to make on your behalf.

An Advance Directive is not just for aging people. The cases of Teri Shivo and Karen Ann Quinlan serve as examples of how any adult, regardless of age, can benefit from having one. Both young adults, Shivo and Quinlan were kept alive by machines for years because they did not tell or write down what they wanted in the event of a tragic accident. The court battles that ensued took not only an emotional toll, but required government involvement because of disagreements between spouses and family members.

### **Description:**

An Advance Directive, sometimes referred to as a Living Will or an Advance Health Care Directive, allows you to make your wishes known if you are unable to speak for yourself. An Advance Directive provides you and your loved ones with peace of mind that your care is compatible with your wishes. This is truly a gift to those you love as it helps them clearly know what to do in this stressful situation.

Advance Directive requirements vary from state to state. You can download the appropriate state form here at no cost prior to completing the form online so that you have the required information prepared in advance.

### **Security:**

Your documents are processed using DocuSign, the leader in global electronic signature and document security.

When you complete your Advance Directive with The ROYL, you can download it as a PDF file to your computer's hard drive. DocuSign will email a final copy to the designees in your Advance Directive. We recommend you print a hard copy and send it via email or mail to others you want to have copies.

Contact us if you have questions in preparing the forms selected.

**NOTICE: You must have the required information available prior to initiating the document (designees, contact information, wishes for care).**

# 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: EXAMPLE  
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. *Initial the line in front of the statement you WANT.*

           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.

           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.

Act alone

Act together

**My primary health care agent**

I appoint:  
 Agent's name: EXAMPLE  
 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 the following powers, I must initial 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.

**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. *Initial one line:* \_\_\_\_\_ Yes \_\_\_\_\_ No
- I authorize donation of organs, tissue, or other body parts after my death. *Initial 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: EXAMPLE

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

(day / month / year)

**Notary Public OR Witnesses**

**Notary Public**

STATE OF MINNESOTA

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

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**

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

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

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

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

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

(month / day / year)

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

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

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

(month / day / year)



# A letter to my loved ones...

Dear Loved Ones,

I want the best quality of life possible during my last days. Therefore, I hereby request as follows...

(a) I ask that medical treatment to alleviate pain, to provide comfort, and to mitigate suffering be provided so that I may be as free of pain and suffering as possible. Please consult with my doctor in this regard.

(b) If my temperature is above normal, I want a cool moist cloth put on my head.

(c) I want my mouth and lips kept moist.

(d) I need to be kept fresh and clean at all times. I wish to have warm baths often or warm showers, if I am stable enough for a shower.

(e) I desire to be massaged with or without warm oils as often as you think will help maintain my skin integrity and provide for my comfort.

(f) I want my personal care such as nail clipping, hair combing, teeth brushing and shaving as long as they do not cause me pain.

*I hope my family and friends would consider that...*

(a) I enjoy your company and want you with me when possible. I desire that one of you stay with me when it seems that my death may be imminent.

(b) Please continue to talk to me about daily happenings and events, even if you think I don't understand, because I might be able to understand.

(c) Please don't be afraid to hold my hand or hug me.

(d) Please tell the members of my church or synagogue I am sick and ask them to pray for me and visit me.

(e) Please maintain a cheerful atmosphere around me.

(f) Please place pictures of my loved ones in my room, near my bed, or near the place I sit during the day.

(g) My clothes and bed linens are to be kept clean, and they are to be changed as soon as possible, if they have been soiled.

(h) If at all possible, allow me to die in my home.

(i) Please arrange for me to watch television or listen to my favorite sports events.

(j) Let me enjoy the outdoors as often as possible by letting me spend time in my yard, garden and other appropriate outdoor places, even if it causes slight discomfort to either you or me.

(k) I want to have my favorite types of music played when possible.

(l) I want to have religious readings read to me when I am near death.

(m) I want to have my favorite poems read to me from time to time.

*I want you to know the following about my thoughts and concerns, if I am disabled and cannot convey these thoughts to you verbally...*

(1) I want you to know that I love you.

(2) I would like to be forgiven for the times I have hurt you.

(3) I forgive you for what you may have done to me in my life.

(4) I want you to know that I do not fear death itself.

(5) I want all of my family members to recommit their love for one another.

(6) Please remember me the way I was before I had a terminal illness.

(7) Please help me maintain meaning to my life during this process of dying by realizing that this is an opportunity for personal growth for all.

(8) Don't be afraid to seek counseling, if you have trouble with my death.

*If friends want to know how I want to be remembered, tell them the following...*

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*The following person(s) know my funeral plans...*

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*At any memorial service for me, I want to include the following music, songs, readings or other plans for such a service...*

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*I also have the following requests...*

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**In Process**

**These are requests of my family members, loved ones, and friends, and are not to be considered legal directives to my attorney-in-fact for health care, if any.**

*(If you wish to change your answer, you may do so by drawing an "X" through the answer you do not want, and circling the answer you prefer.)*

Dated this \_\_\_\_ day of \_\_\_\_\_, 20 \_\_\_\_.

Signature EXAMPLE

Print Name \_\_\_\_\_

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