The Rest Of Your Life www.theroyl.com

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.*

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: 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

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)