South Country
HEALTH ALLIANCE

Health Care Directive

Informing others about your wishes for your health care

Minnesota law allows you to inform others of your health care wishes. You have the right to state your wishes or appoint an agent in writing so that others will know what you want if you can't tell them because of illness or injury.

Information in this booklet tells about health care directives and how to prepare them. Please note the content of this document does not give every detail of the law.

1-866-567-7242, TTY 1-800-627-3529 or 711

Attention. If you need free help interpreting this document, call the above number.

ያስተውሉ፡ ካለምንም ክፍያ ይህንን ዶኩመንት የሚተረጉምሎ አስተርጓሚ ከፈለጉ ከላይ ወደተጻፈው የስልክ ቁጥር ይደውሉ።

ملاحظة: إذا أردت مساعدة مجانية لترجمة هذه الوثيقة، اتصل على الرقم أعلاه.

သတိ။ ဤစာရွက်စာတမ်းအားအခမဲ့ဘာသာပြန်ပေးခြင်း အကူအညီလိုအပ်ပါက၊ အထက်ပါဖုန်းနံပါတ်ကိုခေါ်ဆိုပါ။

កំណត់សំគាល់ ។ បើអ្នកត្រូវការជំនួយក្នុងការបកប្រែឯកសារនេះដោយឥតគិតថ្លៃ សូមហៅទូរស័ព្ទតាមលេខខាងលើ ។

請注意，如果您需要免費協助傳譯這份文件，請撥打上面的電話號碼。

Attention. Si vous avez besoin d’une aide gratuite pour interpréter le présent document, veuillez appeler au numéro ci-dessus.

Thov ua twb zoo nyeem. Yog hais tias koj xav tau kev pab txhais lus rau tsab ntaub ntawv no pub dawb, ces hu rau tus najnpawb xov tooj saum toj no.

ဟ်သူဉ်ဟ်သးဘဉ်တကွ၊်. ဖဲနမ့၊်လိဉ်ဘဉ်တ၊်မၤစၢၤကလီလၢတ၊်ကကျိးထံဝဲဒဉ်လံာ် တီလံာ်မီတခါအံၤန့ဉ်,ကိးဘဉ်လိတဲစီနီ၊်ဂ်၊်လၢထးအံၤန့ဉ်တကွ၊်.

알려드립니다. 이 문서에 대한 이해를 돕기 위해 무료로 제공되는 도움을 받으시려면 위의 전화번호로 연락하십시오.

ໂປຣດຊາບ. ຖ້າຫາກ ທ່ານຕ້ອງການການຊ່ວຍເຫຼືອໃນການແປເອກະສານນີ້ຟຣີ, ຈົ່ງ ໂທຣໄປທີ່ໝາຍເລກຂ້າງເທິງນີ້.

Hubachiisa. Dokumentiin kun tola akka siif hiikamu gargaarsa hoo feete, lakkoobsa gubbatti kenname bilbili.

Внимание: если вам нужна бесплатная помощь в устном переводе данного документа, позвоните по указанному выше телефону.

Digniin. Haddii aad u baahantahay caawimaad lacag-la’aan ah ee tarjumaadda (afcelinta) qoraalkan, lambarka kore wac.

Atención. Si desea recibir asistencia gratuita para interpretar este documento, llame al número indicado arriba.

Chú ý. Nếu quý vị cần được giúp đỡ dịch tài liệu này miễn phí, xin gọi số bên trên.

Civil Rights Notice

Discrimination is against the law. South Country Health Alliance (South Country) does not discriminate on the basis of any of the following:

- race
- color
- national origin
- creed
- religion
- sexual orientation
- public assistance status
- age
- disability (including physical or mental impairment)
- sex (including sex stereotypes and gender identity)
- marital status
- political beliefs
- medical condition
- health status
- receipt of health care services
- claims experience
- medical history
- genetic information

Auxiliary Aids and Services: South Country provides auxiliary aids and services, like qualified interpreters or information in accessible formats, free of charge and in a timely manner to ensure an equal opportunity to participate in our health care programs. **Contact** South Country Member Services at members@mnscha.org or call 1-866-567-7242 (toll free), TTY 1-800-627-3529 or 711.

Language Assistance Services: South Country provides translated documents and spoken language interpreting, free of charge and in a timely manner, when language assistance services are necessary to ensure limited English speakers have meaningful access to our information and services. **Contact** South Country Member Services at members@mnscha.org or call 1-866-567-7242 (toll free), TTY 1-800-627-3529 or 711.

Civil Rights Complaints

You have the right to file a discrimination complaint if you believe you were treated in a discriminatory way by South Country. You may contact any of the following four agencies directly to file a discrimination complaint.

U.S. Department of Health and Human Services' Office for Civil Rights (OCR)
You have the right to file a complaint with the OCR, a federal agency, if you believe you have been discriminated against because of any of the following:

- race
- color
- national origin
- age
- disability
- sex
- religion (in some cases)

Contact the **OCR** directly to file a complaint:

U.S. Department of Health and Human Services' Office for Civil Rights
200 Independence Avenue SW
Room 515F
HHH Building
Washington, DC 20201
Customer Response Center: Toll-free: 800-368-1019
TDD 800-537-7697
Email: ocrmail@hhs.gov

Minnesota Department of Human Rights (MDHR)
In Minnesota, you have the right to file a complaint with the MDHR if you believe you have been discriminated against because of any of the following:

- race
- color
- national origin
- religion
- creed
- sex
- sexual orientation
- marital status
- public assistance status
- disability

Contact the **MDHR** directly to file a complaint:

Minnesota Department of Human Rights
540 Fairview Avenue North, Suite 201
St. Paul, MN 55104
651-539-1100 (voice)
800-657-3704 (toll free)
711 or 800-627-3529 (MN Relay)
651-296-9042 (fax)
Info.MDHR@state.mn.us (email)

Minnesota Department of Human Services (DHS)
You have the right to file a complaint with DHS if you believe you have been discriminated against in our health care programs because of any of the following:

- race
- color
- national origin
- creed
- religion
- sexual orientation
- public assistance status
- age
- disability (including physical or mental impairment)
- sex (including sex stereotypes and gender identity)
- marital status
- political beliefs
- medical condition
- health status
- receipt of health care services
- claims experience
- medical history
- genetic information

Complaints must be in writing and filed within 180 days of the date you discovered the alleged discrimination. The complaint must contain your name and address and describe the discrimination you are complaining about. After we get your complaint, we will review it and notify you in writing about whether we have authority to investigate. If we do, we will investigate the complaint.

DHS will notify you in writing of the investigation's outcome. You have the right to appeal the outcome if you disagree with the decision. To appeal, you must send a written request to have DHS review the investigation outcome. Be brief and state why you disagree with the decision. Include additional information you think is important.

If you file a complaint in this way, the people who work for the agency named in the complaint cannot retaliate against you. This means they cannot punish you in any way for filing a complaint. Filing a complaint in this way does not stop you from seeking out other legal or administrative actions.

Contact **DHS** directly to file a discrimination complaint:

Civil Rights Coordinator
Minnesota Department of Human Services
Equal Opportunity and Access Division
P.O. Box 64997
St. Paul, MN 55164-0997
651-431-3040 (voice) or use your preferred relay service

South Country Complaint Notice

You have the right to file a complaint with South Country if you believe you have been discriminated against because of any of the following:

- medical condition
- health status
- receipt of health care services
- claims experience
- medical history
- genetic information
- disability (including mental or physical impairment)
- marital status
- age
- sex (including sex stereotypes and gender identity)
- sexual orientation
- national origin
- race
- color
- religion
- creed
- public assistance status
- political beliefs

You can file a complaint and ask for help in filing a complaint in person or by mail, phone, fax, or email at:

Attn: Civil Rights Coordinator
South Country Health Alliance
2300 Park Drive, Suite 100
Owatonna, MN 55060
Toll Free: 866-567-7242
TTY: 800-627-3529 or 711
Fax: 507-444-7774
Email: grievances-appeals@mnscha.org

American Indians can continue or begin to use tribal and Indian Health Services (IHS) clinics. We will not require prior approval or impose any conditions for you to get services at these clinics. For elders age 65 years and older this includes Elderly Waiver (EW) services accessed through the tribe. If a doctor or other provider in a tribal or IHS clinic refers you to a provider in our network, we will not require you to see your primary care provider prior to the referral.

SCHA LB/CB-5583
DHS Approved 02/03/2021

Health Care Directive Questions and Answers

What is a health care directive?

A health care directive is a written document that informs others of your wishes about your health care. It allows you to name a person ("agent") to decide for you if you are unable to make that decision. Health care directives are not just for the elderly. Anyone 18 years or older who wants to direct their medical care for the future should complete a health care directive.

Why should I have a health care directive?

A health care directive is a way for you to specify your wishes about health care treatment options and make your voice heard when you no longer can speak. It lets you communicate your wishes to family, friends, and health care professionals and avoid confusion later on. You can appoint a person called an "agent" in writing who will communicate your health care wishes if you can't because of illness or injury. Health care decisions include:

- The use of breathing machines
- Resuscitation if breathing or heartbeat stops
- Tube feeding
- Organ or tissue donation
- Pain medications and other comfort treatments

What if I don't have a health care directive?

Health care providers will listen to what people close to you say about your treatment preferences. The best way to be sure your wishes are followed is to have a health care directive, but you will still receive medical treatment if you don't.

Where can I find a health care directive form? What information is required?

There is a health care directive form beginning on page 1 of this document. You don't have to use this form, but your health care directive must meet the following requirements to be legal:

- Be in writing and dated
- State your name
- Be signed by you, or someone you authorize to sign for you, when you can understand and communicate your health care wishes
- Have your signature verified by a notary public or two witnesses
- Include the appointment of an agent to make health care decisions for you and/or instructions about the health care choices you wish to make

Before you prepare or revise your health care directive, you should discuss your health care wishes with your doctor or other health care provider.

What can I put in a health care directive?

You have many choices of what to put in your health care directive. Here are some examples:

- The person you trust as your agent to make health care decisions for you. You can name joint agents or alternative agents in case the first agent is unavailable
- Your goals, values, and preferences about health care
- The types of medical treatment you would want or not want
- How you want your agent or agents to decide
- Where you want to receive care
- Instructions about artificial nutrition/hydration
- Mental health treatments that use electroshock therapy or neuroleptic medications
- Instructions if you are pregnant
- Donation of organs, tissues, and eyes
- Funeral arrangements
- Who you would like as your guardian or conservator if there is a court action

You may be as specific or as general as you wish. You can choose which issues or treatments to deal with in your health care directive.

Are there any limits to what I can put in my health care directive?

There are some limits about what you can put in your health care directive. For example:

- Your agent must be at least 18 years of age.
- Your agent cannot be your health care provider, unless the health care provider is a family member or you give reasons for naming a provider as an agent in your Directive.
- You cannot request health care treatment that is outside of reasonable medical practice.
- You cannot request assisted suicide.

How long does a health care directive last? Can I change it?

Your health care directive lasts until you cancel or change it. If you want to change it, you must write a new health care directive, meeting the requirements as previously stated. You may cancel your health care directive by:

- Completing a written statement saying you want to cancel it; or
- Destroying *all* copies of it; or
- Telling at least two other people you want to cancel it; or
- Writing a new health care directive

What if my health care provider refuses to follow my health care directive?

Your health care provider will generally follow your health care directive or any instructions from your agent, as long as the health care follows reasonable medical practice. But you or your agent cannot request treatment that will not help you or which the provider cannot provide. If the provider cannot follow your agent's directions about life-sustaining treatment, the provider must inform the agent. The provider must also document the notice in your medical record. The provider must allow the agency to arrange to transfer you to another provider who will follow the agent's directions.

What if I've already prepared a health care document? Is it still good?

Before August 1, 1998, Minnesota law provided for several other types of health care documents, including living wills, durable powers of attorney for health care, and mental health declarations.

The law changed so people can use one form for all their health care instructions.

Forms created before August 1, 1998, are still legal if they follow the law in effect when written. They are also legal if they meet the requirements of the new law (described above). You may want to review any existing documents to make sure they say what you want and meet all requirements.

I prepared my health care directive in another state. Is it still good?

Health care directives prepared in other states are legal if they meet the requirements of the other state's laws or the Minnesota requirements. However, requests for assisted suicide will not be followed.

What should I do with my health care directive after I have signed it?

You should inform others of your health care directive and give copies to your family members, agent(s), and health care providers. Review and update your Directive as your needs change. Keep it in a safe place where it is easily found.

South Country Policies for health care directives

Members have the right to make decisions about their medical care. Members have the right to implement a living will, durable power of attorney for health care, or other advance health care directives. If a member has implemented a health care directive, there will be no condition on treatment or other discrimination by South Country or the provider. South Country has written contracts with providers that require providers to document whether or not a member patient has implemented a health care directive, and to follow the advance health care directives as specified in the member's health care directive document.

What if I believe a health care provider or South Country has not followed health care directive requirements?

File health care provider complaints with the Office of Health Facility Complaints at 1-651-201-4200 (Metro area) or toll-free at 1-800-369-7994.

File South Country complaints with the Minnesota Health Information Clearinghouse at 1-651-201-5178 or toll-free at 1-800-657-3793.

How to obtain additional information and forms

If you want more information about health care directives or additional forms, contact Member Services at 1-866-567-7242 (TTY users call 1-800-627-3529 or 711).

You may also contact the following:

- **Minnesota Board on Aging's Senior LinkAge Line®, 1-800-333-2433**
- **Disability LinkAge Line, 1-866-333-2466**
- **Veterans Linkage Line, 1-888-546-5838**

Another resource is the Minnesota based Twin City Medical Society website: **www.honoringchoices.org** for support in advance care planning. Click on the health care directive to locate forms in a variety of languages.

Your attorney may also have health care directive forms.

Health Care Directive

Complete Part 1 or Part 2 or BOTH.

Complete Part 3 to make this document legal.

PART 1. Appointing a Health Care Agent
Allows you to appoint another person (called a health care agent) to make health care decisions if a doctor decides you are unable to do so.

PART 2. Health Care Instructions
Allows you to give written health care instructions about what you want.

PART 3. Making This Document Legal
Requires you and others to sign and date to make this legal.

My Personal Information

My Name: _____

Address: _____

_____

Home Phone: ( )_____ Work Phone: ( ) _____

Date of Birth (Month/Day/Year): _____

Social Security Number: _____

PART 1. Appointing a Health Care Agent

(I know I can change my agent or alternate agent at any time, and I know I do not have to appoint an agent or an alternate agent.) **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 1 blank and go to Part 2.

When I am unable to decide or speak for myself, I trust and appoint the person named below to make care decisions for me. This person is called my health care agent.

Name of health care agent:

Address: Phone: ( )

Relationship of agent to you:

Optional Appointment of Alternate Health Care Agent

If my health care agent is not reasonably available, I trust and appoint the person named below to be my health care agent instead.

Name of health care agent:

Address: Phone: ( )

Relationship of agent to you:

This is what I want my health care agent to be able to do:

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 be able to have a power listed above in (A) through (D) OR I want to LIMIT any power in (A) through (D), I MUST say that here:

_____

_____

_____

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 to my body when I die (e.g., burial, cremation).

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

_____

If more space is needed for any further directions, attach additional sheets to this document.

PART 2. Health Care Instructions

Note: Complete Part 2 if you wish to give health care instructions. If you appoint an agent in Part 1, completing this Part 2 is optional but would be very helpful to your agent. However, if you chose not to appoint an agent in Part 1, you MUST complete some or all of this Part 2 if you wish to make a valid health care directive. (You can change the choices below or leave any of them blank.)

Health Care Goals

Having a sense of what is important to you can help your decision makers make health care decisions under different and complex circumstances. Read each statement below, and on a scale of "0" to "4," rate how important each of the health care goals are to you. In this case, "0" means "Not Important at All" and "4" means "Extremely Important." Remember reasonable medical care should always include maintaining a person's comfort, hygiene, and human dignity.

Health Care Goals	Not Important 0	1	Somewhat Important 2	3	Extremely Important 4
How Important is Pain Control?					
Being as comfortable and free from pain as possible					
Having pain controlled, even if my ability to think clearly is reduced					
Having pain controlled, even if it shortens my life					
How Important Is the Use of Life-Prolonging Treatment When:					
I have a reasonable chance of recovering both physically and mentally (50/50+)					
I have some physical limitations but can socially relate to those I care about					
I can live a longer life no matter what my physical or mental health					
I have little or no chance of doing everyday activities I enjoy					
I am not able to socially relate to those I care about					
I have a terminal illness, and treatment will only prolong when I die					
I have severe and permanent brain injury, and there is little chance of regaining consciousness					
I have severe dementia or confusion, and my condition will only get worse					
Importance of Finances and Health Care					
Having my wishes followed regardless of whether or not my finances are exhausted					
Not being a financial burden to those around me					
Not having my health care costs affect the financial situations of those I care about					

Medical Treatment Preferences

It is helpful for others to know if and why you have strong feelings about certain medical treatments. Some of the more difficult medical decisions are about treatments used to prolong life, such as those listed below. Most medical treatments can be tried for a while and then stopped if they do not help. Discuss these medical treatments with a health care professional to make sure you understand what they might mean for you given your current, as well as future, health conditions.

Medical Procedure	When It Is Used and Its Effects	My Feelings About This Procedure
Ventilator/Respirator A breathing machine *A Do Not Intubate (DNI) order is put on your medical record when you do not want this procedure.*	When you cannot breathe on your own You cannot talk or eat by mouth on this machine	
Nutrition Support and Hydration	When you cannot eat or drink by mouth, feeding solutions can provide enough nutrition to support life indefinitely Feeding solutions can be put through a tube in your stomach, nose, intestine, or veins	
Cardiopulmonary Resuscitation (CPR) *A Do Not Resuscitate (DNR) order is put on your medical record when you do not want this procedure.*	Actions to make your heart and lungs start if they stop including pounding on your chest, electric shocks, medications, and a tube in your throat	□ I do not want CPR attempted if my heart or breathing stops, but rather, want to permit a natural death. □ I want CPR attempted unless my doctor determines any of the following: • I have an incurable illness or injury and am dying; or • I have no reasonable chance of survival if my heart or breathing stops; or • I have little chance of long-term survival if my heart or breathing stops and the process of resuscitation would cause significant suffering. □ I want CPR if my heart or breathing stops.
Dialysis	A mechanical means of cleaning the blood when kidneys are not working	

Beliefs, Values, and Preferences

Who I would like to be my doctor: _____

Where I would like to live to receive health care: _____

_____

My fears about my health care: _____

My beliefs about when life would be no longer worth living: _____

_____

My thoughts about how my medical condition might affect my family: _____

_____

If I had a reasonable chance of recovery, and were temporarily unable to decide or speak for myself, I would want: _____

If I were permanently unconscious and unable to decide or speak for myself, I would want: _____

_____

If I were completely dependent on others for my care and unable to decide or speak for myself, I would want:

_____

In all circumstances, my doctors 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: _____

_____

If I am pregnant, my feelings about medical treatment include: _____

_____

Religious and Spiritual Beliefs

Religious or spiritual beliefs and traditions influence how people feel about certain medical treatments, what quality of life means to them, and how they wish to be treated when they are dying or when they have died. My decision makers should know the following about how my religious or spiritual beliefs should affect my health care: _____

_____

My religion/spirituality is: _____

My congregation/spiritual community (name, city, state): _____

_____

I wish to have my (priest/pastor/rabbi/shaman/spiritual leader) consulted. ____Yes ____No

If yes, the person to be contacted is (name/contact information): _____

_____

Preferences for Care When Dying

If a choice is possible and reasonable when I am dying, I would prefer to receive care:

_____ At home _____

_____ At a hospital. Which one? _____

_____ At a nursing home. Which one? _____

_____ Through hospice services/care. Which one? _____

_____ From other health care providers. Which ones? _____

If I were dying and unable to decide or speak for myself, I would want: _____

_____

My wishes about what happens to my body when I die (e.g., cremation, burial): _____

_____

Other wishes I have about my care if I am dying: _____

_____

Wishes About Donating Organs, Tissues, or Other Body Parts

Initial the option that applies:

_____ I DO NOT wish to donate organs, tissue, or other body parts when I die.

_____ I DO wish to donate organs, tissue, or other body parts when I die.

- _____ Any needed organs, tissue, or other body parts
- _____ Only the following listed organs, tissue, or body parts: _____

_____

Limitations or special wishes I have include: _____

_____

PART 3. Making This Document Legal

A.

My Signature/ Mark & Date	I am thinking clearly. I agree with everything in this document and have made this document willingly. If I cannot sign my name, I can ask someone to sign this document for me. Signature: _____ Date Signed: _____ Date of Birth: _____ My Address: _____ Printed name of who I asked to sign this document: _____

Notary Public or Witnesses

Your signature must be verified by either: (B) a Notary Public OR (C) Two (2) Witnesses

B.

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 ____ of _____, _____ by the above named principal. (day) (month) (year) (Notary Stamp) _____ Signature of Notary Public

OR

C.

Two Witnesses *Must* Sign **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 at least 18 years of age, and I am not named as agent or alternate agent in this document. Witness: _____ Address: _____ _____ Signature: _____ Date: _____ ☐ I am a health care provider or an employee of a health care provider giving direct care to the person listed above in (A). Witness:_____ Address: _____ _____ Signature: _____ Date: _____ ☐ I am a health care provider or an employee of a health care provider giving direct care to the person listed above in (A).

Reminder: Keep this document with your personal papers in a safe place. Give signed copies to your doctors, family, close friends, health care agent, and alternate health care agent. This document should be part of your medical record at your doctor's office and at the hospital, home care agency, hospice, or nursing facility where you receive your care.