Advance Directive Short Form

SANFORD HEALTH

Completion Directions

Do I Have to Complete This Advance Directive?

No. You may complete it today or at a later date, or you can decline to complete it. However, completing this form will help make sure you get the care you want. Putting your choices in writing helps loved ones know if they're doing what you would want.

What Information Am I Being Asked For?

Question 1: This question is about your health care "agent." An agent is also known as Healthcare Power of Attorney. Your agent is someone you choose to speak and make health care decisions for you if you cannot. Consider naming a family member or friend who knows you well and understands your values. Showing your agent this document and talking about it with him or her is important. Make extra copies to share with your health care agent, health care providers, and other important people in your life.

Question 2 (Optional): This question is about health care and other wishes you may have. You may be as specific or general as you like. You may include:

- Your goals, values, and preferences about medical care
- The types of medical treatment you would want or not want
- How you want your agent or agents to decide
- Where you would like to receive care (such as at home or a hospital)
- Whether or not you would like to donate your organs, tissues, and eyes

Requirements for Witnesses by State

Iowa: Notary or 2 adult witnesses are required. A witness cannot be: (1) a provider attending the principal on the date this document is signed; (2) an employee of the provider attending the principal on the date this document is signed; (3) the Health Care Agent named in this document; and (4) at least one witness cannot be related to the principal by blood, marriage, or adoption within the third degree of relation.

Minnesota: Notary or 2 adult witnesses are required. A witness cannot be the health care agent or alternate health care agent. Of the two witnesses, only one can be a health care provider or an employee of a provider giving direct care on the date the document is signed.

North Dakota: Notary or 2 adult witnesses are required. A witness cannot be: (1) the Health Care Agent; (2) the principal's spouse or heir; (3) a person related to the principal by blood, marriage, or adoption; (4) a person entitled to any part of the Estate of the principal upon the death of the principal under a will or deed; (5) any other person who has any claims against the Estate of the principal; (6) a person directly financially responsible for the principal's medical care; or (7) the principal's attending physician. In addition, at least one witness may not be a health care or long term care provider providing direct care to the principal on the date this document is signed or an employee of a health care or long term care provider providing direct care to the principal on the date this document is signed.

South Dakota: Notary or 2 adult witnesses are required. A witness cannot be: (1) related to the signer by blood, marriage, or adoption; or (2) be a creditor of the signer nor entitled to any part of the signer's estate under a will now existing or by operation of law. What should I do after I complete this form? Tell the people you named as your primary and alternate health care agents, if you have not already done so. Make sure they feel able to do this important job for you in the future. Give a copy of the completed form to your health care provider. Keep additional copies for your records and to share with your health care agents and family or others as you wish. Who can I talk with if I have questions? Your health care provider can answer your questions or concerns. He or she may refer you to an Advance Care Planning Facilitator for help.

What Should I Do After I Complete This Form?

Tell the people you named as your primary and alternate health care agents, if you have not already done so. Make sure they feel able to do this important job for you in the future. Give a copy of the completed form to your health care provider. Keep additional copies for your records and to share with your health care agents and family or others as you wish.

Who Can I Talk With if I Have Questions?

Your health care provider can answer your questions or concerns. He or she may refer you to an Advance Care Planning Facilitator for help.

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Advance Care Plan Short Form

I have completed this Advance Directive with much thought. This document gives my treatment choices and preferences, and/or appoints a Health Care Agent to speak for me if I cannot communicate or make my own health care decisions. I understand I may complete: 1) both Sections 1 and 2 below; or 2) only Section 1; or 3) only Section 2.

Full Name: _____ Date of birth: _____

1. I appoint the following person to serve as my primary (main) health care agent. An agent is also known as a power of attorney. This person will make health care decisions for me if I cannot communicate or make these decisions myself:

Name _____ Relationship _____

Cell phone _____ Other phone _____

(Optional): I appoint the following person as my alternate health care agent in the event my primary health care agent is not available:

Name _____ Relationship _____

Cell phone _____ Other phone _____

2. I give the following instructions about my health care (my values and beliefs, what I do and do not want, views about specific medical treatments or situations including whether or not I wish to receive artificial nutrition and hydration):

_____

_____

_____

_____

_____

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_____

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2A. If I live in South Dakota I give the following instructions about the use of artificial nutrition and hydration (such as tube feedings or IV (intravenous) fluids). If I can no longer make decisions for myself, and my health care team and agent believe I will not recover my ability to know who I am, I want (initial one):

☐ to stop or withhold all artificial nutrition and hydration.

Or

☐ to continue artificial nutrition and hydration until my health care team and agent agree such treatments are harmful or no longer helpful.

Signature _____ Date _____ Time _____

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Note: Two witnesses or a notary public must verify your signature and the date.
[See individual state requirements on p1.]

Option 1: Notary Public

State of _____ County of _____

In my presence on _____(date), _____(name) acknowledged his or her signature on this document, or acknowledged that he or she authorized the person signing this document to sign on his or her behalf.

Signature of Notary _____ **Notary Seal** _____

My commission expires: _____

Or

Option 2: Statement of Witnesses

Witness 1: In my presence on _____(date), _____(name) voluntarily signed this document (or authorized the person signing this document to sign on his or her behalf).

Signature_____ Date_____ Time_____

Printed Name_____

Witness 2: In my presence on _____(date), _____(name) voluntarily signed this document (or authorized the person signing this document to sign on his or her behalf).

Signature_____ Date_____ Time_____

Printed Name_____