A greater Minnesota health plan™

Health Care Directives

Questions & Answers about *Health Care Directives*

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 others know what you want if you can't tell them because of illness or injury. The information that follows tells about ***Health Care Directives*** and how to prepare them. **It does not give every detail of the law**.

How to Obtain Additional Information

If you want more information about ***Health Care Directives***, please contact your health care provider, your attorney, or the Minnesota Board on Aging's Senior LinkAge® Line at **1-800-333-2433** (toll free). A suggested ***Health Care Directive*** form is available on the Internet at **http://www1.extension.umn.edu/family/financial-security/health-care-directives/mn-health-care-directive/**. At this web page, you can print off the ***Health Care Directive*** and fill out a hard copy or you can fill it out electronically on the Internet and then print it. A ***Health Care Directive*** form is also included in this folder.

PrimeWest HEALTH

Dear PrimeWest Health Member:

If a time comes when someone close to you has to make health care decisions on your behalf, would he/she know what you want?

Inside are questions and answers about ***Health Care Directives***. A ***Health Care Directive*** is advance planning for health care decisions should you become severely ill and lose your ability to make decisions about your health care.

One of your basic rights is the right to make decisions about your health care. After being informed about available options, you have the right to accept or refuse care. State law requires that PrimeWest Health tell you these rights when you enroll. PrimeWest Health has developed a set of materials to help you in advance planning of your health care.

PrimeWest Health has written policies and procedures that make sure your rights regarding ***Health Care Directives*** are protected. Specifically, PrimeWest Health cannot condition or refuse treatment or otherwise discriminate against you based on whether or not you have a ***Health Care Directive***. PrimeWest Health expects providers to comply with your wishes to the fullest extent possible within reasonable medical practice.

To formalize your advance health care decisions, fill out a ***Health Care Directive*** form. A form is enclosed for your convenience. Contact PrimeWest Health Member Services at **1-866-431-0801** (toll free) if you need additional forms.

If you have questions, be sure to discuss them with your health care provider.

Sincerely,

PrimeWest Health

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 decide. It also allows you to name an agent if you want someone else to decide for you. You must be at least 18 years old to make a ***Health Care Directive***.

Why have a *Health Care Directive*?

A ***Health Care Directive*** is important if your attending physician determines you can't communicate your health care choices (because of physical or mental incapacity). It is also important if you wish to have someone else make your health care decisions. In some circumstances, your ***Directive*** may state that you want someone other than an attending physician to decide when you cannot make your own decisions.

Must I have a *Health Care Directive*? What happens if I don't have one?

You don't have to have a ***Health Care Directive***. But, writing one helps to make sure your wishes are followed.

You will still receive medical treatment if you don't have a written ***Directive***. Health care providers will listen to what people close to you say about your treatment preferences, but the best way to be sure your wishes are followed is to have a ***Health Care Directive***.

How do I make a *Health Care Directive*?

There are forms for ***Health Care Directives***. You can get them from your health care provider or attorney. A suggested ***Health Care Directive*** form is available from the Minnesota Board of Aging on the Internet at **www1.extension.umn.edu/family/financial-security/health-care-directives/mn-health-care-directive/**. At this web page, you can print off the ***Health Care Directive*** and fill out a hard copy or you can fill it out electronically on the Internet and then print it. A ***Health Care Directive*** form is also included in this folder. You don't have to use a 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 ***Directive***, you should discuss your health care wishes with your doctor or other health care provider.

I prepared my *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. But requests for assisted suicide will not be followed.

What can I put in a *Health Care Directive*?

You have many choices of what to put in your ***Health Care Directive***. For example, you may include the following:

- The person you trust as your agent to make health care decisions for you. You can name alternate agents in case the first agent is unavailable, or joint agents.
- 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 and hydration
- Instructions about mental health treatments that use electroshock therapy or neuroleptic medications
- Instructions if you are pregnant
- Instructions about donation of organs, tissues, and eyes
- Funeral arrangements
- Who you would like as your guardian or conservator if there is a court action

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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 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***. These are some examples:

- 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 the naming of the 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 change or cancel it. As long as the changes meet the ***Health Care Directive*** requirements listed above, you may cancel your ***Directive*** by doing any of the following:

- Writing a statement saying you want to cancel it
- Destroying it
- Telling at least two other people you want to cancel it
- Writing a new ***Health Care Directive***

What if my health care provider refuses to follow my ***Health Care Directive***?

Your health care provider generally will 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 agent to arrange to transfer you to another provider who will follow the agent's directions.

What if I've already prepared a ***Health Care Directive***? Is it still good?

Before August 1, 1998, Minnesota law provided for several other types of directives, 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 followed 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.

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 people copies of it. You may wish to inform family members, your health care agent or agents, and your health care providers that you have a ***Health Care Directive***. You should give them a copy. It's a good idea to review and update your ***Directive*** as your needs change. Keep it in a safe place where it is easily found.

What if I believe a health care provider has not followed ***Health Care Directive*** requirements?

Complaints of this type can be filed with the Office of Health Facility Complaints at **1-800-369-7994** (toll free) or **1-651-201-4200** (Metro area).

What if I believe a health plan has not followed ***Health Care Directive*** requirements?

Complaints of this type can be filed with the Minnesota Health Information Clearinghouse at **1-800-657-3793** (toll free) or **1-651-201-5178** (Metro area).

Minnesota Health Care Directive

Purpose of Form	**Part 1. NAMING AN AGENT** Allows you to appoint another person (called an 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 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		Social Security #	

I revoke all living wills, durable powers of attorney for health care, or other written advance health care directives I have signed in the past.

Part 1. NAMING AN AGENT

Agent Duties	My health care agent can: • Make health care decisions for me if I am unable to make and communicate decisions for myself • Make decisions based on my instructions in Part 2 of this document or in other documents • Make decisions based on what he/she knows about my wishes • Act in my best interests if instructions are not available
Agent Roles	When naming my health care agent, I must choose one of the following options. *Initial the line in front of the statement you WANT.*
	Act alone _____ I appoint one person to serve as my primary health care agent to make decisions for me if I am unable to make or communicate these decisions for myself. My primary agent may act alone. If my primary agent is not able, willing, or available, each alternate agent I name may act alone, in the order listed.
	Act together _____ I appoint two or more people to act together as my health care agent. My primary agent and alternate agents must act together and be in agreement when making decisions. If they are not all readily available, or if they disagree, a majority of the agents who are readily available may make decisions for me.

My Primary Health Care Agent	I appoint:			
	Agent's name			
	Address			
	Home phone	( )	Work phone	( )
My First Alternate Health Care Agent	I appoint:			
	Agent's name			
	Address			
	Home phone	( )	Work phone	( )
My Second Alternate Health Care Agent	I appoint:			
	Agent's name			
	Address			
	Home phone	( )	Work phone	( )

(If Needed) Reasons for Naming a Health Care Provider

I have named as my agent a health care provider, or employee of a health care provider, who is currently or might be providing direct care to me when decisions are needed. Choose the option that applies:

_____That person is related to me by blood, marriage, registered domestic partnership, or adoption

_____My reasons for wanting to appoint that person as my agent are:

_____

_____

_____

_____

_____

Powers of My Agent

If I am unable to decide or speak for myself, my agent has the power to:

- Consent to, refuse, or withdraw any health care, treatment, service, or procedure
- Stop or not start health care that is keeping or might keep me alive
- Choose my health care providers
- Choose where I live when I need health care and what personal security measures are needed to keep me safe
- Obtain copies of my medical records and allow others to see them

Additional Powers of My Agent	If I WANT my agent to have any of the following powers, I must initial the line in front of the statement. I also authorize my agent to: _____ Make health care decisions for me even if I am able to decide or speak for myself _____ Carry out my wishes regarding a funeral, burial, or what will happen to my body when I die _____ Make decisions about mental health treatment including electroconvulsive therapy and antipsychotic medication, including neuroleptics _____ In the event I am pregnant, determine whether to attempt to continue my pregnancy to delivery based upon my agent's understanding of my values, preferences, or instructions _____ Continue as my health care agent even if a dissolution, annulment, or termination of our marriage or domestic partnership is in the process or has been completed
Limiting the Powers of My Agent	I wish to limit the powers of my health care agent in the following way(s):

Part 2. HEALTH CARE INSTRUCTIONS (Please refer to page 6 for a Health Care Instructions Worksheet.)

I give the following instructions about my health care (my values and beliefs, what I do and do not want, views about medical treatments or situations):

I am attaching additional instructions concerning my health care values and preferences.
➔**Initial one line: _____ Yes _____ No**

I authorize donation of my organs, tissue, or other body parts after my death.
➔**Initial one line: _____ Yes _____ No**

Part 3. MAKING THIS DOCUMENT LEGAL

<table>
<tr><td rowspan="3">My Signature/ Mark and Date</td><td colspan="2">I agree with everything in this document and have made this document willingly.</td></tr>
<tr><td>My signature</td><td></td></tr>
<tr><td>Date (month/day/year)</td><td></td></tr>
<tr><td rowspan="13">Notary Public or Witnesses</td><td colspan="2">Notary Public</td></tr>
<tr><td colspan="2">➔NOTE: Must not be named as agent or alternate agent</td></tr>
<tr><td colspan="2">STATE OF MINNESOTA
County of_____
This document was signed or acknowledged before me
this _____ of _____, _____ by the above-named principal.
(day) (month) (year)</td></tr>
<tr><td>Signature of Notary Public</td><td></td></tr>
<tr><td colspan="2">Two Witnesses</td></tr>
<tr><td colspan="2">➔NOTE: Only one witness can be a direct care provider or employee of a provider on the day this is signed.</td></tr>
<tr><td colspan="2">This document was signed or acknowledged in my presence. I am not an agent or alternate agent in this document.</td></tr>
<tr><td>Witness signature</td><td></td></tr>
<tr><td rowspan="2">Address</td><td></td></tr>
<tr><td></td></tr>
<tr><td>Date (month/day/year)</td><td></td></tr>
<tr><td>Witness signature</td><td></td></tr>
<tr><td rowspan="2">Address</td><td></td></tr>
<tr><td></td></tr>
<tr><td>Date (month/day/year)</td><td></td></tr>
</table>

Minnesota Health Care Directive
Health Care Instructions Worksheet

MY 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, "4" means "Extremely Important" and "0" means "Not Important At All." 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					

I also want my decision makers to know the following things are important to me when receiving health care:

My 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	
Dialysis	A mechanical means of cleaning the blood when kidneys are not working	

My feelings or concerns about other medical treatments include:

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

My 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) _____ _____

Feelings About Quality and Length of Life

I have the following beliefs about whether life should be preserved as long as possible:
The following kinds of mental or physical conditions would make me think that medical treatment should no longer be used to keep me alive:

My 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?
Other wishes I have about my care if I am dying:	

My Wishes About Donating Organs, Tissues, or Other Body Parts

Initial the lines that apply to you:

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

Additional Health Care Instructions

My decision makers should also know these things about me to help them make decisions about my health care:
I agree that these are my health care instructions and have completed this willingly.
My signature:
Date completed (month/day/year):
• This worksheet is an attachment to my ***Health Care Directive***: ➔**Initial one line: _____ Yes _____ No**

PrimeWest Health

Member Services

Monday – Friday, 8 a.m. – 8 p.m.

1-866-431-0801 (toll free)

WEBSITE
www.primewest.org

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

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

កំណត់សំគាល់ ។ បើអ្នកត្រូវការជំនួយក្នុងការបកប្រែឯកសារនេះដោយឥតគិតថ្លៃ សូមហៅទូរស័ព្ទតាមលេខខាងលើ ។

Pažnja. Ako vam treba besplatna pomoć za tumačenje ovog dokumenta, nazovite gore naveden broj.

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.

ໂປຣດຊາບ. ຖ້າຫາກ ທ່ານຕ້ອງການການຊ່ວຍເຫຼືອໃນການແປເອກະສານນີ້ຟຣີ, ຈົ່ງໂທຣໄປທີ່ໝາຍເລກຂ້າງເທິງນີ້.

Hubachiisa. Dokumentiin kun bilisa akka siif hiikamu gargaarsa hoo feete, lakkoobsa gubbatti kenname bibili.

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 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.

LB3-0010 (3-13)

This information is available in other forms to people with disabilities by calling:

TOLL FREE
1-866-431-0801

TOLL FREE MINNESOTA RELAY
TTY, Voice, ASCII, or Hearing Carry Over:
1-800-627-3529 or 711

TOLL FREE SPEECH-TO-SPEECH RELAY SERVICE
1-877-627-3848

PrimeWest Health will enroll all eligible people who select or are assigned to PrimeWest Health without regard to physical or mental condition, health status, need for health services, claims experience, medical history, genetic information, disability, marital status, age, sex, sexual orientation, national origin, race, color, religion, or political beliefs. PrimeWest Health will not use any policy or practice that has the effect of such discrimination.

American Indians can continue or begin to use tribal and Indian Health Service (IHS) clinics. We will not require prior approval or impose any conditions for you to get services at these clinics. For enrollees 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.