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Legal Forms & Services

FirstName LastName

MINNESOTA HEALTH CARE DIRECTIVE & LIVING WILL

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The answers you provide in the questionnaire are incorporated in this document at your direction. The form was developed by attorneys based on the laws of your state. You are responsible for finalizing the document and having it reviewed by an attorney.

Finalizing a Health Care Directive & Living Will in Minnesota

After printing your document, you will need to finalize it. Below are the steps:

Option 1: Witnesses Only

1. Print out your document
2. Review, initial, sign, and date in front of two witnesses
3. Have witnesses sign and date
4. Keep document in a safe place

Option 2: Notary Only

1. Print out your document
2. Review, initial, sign, and date in front of a notary
3. Have notary sign and date
4. Keep document in a safe place

Notice: Some state laws require the principal to initial next to the instructions they have provided in order for that instruction to be effective. Review the state laws applicable to health care directives and living wills, review the document carefully, and initial where required by law.

Some state laws prohibit the designation of certain people as a health care agent. To avoid that result, you should review your state laws applicable to who can and cannot be a health care agent.

Some state laws prohibit certain people from being witnesses to a health care directive and living will. Review your state's laws on witness requirements for health care directives and living wills.

HEALTH CARE DIRECTIVE & LIVING WILL

for

FirstName LastName

I, FirstName LastName, 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/her/them 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: 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

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:

Name: FirstName LastName

Relationship of my health care agent to me: Spouse
Telephone number of my health care agent: 555-555-5555
Address of my health care agent: 111 Street Address, City, Minnesota 12345
to make health care decisions for me. This person is called my health care agent.

(OPTIONAL) APPOINTMENT OF ALTERNATE HEALTH CARE AGENT:

If my health care agent is not reasonably available, I trust and appoint:

Name: FirstName LastName

Relationship of my alternate health care agent to me: Son
Telephone number of my alternate health care agent: 555-555-5555
Address of my alternate health care agent: 222 Street Address, City, Minnesota 12345
to be my agent instead.

THIS IS WHAT I WANT MY HEALTH CARE AGENT TO BE ABLE TO DO IF I AM UNABLE TO DECIDE OR SPEAK FOR MYSELF

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.

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:

I do not wish to limit any power in (A) through (D).

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 any parts of my body, including organs, tissues, and eyes, when I die.

_____☑ (2) To decide what will happen with my body when I die (burial, cremation).

If I want to say anything more about my health care agent's powers or limits on the powers, I can say it here:

I choose not to say anything more about my health care agent’s powers or limits on the powers.

If either of the above options are initialed, then my agent may execute all documents and take all actions necessary, appropriate, incidental to, or convenient in exercising the powers granted. Unless revoked by me in writing, the authority granted in this subsection shall take effect upon and survive my death.

If Option 2 is initialed, then my health care agent shall be entitled to be reimbursed for any reasonable expenses advanced in the course of exercising the powers granted. Unless revoked by me in writing, the authority granted in this subsection shall take effect upon and survive my death.

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 want you to know these things about me to help you make decisions about my health care:

My goals for my health care: I do not wish to state my goals at this time.

My fears about my health care: I do not wish to state my fears at this time.

My spiritual or religious beliefs and traditions: I do not wish to state my spiritual or religious beliefs at this time.

My beliefs about when life would be no longer worth living: I do not wish to state my beliefs about when life would no longer be worth living at this time.

My thoughts about how my medical condition might affect my family: I do not wish to state my thoughts about how my medical condition might affect my family at this time.

THIS IS WHAT I WANT AND DO NOT WANT FOR MY HEALTH CARE

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:

(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: I do not wish to state instructions at this time.

If I were dying and unable to decide or speak for myself, I would want: I do not wish to state instructions at this time.

If I were permanently unconscious and unable to decide or speak for myself, I would want: I do not wish to state instructions at this time.

If I were completely dependent on others for my care and unable to decide or speak for myself, I would want: I do not wish to state instructions at this time.

In all circumstances, my doctors or advanced practice registered nurses 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: I do not wish to state how I feel about pain relief at this time.

There are other things that I want or do not want for my health care, if possible: I do not wish to state other things at this time.

Who I would like to be my doctor or advanced practice registered nurse: I do not wish to name my doctor or advanced practice registered nurse at this time.

Where I would like to live to receive health care: I do not wish to state instructions at this time.

Where I would like to die and other wishes I have about dying: I do not wish to state instructions at this time.

My wishes about donating parts of my body when I die: I do not wish to state instructions at this time.

My wishes about what happens to my body when I die (cremation, burial): I do not wish to state instructions at this time.

Any other things: I do not wish to state any other things at this time.

PART III: MAKING THE DOCUMENT LEGAL

This document must be signed by me. It also must either be verified by a notary public (Option 1) OR witnessed by two witnesses (Option 2). It must be dated when it is verified or witnessed.

I am thinking clearly, I agree with everything that is written in this document, and I have made this document willingly.

My Signature: _____

Date signed: _____

Date of birth: 05/01/2023

Address: 111 Street Address, City, Minnesota 12345

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:_____

Option 1: Notary Public

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

I am not named as a health care agent or alternate health care agent in this document.

_____

(Notary Public)

Option 2: Two Witnesses

Two witnesses must sign. Only one of the two witnesses can be a health care provider or an employee of a health care provider giving direct care to me on the day I sign this document.

Witness One:

(i) In my presence on _____ (date), FirstName LastName (name) acknowledged his/her/their signature on this document or acknowledged that he/she/they authorized the person signing this document to sign on his/her/their 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) If I am a health care provider or an employee of a health care provider giving direct care to the person listed above in (A), I must initial on this line _____

I certify that the information in (i) through (iv) is true and correct.

Witness One Signature:_____

Address: _____

Witness Two:

(i) In my presence on _____ (date), FirstName LastName (name) acknowledged his/her/their signature on this document or acknowledged that he/she/they authorized the person signing this document to sign on his/her/their 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) If I am a health care provider or an employee of a health care provider giving direct care to the person listed above in (A), I must initial on this line:_____

I certify that the information in (i) through (iv) is true and correct.

Witness Two Signature: _____

Address:_____

REMINDER: Keep this document with your personal papers in a safe place (not in a safe deposit box). Give signed copies to your doctors or advanced practice registered nurses, family, close friends, health care agent, and alternate health care agent. Make sure your doctor or advanced practice registered nurse is willing to follow your wishes. This document should be part of your medical record at your physician's or advanced practice registered nurse's office and at the hospital, home care agency, hospice, or nursing facility where you receive your care.