The Rest Of Your Life www.theroyl.com

Advance Directive and Durable Power of Attorney

Statutory Sample Living Will Declaration

State of South Dakota

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.

South Dakota does not have a statutory law describing durable power of attorney for health issues. A generic Power of Attorney for Health Issues form is attached. You should consult with your doctor and/or your attorney regarding formation of durable power of attorney for health issues.

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).

South Dakota Statutory Sample Living Will Declaration

This is an important legal document. This document directs the medical treatment you are to receive in the event you are unable to participate in your own medical decisions and you are in a terminal condition. This document may state what kind of treatment you want or do not want to receive.

This document can control whether you live or die. Prepare this document carefully. If you use this form, read it completely. You may want to seek professional help to make sure the form does what you intend and is completed without mistakes.

This document will remain valid and in effect until and unless you revoke it. Review this document periodically to make sure it continues to reflect your wishes. You may amend or revoke this document at any time by notifying your physician and other health-care providers. You should give copies of this document to your physician and your family. This form is entirely optional. If you choose to use this form, please note that the form provides signature lines for you, the two witnesses whom you have selected and a notary public.

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

I, EXAMPLE willfully and voluntarily make this declaration as a directive to be followed if I am in a terminal condition and become unable to participate in decisions regarding my medical care.

With respect to any life-sustaining treatment, I direct the following:

(Initial only one of the following optional directives if you agree. If you do not agree with any of the following directives, space is provided below for you to write your own directives).

_____ NO LIFE-SUSTAINING TREATMENT. I direct that no life-sustaining treatment be provided. If life-sustaining treatment is begun, terminate it.

_____ TREATMENT FOR RESTORATION. Provide life-sustaining treatment only if and for so long as you believe treatment offers a reasonable possibility of restoring to me the ability to think and act for myself.

_____ TREAT UNLESS PERMANENTLY UNCONSCIOUS. If you believe that I am permanently unconscious and are satisfied that this condition is irreversible, then do not provide me with life-sustaining treatment, and if life-sustaining treatment is being provided to me, terminate it. If and so long as you believe that treatment has a reasonable possibility of restoring consciousness to me, then provide life-sustaining treatment.

_____ MAXIMUM TREATMENT. Preserve my life as long as possible, but do not provide treatment that is not in accordance with accepted medical standards as then in effect.

(Artificial nutrition and hydration is food and water provided by means of a nasogastric tube or tubes inserted into the stomach, intestines, or veins. If you do not wish to receive this form of treatment, you must initial the statement below which reads: "I intend to include this treatment, among the 'life-sustaining treatment' that may be withheld or withdrawn.")

With respect to artificial nutrition and hydration, I wish to make clear that

(Initial only one)

_____ I intend to include this treatment among the "life-sustaining treatment" that may be withheld or withdrawn.

_____ I do not intend to include this treatment among the "life-sustaining treatment" that may be withheld or withdrawn.

(If you do not agree with any of the printed directives and want to write your own, or if you want to write directives in addition to the printed provisions, or if you want to express some of your other thoughts, you can do so here.)

_____

_____

_____

_____

_____

_____

Date: _____

EXAMPLE

_____

(your signature)

_____

(type or print your signature)

_____

(your address)

The declarant voluntarily signed this document in my presence.

Witness _____
Address _____

Witness _____
Address _____

On this the _____ day of _____, _____, the declarant, _____, and witnesses _____, and _____ personally appeared before the undersigned officer and signed the foregoing instrument in my presence. Dated this _____ day of _____, _____.

_____

Notary Public

My commission expires: _____.

South Dakota does not have a statutory law describing durable power of attorney for health issues. A generic Power of Attorney for Health Issues form is attached. You should consult with your doctor and/or your attorney regarding formation of durable power of attorney for health issues.

HEALTH CARE POWER OF ATTORNEY: **General form that names a Health Care Representative and grants authority to make limited health care decisions.**

HEALTH CARE POWER OF ATTORNEY

EXAMPLE

I, _____, residing at [address]; make, constitute and appoint _____, _____, residing at [address] (hereinafter referred to as my "Health Care Representative"), my true and lawful attorney-in-fact to be my Health Care Representative with respect to all health care matters, upon the terms and conditions hereinafter set forth.

1. Although I wish to live and enjoy life as long as possible, I do not wish to receive futile medical treatment, which I define as treatment that will provide little or no benefit to me and will only prolong my inevitable death or irreversible coma.

2. I desire that my wishes with respect to all health care matters be carried out through the authority given to my Health Care Representative under this Health Care Power of Attorney despite any contrary feelings, beliefs or opinions of other members of my family, relatives or friends. I have thoroughly discussed my personal preferences and desires with my Health Care Representative, and his or her successor. I am fully satisfied that each will know best what I would wish and I have the utmost faith and confidence in their respective good judgments.

3. In exercising the authority herein given to my Health Care Representative, my Health Care Representative should try to discuss with me the specifics of any proposed health care decision if I am able to communicate in any manner whatsoever, even by blinking my eyes. I hereby further direct and instruct my Health Care Representative that if I am unable to give an informed consent to my medical treatment or if the physician(s) providing me with medical care determine that I lack capacity to make a particular health care decision, my Health Care Representative shall make such health care decision for me based upon any treatment choices or other desires that I have previously expressed while competent, whether under this Health Care Power of Attorney or otherwise.

4. In order to aid my Health Care Representative in making decisions under this Health Care Power of Attorney, but in no way to limit the absolute authority and discretion granted herein to my Health Care Representative, if:

(A) Two licensed physicians who are familiar with my condition have diagnosed and noted in my medical records that I am in the terminal stage of an irreversible fatal illness, disease or condition and/or my condition is expected to result in my death within six (6) months or less regardless of what medical treatment I may receive;

(B) Two licensed physicians who are familiar with my condition have diagnosed and noted in my medical records that I am permanently unconscious. "Permanently unconscious" shall mean a medical condition that has been diagnosed in accordance with currently accepted medical standards and with reasonable medical certainty as total and irreversible loss of consciousness and capacity for interaction with the environment. The term "permanently unconscious" shall include without limitation a persistent vegetative state or irreversible coma;

(C) There have been two electroencephalograms (EEGs) which have been taken more than twenty-four (24) hours apart, and each scan indicates a flat brain wave pattern; or

(D) Two licensed physicians who are familiar with my condition have determined that my life may only be maintained by artificial means, including, but not limited to, respirators and feeding tubes, and that there is no reasonable possibility that I will ever be able to sustain my life without such artificial means; then, and in any of such events, my Health Care Representative is authorized to do any one or more of the following:

(i) To sign on my behalf any documents necessary to carry out the authorizations described below, including waivers or releases of liabilities required by any health care provider;

(ii) To give or withhold consent to any medical care or treatment, to revoke or change any consent previously given or implied by law for any medical care or treatment, and to arrange for my placement in or removal from any hospital, convalescent home or other health care institution;

(iii) To require that medical treatment that would only prolong my inevitable death or permanent unconsciousness (including by way of example, but not limited to, such treatment as cardiopulmonary resuscitation, surgery, dialysis, the use of a respirator, blood transfusion, antibiotics, antiarrhythmic and pressure drugs, or transplants) not be instituted, or if previously instituted, to require that it or they be discontinued;

(iv) To require, if I have been permanently unconscious, as defined above, for _____

(___)days or more, that procedures used to provide me with fluids and nutrition (including, by way of example only, parenteral feeding, intravenous feedings, misting, endotracheal or nasogastric tube use) not be instituted or if previously instituted, to require that they be discontinued; and

(v) To authorize the administration of pain relieving drugs, even if they may shorten my remaining life.

5. The rights and authority conferred on my Health Care Representative herein appointed shall include, but is by no means limited to, the right to receive information and reports from all treating physicians, other health care professionals, health care institutions, etc., regarding proposed health care, surgery, or any other aspect of my medical treatment; the right to receive and review my medical records and information to the same extent that I am entitled to and to disclose or consent to the disclosure of my medical records to others; to contract on my behalf for any health care related service or facility (without my Health Care Representative incurring personal financial liability for such contracts) and to hire and fire medical, social service and other support personnel responsible for my care.

6. This instrument is to be construed and interpreted as an "advance directive for health care" as such term is defined in [state statute] (hereinafter the "Act") In determining the rights of my Health Care Representative herein appointed, the enumeration of the specific items, rights, acts or powers set forth herein is not intended to nor does it limit, and it is not to be construed or interpreted as limiting, the specific power of my Health Care Representative to do and perform any and all acts with respect to my health care which I would be able to perform if I were competent and able to do so and as are within the bounds of authority granted by the Act.

7. In the event _____, _____, shall become unable to act as my Health Care Representative hereunder for any reason whatsoever, including, but not limited to, death, incapacity, or resignation, then I do hereby make, constitute and appoint _____ as successor Health Care Representative to serve in the place of the Health Care Representative first above named.

8. No person who relies in good faith upon any representations by my Health Care Representative or any successor Health Care Representative shall be liable to me, my estate, my heirs or my assigns, for recognizing the Health Care Representative's authority. The directions of my Health Care Representative shall be binding in all respects upon all those involved in my care. My Health Care Representative and all those acting upon his or her directions shall be entitled to indemnification from my estate in connection with all claims asserted against them, unless the directions given and relied on are wholly inconsistent with my intentions as expressed above.

9. If a guardian of my person should for any reason be appointed, I hereby nominate my Health Care Representative (or his or her successor), named above.

10. ADMINISTRATIVE PROVISIONS.

(A) I hereby revoke any prior Health Care Power of Attorney.

(B) This Health Care Power of Attorney is intended to be valid in any jurisdiction in which it is presented.

(C) My Health Care Representative shall not be entitled to compensation for services performed under this Health Care Power of Attorney, but he or she shall be entitled to reimbursement for all reasonable expenses incurred as a result of carrying out any provisions of this Health Care Power of Attorney.

(D) In the event of any disagreement between my Health Care Representative and my attending physician concerning my decision-making capacity or the appropriate interpretation and application of the terms of this Health Care Power of Attorney to my course of treatment, it is my wish and desire that such disagreement be resolved in accordance with the written direction of my Health Care Representative.

(E) The powers delegated under this Health Care Power of Attorney are separate, so that the invalidity of any one (1) or more powers shall not affect any others.

11. By this instrument, I intend to create a durable power of attorney effective upon and only during any period of incapacity in which, in the opinion of (i) my Health Care Representative and (ii) one or more other confirming physicians, I lack capacity to make a particular health care decision (i.e. "Period of Incapacity"). The rights, powers and authority of my Health Care Representative herein appointed shall commence and shall be in full force and effect upon any such determination as to the commencement of a Period of Incapacity, and such rights, powers and authority shall remain in full force and effect from the abovementioned date until such time as I have regained my capacity to make such health care decision(s) or until my death, as the case may be; PROVIDED, HOWEVER, that this Health Care Power of Attorney may be revoked by me by a written instrument duly acknowledged before a notary public or by such other manner as shall be allowed under the Act; and PROVIDED, FURTHER, that my regaining capacity following any Period of Incapacity shall not be treated as an event causing the revocation of this Health Care Power of

Attorney and this Health Care Power of Attorney shall be construed as if such Period of Incapacity never occurred.

I UNDERSTAND THE PURPOSE AND EFFECT OF THIS HEALTH CARE POWER OF ATTORNEY AND SIGN IT AFTER CAREFUL DELIBERATION THIS _____ DAY OF _____, 2____.

EXAMPLE

_____

(Signature.)

Each of the undersigned declares that the person who signed this Health Care Power of Attorney did so in the presence of the undersigned; that said person is personally known to the undersigned and appears to be of sound mind and acting willingly and free from duress or undue influence; and that each of the undersigned and the person executing this Health Care Power of Attorney is 18 years of age or older; and the undersigned is not designated as the person's Health Care Representative under this Health Care Power of Attorney.

_____ residing at _____ residing at

_____ _____

_____ _____

STATE OF)

) SS:

COUNTY OF)

I hereby certify that on [date] _____ personally came before me and acknowledged under oath, to my satisfaction, that [he/she] is the person named in and personally signed this Health Care Power of Attorney, and that [he/she] signed, sealed and delivered this Health Care Power of Attorney as [his/her] act and deed for the uses and purposes therein expressed.

_____

(Signature.)

Additional Pages: