



# Minnesota Advance Health Care Directive

*The right to make your own health care treatment decisions*

**Important notice to medical personnel**

I have an Advance Health Care Directive.

In case of emergency, please consult this document  
or contact my health care agent.

My health care agent is: \_\_\_\_\_

address: \_\_\_\_\_

phone: \_\_\_\_\_

My document is located: \_\_\_\_\_

\_\_\_\_\_

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\_\_\_\_\_

## Minnesota Advance Health Care Directive wallet cards

1. Tear off card.
2. Fill it out.
3. Keep it with you.

# CALL (651) 662-5545 or 1-800-711-9862

Attention. If you want free help translating this information, call the above number.

ملاحظة: إذا أردت مساعدة مجانية في ترجمة هذه المعلومات، فاتصل على الرقم الموجود أعلاه.

អំណាចសំគាល់ បើអ្នកចង់បានជំនួយបកប្រែឥតមានថវិកាដោយមិនគិតថ្លៃ សូមទូរស័ព្ទ ទៅលេខនៅខាងលើ។

Pažnja. Ako vam je potrebna besplatna pomoć za prevod ove informacije, nazovite gornji broj.

Ceeb toom. Yog koj xav tau kev pab txhais cov xov no dawb, thov hu rau tus xov tooj saud.

ໂປຼດຊາບ. ຖ້າຫາກທ່ານຕ້ອງການ ການຊ່ວຍເຫຼືອ ໃນການແປ ອ້ອວາມດັ່ງກ່າວນີ້ຟຣີ,

ຈົ່ງໂທ ຕາມເລກໂທ ທີ່ຢູ່ຂ້າງເທິງນີ້.

Hubaddhu. Yoo akka odeeffannoon kun sii hiikamu gargaarsa tolaa feeta ta'e, lakkoofsa armaa olii bilbili.

Внимание. Если вам нужна бесплатная помощь в переводе этой информации, позвоните по указанному выше телефону.

Ogow. Haddii aad dooneyso in lagaa kaalmeeyo tarjama dda macluumaadkani oo lacag la'aan ah, wac lambarka kore.

Atención. Si desea recibir asistencia gratuita para traducir esta información, llame al número que aparece más arriba.

Chú Ý. Nếu quý vị cần dịch thông tin này miễn phí, xin gọi số nêu trên.

This information is available in other forms to people with disabilities by calling Blue Plus customer service at (651) 662-5545, toll free 1-800-711-9862 (voice), or (651) 662-8700 or 1-888-878-0137 (TDD), or 711, or through the Minnesota Relay Service at 1-877-627-3848 (speech-to-speech relay service).

# Minnesota Advance Health Care Directive

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*This form helps you tell someone, or write down for yourself, how you want to be treated if you get very sick.*

If you fill out this form, you have met the Minnesota state legal requirements for it to be honored. The health care directive replaces the living will and durable power of attorney for health care.

You do not need to get help from a lawyer to fill out this form.

It is your choice to fill out this form. Even if you don't have a form, doctors will still treat you.

You can cancel or change this form at any time by making a new one.

***This form has 3 parts. It lets you:***

**Part 1: Choose and write down the name of a health care agent.**

A health care agent is a person who can make medical decisions for you if you choose not to, or are too sick to make them yourself.

**Part 2: Make your own health care choices.**

This form lets you choose the kind of health care you want. This way, those who care for you will not have to guess what you want if you are too sick to tell them yourself.

**Part 3: Sign and date the form.**

Before it can be used, the form must be signed and dated by you and two witnesses or a notary.

- **You can fill out part 1, part 2 or both.**
- **Fill out only the parts you want.**
- **Always sign the form in part 3.**

# Minnesota Advance Health Care Directive

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## What do I do with the form after I fill it out?

Share the form with those who care for you:

- doctors
- nurses
- social workers
- family
- friends

## What if I change my mind?

- Change the form.
- Tell those who care for you about your changes.
- Re-sign the document in front of two witnesses or a notary.

## What if I have questions about the form?

- Bring it to your doctors, nurses, social workers, family or friends to answer your questions.

## What if I want to make health care choices that are not on this form?

- Page 9 has space for you to write other choices.
- Or you can write your choices on a piece of paper and sign it in front of two witnesses or a notary. Keep the paper with this form.
- Share your choices with those who care for you.

➤ **If you only want a health care agent, go to part 1.**

➤ **If you only want to make your own health care choices, go to part 2.**

➤ **If you want both, then fill out part 1 and part 2.**

➤ **Always sign the form in part 3.**

# Part 1: Choose your health care agent

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A health care agent is a person who can make medical decisions for you if you are too sick to make them yourself.

## **Whom should I choose to be my health care agent?**

A family member or friend who:

- is at least 18 years old
- knows you well
- can be there for you when you need him or her
- you trust to do what is best for you
- can tell your doctors about the decisions you made on this form

You can choose to have one or more people act together as your health care agent. It is up to you to decide. However, your agent cannot be your doctor or someone who works at your hospital or clinic, unless you explain in writing why you want this person to be your agent.

## **What will happen if I do not choose a health care agent?**

If you are too sick to make your own decisions and you do not have an agent, your doctors will ask your closest family members to make decisions for you. This is why it is important to name the person you want to be your health care agent.

## **What kind of decisions can my health care agent make?**

Your health care agent can agree to, say no to, change, stop or choose:

- doctors, nurses, social workers
- hospitals or clinics
- medications, tests or treatments
- what happens to your body and organs after you die

# Part 1: Choose your health care agent

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*Other decisions your agent can make:*

## **Life-support treatments**

Medical care to try to help you live longer

- **CPR or cardiopulmonary resuscitation**  
cardio (heart ), pulmonary (lungs), resuscitation (to bring back)  
CPR may involve:
  - pressing hard on your chest to keep your blood pumping
  - electrical shocks to jumpstart your heart
  - medicines in your veins
- **Breathing machine or ventilator**  
The machine pumps air into your lungs and breathes for you. You are not able to talk when you are on the machine.
- **Dialysis**  
A machine that cleans your blood if your kidneys stop working
- **Feeding tube**  
A tube used to feed you if you cannot swallow. The tube is placed down your throat into your stomach. It can also be placed by surgery.
- **Intravenous fluids**  
Puts fluid into your veins so you can stay fed and hydrated
- **Blood transfusions**  
Puts blood into your veins
- **Surgery**
- **Medicines**  
Such as antibiotics

## **End-of-life care**

If you might die soon, your health care agent can:

- call in a spiritual leader such as a priest, minister or rabbi
- decide where you are cared for (examples: home or hospital)

☛ **Show your health care agent this form.**

☛ **Tell your agent what kind of medical care you want.**



# Part 2: Make your own health care choices

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*Write down your choices so those who care for you will not have to guess.*

*Think about what makes your life worth living. Put an 'X' in the box next to all the sentences you most agree with.*

**My life would not be worth living if I could not:**

- talk to family or friends
- wake up from a coma
- feed, bathe, or take care of myself
- be free from pain
- live without being hooked up to machines
- I am not sure

**My life is always worth living no matter how sick I am**

*If I am dying, I would like to be:*

- at home
- in the hospital
- I am not sure

What I want people to know about my religion or spirituality: \_\_\_\_\_

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# Part 2: Make your own health care choices

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Life-support treatments are used to try to keep you alive. These can be CPR, a breathing machine, feeding tube, dialysis, blood transfusions or medicine.

*Put an 'X' in the box next to the sentences you most agree with.*

*Please read this whole page before you make your choices.*

**If I am so sick that I may die soon:**

- Try all life-support treatments that my doctors think might help. If the treatments do not work and there is little hope of getting better, I want to stay on life-support machines.
- Try all life-support treatments that my doctors think might help. If the treatments do not work and there is little hope of getting better, I do not want to stay on life-support machines.
- Try all life-support treatments that my doctors think might help, but not these treatments. (Mark what you do not want.)

- CPR       feeding tube       dialysis       blood transfusion
  - medicine    fluids               breathing machine
  - other treatments (list) \_\_\_\_\_
- 

- I do not want any life-support treatments.
  - I want my health care agent to decide for me.
  - I am not sure.
  - Other things I'd like to have or not have (write them below)
- 
-

## Part 2: Make your own health care choices

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*Your doctors may ask about organ donation after you die. Donating (giving) your organs can help save lives.*

*Please tell us your wishes.*

*Put an 'X' in the box next to the sentences you most agree with.*

Yes, I want to donate my organs.

any organs

only \_\_\_\_\_

No, I do not want to donate my organs.

I want my health care agent to decide.

I am not sure.

**What my doctors should know about how I want my body to be treated after I die:**

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**➤ To sign this form, go to part 3.**



## Part 3: Sign the form

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### *Instructions*

Before this form can be used, you must:

- sign this form in front of two witnesses or a notary, and
- have two witnesses or a notary sign the form.

**Witnesses need to sign their names on page 11.**

**Your witnesses must:**

- be over 18 years of age
- know you
- see you sign this form.

**Your witnesses cannot:**

- be your health care agent
- benefit financially (get any money) after your death
- both be your direct care providers (only one of the witnesses can be your direct care provider).

If you do not have witnesses, you need a notary public. A notary public's job is to make sure it is you signing the form.

Take this form to a notary public and have them sign on page 12.

## Part 3: Sign the form

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*Sign your name and write the date.*

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sign your name \_\_\_\_\_ date \_\_\_\_\_

---

print your first name \_\_\_\_\_ print your last name \_\_\_\_\_

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address \_\_\_\_\_ city \_\_\_\_\_ state \_\_\_\_\_ ZIP code \_\_\_\_\_

*Have your witnesses sign their names and write the date.*

### **Witness #1**

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sign name \_\_\_\_\_ date \_\_\_\_\_

---

print first name \_\_\_\_\_ print last name \_\_\_\_\_

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address \_\_\_\_\_ city \_\_\_\_\_ state \_\_\_\_\_ ZIP code \_\_\_\_\_

### **Witness #2**

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sign name \_\_\_\_\_ date \_\_\_\_\_

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print first name \_\_\_\_\_ print last name \_\_\_\_\_

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address \_\_\_\_\_ city \_\_\_\_\_ state \_\_\_\_\_ ZIP code \_\_\_\_\_

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*You are now done with this form.*

**Give copies of this form to your doctors, nurses, social workers, friends, family and health care agent(s). Talk with them about your choices.**

**Keep the original form in a safe place. Do not put the completed form in a safe deposit box. Make sure it is easy to find.**

# Part 3: Sign the form

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## Notary Public

*Take this form and your photo identification (driver's license, passport, etc.) to a notary public if two witnesses have not signed this form.*

*Sign your name and write the date.*

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sign your name \_\_\_\_\_ date \_\_\_\_\_

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print your first name \_\_\_\_\_ print your last name \_\_\_\_\_

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address \_\_\_\_\_ city \_\_\_\_\_ state \_\_\_\_\_ ZIP code \_\_\_\_\_

## Certificate of Acknowledgement of Notary Public

### State of Minnesota

In my presence on this \_\_\_\_\_ day of \_\_\_\_\_ in the year \_\_\_\_\_

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print name of person completing this form \_\_\_\_\_

acknowledged his/her signature on this document or acknowledged that he/she authorized the person signing this document to sign on his/her behalf. I am not named as a health care agent or alternate health care agent in this document.

### Notary Seal

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Signature \_\_\_\_\_ Date \_\_\_\_\_

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My primary care physician is: \_\_\_\_\_

address: \_\_\_\_\_

phone : \_\_\_\_\_

My primary care physician is: \_\_\_\_\_

address: \_\_\_\_\_

phone : \_\_\_\_\_



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