



# Advance Care Planning

Communicating Your Healthcare Wishes

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# Getting Started

## Why Is an Advance Care Plan Important?

Advance care planning is the process of deciding your own future health care. It makes sure your wishes will be carried out if you cannot speak for yourself. Having an advance directive can help you and your family be ready in case of a major illness or injury.

Everyone over the age of 18 should have an advance care plan.

## Why Do I Need an Advance Care Plan?

Think about this situation: You become suddenly ill or injured. You are getting all the medical treatments needed to keep you alive. But, your doctors believe there is little or no chance you will be able to know who you are or know those around you.

- Who will make your decisions for you?
- What do you want the goals of your care to be?
- What kinds of treatments do you want to continue or to stop?
- How can you help your loved ones make these decisions?
- Are you concerned about the costs of futile medical treatments?

Such a situation might arise at any age because of an injury to the brain from an accident, a stroke, or a slowly progressive disease like Alzheimer's. Your loved ones may be frightened, overwhelmed, and confused about what your wishes are.

When doing advance care planning, people may make statements that are not very clear and do not provide enough information to guide decision making about your health care. These may include comments like:

- "If I'm going to be a vegetable, let me go."
- "No heroics."
- "Do everything possible to keep me alive."

Advance care planning is different for everyone. For example, what does being a "vegetable" mean to you? Or, what does "heroic" medical care mean to you? Or how long should "everything possible" be done? Expressing your wishes clearly is important for those who will make decisions for you.

If you would like help to state your wishes clearly, contact your health care provider for a consultation, or set up an appointment with a trained Advance Care Planning Facilitator in your area.

Advance care planning may lessen your suffering and may bring peace of mind to you and to those who may be making your decisions.

# Choose a Health Care Agent

Choosing your health care agent or decision maker is a very important step. This person does not need to be the same person as anyone associated with matters of your finances or estate. Your health care agent's duty is to see that your health care wishes are followed.

- If your wishes are not known, your agent would try to decide what you want.
- Your agent's choices for you will be honored before anyone else's wishes for you.
- Your agent will make health care decisions for you only if you cannot make your own decisions.

**Note:** Legal requirements for health care agent's may vary by state. See the included advance care plan document for specifics.

## Tips for Choosing an Agent

Your health care agent should:

- Be someone you trust
- Know your wishes well
- Speak up on your behalf when you cannot speak
- Honor your wishes

## Choose an Alternate Agent

It is a good idea to choose a second person to be an agent in case your first choice is not available when needed. After choosing an agent, ask your agent to read or photocopy the letter on the next page to give your agent more information about the responsibilities of being an agent.

## For Those Living in North Dakota

In ND, your agent must agree **in writing** to be your agent. Your agents will need to sign the advance care plan on page 9 of 9.

Use this space to list possible agents, their addresses, and phone numbers before filling out the legal form.

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# A Message for My Health Care Agent

I have chosen you to be my health care agent. A health care agent is a person who knows my treatment wishes and is willing to carry them out after one or more doctors decide that I cannot make my own decisions. You will need to learn what is important to me. I will need to talk with you about my choices. I plan to write down my decisions about my care in an advance care plan. I will give you a copy of the plan.

Thank you for being my agent.

## What You Can Do

Restrictions on what an agent can and cannot do vary by state. Together, we will check my state laws. In most states, as my agent, you can:

- Choose or refuse life-sustaining and other medical treatment for me.
- Consent to and then stop treatment if my condition does not improve.
- Access and release my medical records.
- Move me to another care center and choose my health care provider.
- Request an autopsy and donate my organs, unless I have stated otherwise on my advance care plan.

Being my health care agent does not give you control of my money or responsibility for my bills.

## Questions to Ask Yourself

- Am I willing to take on this role and responsibility?
- Do I know the person's wishes for future health care?
- Can I make the decisions the person would want me to make, even if my views are different?
- Can I make important health care decisions under stressful situations?

If you answer "No" to any of these questions, talk to me about your concerns.

## If You Are Not Comfortable With Being My Agent

We can talk about your feelings and concerns. The more information you have, the more confident you will feel about making decisions for me. There may be ways to help you feel more comfortable making decisions for me.

- You may want to come to a doctor's appointment with me. You will be able to ask questions about my health condition and health choices that may arise.
- Review my advance care plan. Make sure that I have clearly stated my wishes.
- You may want to visit with trained professionals who help people make health decisions. They include advance care planning facilitators, social workers, case managers, and religious and spiritual leaders.

# Consider What It Means for You to Live Well

Gather your thoughts using this **optional** worksheet. Consider your future health care and values before you fill out the advance care plan form.

## Reflect on Your Beliefs and Values

1. If you were having a really good day, what would happen on that day? Who would you talk to? What would you do?

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2. What helps you face serious challenges in your life?

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3. What role does religion, faith, or spirituality play in how you live your life?

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4. If you have significant health problems, what are they and what do you fear in the future?

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5. Considering future medical treatments, what would you not want to happen to you?

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6. How does cost influence your decisions about medical care?

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7. When would you want the goals of medical treatment to switch from trying to prolong your life to focusing on comfort? Describe these circumstances in as much detail as possible.

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8. What would a “natural death” be like for you?

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# Learn More About Possible Medical Treatments

The following are medical treatments that may be used to save or extend your life. Each of these treatments can be successful if they are used as a bridge to your recovery. When you are approaching the end of your life, using them could cause you to suffer without hope of recovering the ability to know who you are or who you are with.

## CPR (Cardiopulmonary Resuscitation)

CPR refers to the methods used to try to restart the heart and lungs if they stop working.

- **CPR** is used to try to restart your heart if it stops beating. It involves pressing down on your chest and breathing into your mouth.
- **Intubation** is used if you cannot breathe. A tube is placed through your mouth or nose into your windpipe. The tube may be attached to a breathing machine (ventilator). The machine pumps air through the tube and into your lungs.
- **Electric shocks (defibrillation)** may be used to send brief shocks to your heart through small pads on your chest. It may help restore your heart rhythm to normal.
- **Medications** may be used to help restart your heart.

## What Is the Likely Outcome of CPR?

CPR can save lives, but the success rate is low. Your age, health, and illness can affect the outcome. When CPR is started on older, weaker people in nursing homes, about 1 out of 30 survives. CPR works best if you are in mostly good health and it is started quickly. When it is started in the hospital about 1 out of 5 survives. Even if you survive, complications can occur during CPR that may cause more health problems. Health care after CPR may involve care in an ICU (intensive care unit) for:

- A ventilator to support breathing
- Damage to your ribs
- Possible brain damage from being without oxygen

## How Do I State My Decision About CPR?

In the hospital, your doctor and other health care providers will do CPR when needed unless you tell them not to or have your wishes written in an advance care plan. If you choose not to have CPR, a **Do Not Resuscitate (DNR)** order is written by the doctor. This order tells health care providers not to do CPR if your heart and lungs stop working. You may change this decision any time.

## What if I Do Not Want CPR?

Your heart will stop beating and you will have a natural death. You can be kept comfortable.

## Ventilators or BiPap

A ventilator can be used for a few hours to a few months or years.

- A **ventilator** is a machine that helps a person breathe. The machine is connected to a tube that goes through your nose or mouth and into the windpipe. It pushes air into your lungs if you are too weak to breathe on your own.
- **BiPap** (bi-level positive airway pressure) pushes air into your lungs through a face mask that fits tightly over your mouth and nose.



## Possible Concerns With Ventilators or BiPap

- You may need to be cared for in an intensive care unit (ICU).
- You may need medicine to keep you drowsy or asleep.
- You cannot speak or swallow when the ventilator tube is in your windpipe.
- The ventilator may not work well if your body is shutting down from long-lasting health problems.
- For long-term use the breathing tube may be placed into an opening made in your throat (tracheotomy).
- With a BiPap mask, some of the air may go into your stomach and cause gas pain. Wearing a mask, it may be difficult to talk or eat.

## What if I Do Not Want a Ventilator or BiPap?

If you are not able to breathe on your own or with a breathing machine, you will die naturally. You can be kept comfortable.

## Kidney Dialysis

Dialysis is a treatment that does the work of the kidneys by filtering the blood. There are 2 types of dialysis:

- **Hemodialysis** removes fluids and wastes from the blood using a filter. Blood flows from your body to the dialysis machine then through a special filter, called a dialyzer or an artificial kidney, and back to your body again. As blood goes through the dialyzer, fluid and wastes are taken out.
- **Peritoneal dialysis (PD)** is a treatment for kidney failure that uses the body's own peritoneal membrane in the belly as a filter. PD is done about four times every day at the normal breaks in the day: morning, noon, evening, and bedtime.

## What Happens if I Choose Not to Have Dialysis?

All patients have the right to decide not to start dialysis. If you started dialysis, you have the right to stop. Choosing no treatment or stopping dialysis will cause a natural death within a few days to a few weeks. You also have the right to start dialysis again if you change your mind.

## Artificial Feeding or Artificial Hydration

Artificial feeding (feeding tube) or artificial hydration are used to support your body if you can no longer take in food or fluids by mouth. Some types of tubes used include:

- **An NG tube (nasogastric)** can be placed through the nose and into the stomach. It sends formula and water directly to the stomach.
- **A G tube (gastrostomy) or PEG tube (percutaneous endoscopic gastrostomy)** can be placed through a small hole in the belly. It sends formula and water directly into the stomach.
- **An IV line (intravenous)** line is placed into a vein. It sends nutrition and fluids directly into the blood vessels.

## Possible Concerns About Artificial Feeding

Risks can include bleeding or infection at the tube site and problems with the tube. Inhaling the formula by accident can cause pneumonia, a life-threatening problem. A swollen belly, belly discomfort, and diarrhea can be burdens of tube feedings.

## **What Happens if I Choose to Have Artificial Feeding?**

Artificial feedings may help you feel better and improve your quality of life for a time. If you are near the end of your life, it may be hard to tolerate the problems that can occur with the treatment.

## **What Happens if I Choose Not to Have Artificial Feeding?**

If you cannot take in any food by mouth and choose not to have artificial feeding, your body will slowly shut down. Death will likely occur within a few days or weeks. You may find it reassuring to know that most patients near the end of life do not typically feel hunger or thirst.

## **Possible Concerns About Artificial Hydration**

Artificial hydration can cause too much fluid to build up in the body. This can cause uncomfortable swelling in the arms, legs, and belly. Fluid can also build up in the lungs, which can cause trouble breathing and shortness of breath. Risks also include bleeding and infection at the tube site.

## **What Happens if I Choose to Have Artificial Hydration?**

Artificial hydration will help your body function. This may increase comfort and improve quality of life for a time. If you are near the end of your life, you may find it hard to tolerate the problems that can occur with this treatment.

## **What Happens if I Choose Not to Have Artificial Hydration?**

Without enough fluids, the body will slowly shut down. Death will occur within a few days or weeks. You may find it reassuring to know that dehydration is a natural part of the dying process. Most patients near the end of life do not feel thirst. In the last days of life, dehydration may help trigger the release of chemicals in the brain that can leave you with a sense of calm and well-being. This may help you pass your final hours in greater comfort.

## **Deactivation of Cardiac Devices**

Implanted cardiac defibrillators (ICD) or left ventricular assistive devices (LVAD) can be used to support your heart function. There may come a time when you wish to deactivate these devices and have a natural death. It will help to talk to your doctor about this ahead of time and have a plan in place.

## **Antibiotics for Infections**

Sometimes death occurs as a result of an infection rather than a medical problem such as cancer or heart disease. Some examples of serious infections are pneumonia and sepsis. You can decide to treat infections or not depending on your wishes and long-term health outcome. Antibiotics are medicines used to treat infections caused by bacteria. Other medicines can be used to treat viruses or fungal infections. These medications may need to be given through an IV.

## Palliative Care and Hospice Care

You may want to include your wishes about where and how you would like to receive care.

**Palliative care** is a method of providing comfort care. The goal is to prevent or treat symptoms and side effects of a disease. It should be part of the plan from the first day a serious illness is diagnosed. Palliative care can be provided regardless of how long you are expected to live. Palliative care can provide:

- Relief of pain and other symptoms
- Emotional and spiritual support for you and your family
- Help with making complex treatment decisions

**Hospice care** is a level of comfort care provided to those who are expected to die within the next 6 months. The focus is on symptom management, a peaceful death, and life after death. As your health declines, hope shifts to the meaningful time with family and friends. Hospice care can give all the benefits listed for palliative care plus:

- Physical therapy or occupational therapy to help develop new energy or conserve energy
- Art, music, and other complementary therapies
- Respite care to provide a break for caregivers
- Home health aides to help with bathing, grooming, eating and other personal health needs
- Trained volunteers for support like running errands and meal preparation
- Support services for caregivers including grief counseling

## Organ Donation

Consider these facts about organ donation when making your decision. Register at [www.life-source.org](http://www.life-source.org) or place your wishes on your driver's license.

- More than 3000 people in the upper Midwest are waiting for a transplant.
- Organ donation may help your family in the grieving process. One person can save or heal up to 60 lives.
- There is no cost to you or your family when you donate organs.
- Even if you have health conditions, you will likely be able to donate.
- All major religions support organ donation.
- Organ donation will not affect any funeral plans for viewing.
- Organ donations are confidential.

**Donating your whole body** to science may require separate forms.

The following ten pages are the Advance Care Plan form.

- Fill out these pages. You can leave them in the booklet or remove them as you wish.
- Print your name, date of birth, and completion date at the bottom of each page.
- Do not sign Part 4 “Legal Authority” on page 8 of 10 until you have your witnesses or notary public present.
- Make copies for your records and to share with family.
- Return the completed forms to your healthcare provider and/or health care facility to be placed in your medical record.
- See page 10 of 10 to learn what to do with the completed Advance Care Plan form.

# My Advance Care Plan

I have completed this Advance Directive with much thought. This document gives my treatment choices and preferences, and/or appoints a Health Care Agent (also known as Health Care Power of Attorney) to speak for me if I cannot communicate or make my own health care decisions. My Health Care Agent, if named, is able to make medical decisions for me, including the decision to refuse treatments that I do not want.

**This document will replace any previous advance directive.**

My name: \_\_\_\_\_ Date: \_\_\_\_\_

My date of birth: \_\_\_\_\_

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

My telephone numbers: (home) \_\_\_\_\_ (cell) \_\_\_\_\_

My initials here indicate a professional medical interpreter helped me complete this document.

## Part 1: My Health Care Agent

(Also Known as Health Care Power of Attorney)

If I cannot communicate my wishes and health care decisions due to illness or injury, or if my health care team determines that I cannot make my own health care decisions, I choose the person named below to communicate my wishes and make my health care decisions. My health care agent must:

- Follow my health care instructions in this document
- Follow any other health care instructions I have given to him or her
- Make decisions in my best interest and in accordance with accepted medical standards

### Requirements for Who May Be an Agent or Health Care Power of Attorney Under State Law

**Iowa:** My agent cannot be a health care provider caring for me on the date I sign this document. My agent also cannot be an employee of a health care provider unless related to me by blood, marriage, or adoption within the third degree of relation.

**Minnesota:** My agent must be an adult. My agent cannot be a health care provider or employee of a health care provider giving me direct care unless I am related to that person by blood or marriage, registered domestic partnership, or adoption or unless I have specified otherwise in this document (Specify here: \_\_\_\_\_).

In addition, a person appointed to determine my capacity to make decisions cannot be my agent.

**North Dakota:** My agent must be an adult. My agent cannot be: 1) my health care provider; 2) someone who is an employee of my health care provider but is not related to me; 3) my long term care services provider; or 4) someone who is an employee of my long term care services provider but is not related to me.

**South Dakota:** My agent must be an adult.

**My Primary (Main) Health Care Agent Is:**

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Telephone numbers: (H) \_\_\_\_\_ (C) \_\_\_\_\_ (W) \_\_\_\_\_

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

If my primary agent is not willing, able, or reasonably available to make health care decisions for me, I choose an alternate Health Care Agent.

**My Alternate Health Care Agent Is:**

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Telephone numbers: (H) \_\_\_\_\_ (C) \_\_\_\_\_ (W) \_\_\_\_\_

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

**Powers of My Health Care Agent:**

My Health Care Agent automatically has all the following powers when I do not have the capacity to make decisions and/or I am unable to communicate for myself:

- A. Agree to, refuse, or cancel decisions about my health care. This includes tests, medications, surgery, withdrawing or starting artificial nutrition and hydration (such as tube feedings or IV (intravenous) fluids), and other decisions related to treatments. If treatment has already begun, my agent can continue it or stop it based on my instructions.
- B. Interpret any instruction in this document based on his or her understanding of my wishes, values and beliefs.
- C. Review and release my medical records and personal files as needed for my health care, as stated in the Health Insurance Portability and Accountability Act of 1996 (HIPAA).
- D. Arrange for my health care and treatment in a location he or she thinks is appropriate.
- E. Decide which health care providers and organizations provide my health care.
- F. Make decisions about organ and tissue donation according to my instructions in Part 2 of this document.

Comments or limits on the above: \_\_\_\_\_

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The ACP of \_\_\_\_\_ (print name) Birth Date \_\_\_\_\_ Completion Date \_\_\_\_\_



### Additional Powers of My Health Care Agent:

My initials below indicate I also authorize my health care agent to:

Make decisions about the care of my body after death.

If I live in North Dakota or Minnesota, my initials below indicate I also authorize my health care agent to:

Continue as my health care agent even if our marriage or domestic partnership is legally ending or has been ended.

Make health care decisions for me even if I am able to decide or speak for myself, if I so choose.

## Part 2: My Health Care Instructions

My choices and preferences for health care are indicated below. I ask my Health Care Agent to communicate these choices, and my health care team to honor them, if I cannot communicate or make my own choices.

**I have initialed a box below for the option I prefer for each situation.**

**Note:** You do not need to write instructions about treatments to extend your life, but it is helpful to do so. If you do not have written instructions, your agent will make decisions based on your spoken wishes, or in your best interest if your wishes are unknown.

### A. Cardiopulmonary Resuscitation: A Decision for the Present

This decision refers to a treatment choice I am making today based on my current health. **Section C below (Treatments to Prolong My Life: A Decision for the Future)** indicates treatment choices I want if my health changes in the future and I cannot communicate for myself.

CPR is a treatment used to attempt to restore heart rhythm and breathing when they have stopped. CPR may include chest compressions (forceful pushing on the chest to make the blood circulate), medications, electrical shocks, a breathing tube, and hospitalization.

The ACP of \_\_\_\_\_ (print name) Birth Date \_\_\_\_\_ Completion Date \_\_\_\_\_

I understand that CPR can save a life but does not always work. I also understand that CPR does not work as well for people who have chronic (long-term) diseases or impaired functioning, or both. I understand that recovery from CPR can be painful and difficult.

**Therefore (initial one)**

I want CPR attempted if my heart or breathing stops.

**Or**

I want CPR attempted if my heart or breathing stops based on my current state of health. However, in the future if my health has changed, then my agent or I (if I am able) should discuss CPR with my health care team. My choices in **Section B: Treatment Preferences and Section C: Treatments to Prolong My Life** below should be considered when making this decision. Examples of when my health has changed include:

- I have an incurable illness or injury and am dying
- I have no reasonable chance of survival if my heart or breathing stops
- I have little chance of long-term survival if my heart or breathing stops and CPR would cause significant suffering

**Or**

I do not want CPR attempted if my heart or breathing stops. I want to allow a natural death. I understand if I choose this option I should see my health care provider about writing a Do Not Resuscitate (DNR) order.

**B. Treatment Choices: My Health Condition**

My treatment choices for my specific health condition(s) are written here. With any treatment choice, I understand I will continue to receive pain and comfort medicines, as well as food and liquids by mouth if I am able to swallow.

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My initials here indicate additional documents are attached.

The ACP of \_\_\_\_\_ (print name) Birth Date \_\_\_\_\_ Completion Date \_\_\_\_\_





### C. Treatments to Prolong My Life: A Decision for the Future

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):

**NOTE:** With either choice, I understand I will continue to receive pain and comfort medicines, as well as food and liquids by mouth if I am able to swallow.

To **stop or withhold all treatments** that may extend my life. This includes but is not limited to artificial nutrition and hydration (for example, tube feedings and IV (intravenous) fluids), respirator/ventilator (breathing machine), cardiopulmonary resuscitation (CPR), dialysis, and antibiotics.

**Or**

**All treatments recommended** by my health care team. This includes but is not limited to artificial nutrition and hydration (for example, tube feedings, IV (intravenous) fluids), respirator/ventilator (breathing machine), cardiopulmonary resuscitation (CPR), dialysis, and antibiotics. I want treatments to continue until my health care team and agent agree such treatments are harmful or no longer helpful.

Comments or directions to my health care team:

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### D. Organ Donation (Initial One)

I want to donate my eyes, tissues and/or organs, if able. My Health Care Agent may start and continue treatments or interventions needed to maintain my organs, tissues and eyes until donation has been completed. My specific wishes (if any) are:

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I do not want to donate my eyes, tissues and/or organs.

**Or**

My Health Care Agent can decide.

The ACP of \_\_\_\_\_ (print name) Birth Date \_\_\_\_\_ Completion Date \_\_\_\_\_



**E. Autopsy** (Initial One)

I want my agent to make decisions about an autopsy of my body.

I do not want an autopsy unless required by law.

**F. Comments or Directions to My Health Care Team**

You may use this space to write any additional instructions or messages to your health care team which have not been covered in this directive, or to elaborate on a point for clarification. You may also leave this space blank.

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My initials here indicate additional documents are attached.

The ACP of \_\_\_\_\_ (print name) Birth Date \_\_\_\_\_ Completion Date \_\_\_\_\_



# Part 3: My Hopes and Wishes (Optional)

I want my loved ones to know my following thoughts and feelings.

**The things that make life most worth living to me are:**

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

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**My thoughts about specific medical treatments, if any:**

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**My thoughts and feelings about how I would like to die and where I would like to die:**

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**If I am nearing my death, I want my loved ones to know that I would appreciate the following for comfort and support** (rituals, prayers, music, etc.):

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**Religious affiliation:**

I am of the \_\_\_\_\_ faith, and am a member of \_\_\_\_\_ faith community in (city) \_\_\_\_\_.

I would like my Health Care Agent to notify my faith community of my death and arrange for them to provide my funeral/memorial/burial.

**I would like my funeral to include, if possible, the following** (people, music, rituals, etc.):

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**Other wishes and instructions:**

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My initials here indicate additional documents are attached:

The ACP of \_\_\_\_\_ (print name) Birth Date \_\_\_\_\_ Completion Date \_\_\_\_\_



# Part 4: Legal Authority

**Do not sign unless the witnesses or notary are present.**

**Note:** This document must be notarized or witnessed. [See individual state requirements on page 9 of 9].  
Two witnesses OR a Notary Public must verify your signature and the date.

I have made this document willingly. I am thinking clearly. This document states my wishes about my future health care decisions:

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

**If I cannot sign my name, I ask the following person to sign for me:**

Signature (of person asked to sign) \_\_\_\_\_ Date \_\_\_\_\_

Printed Name \_\_\_\_\_

## 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 \_\_\_\_\_

Printed Name \_\_\_\_\_ Date \_\_\_\_\_

**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 \_\_\_\_\_

Printed Name \_\_\_\_\_ Date \_\_\_\_\_

The ACP of \_\_\_\_\_ (print name) Birth Date \_\_\_\_\_ Completion Date \_\_\_\_\_



**Required in ND**

**Acceptance of Appointment of Health Care Agent (Health Care Power of Attorney)**

I accept this appointment and agree to serve as an agent for health care decisions. I understand I have a duty to act consistently with the desires expressed in this document and to act in good faith. I understand this individual can revoke my designation as an agent at any time in any manner. I will notify this individual if I choose to withdraw from this role while this individual is competent. I will notify this individual's health care provider if I choose to withdraw from this role when this individual is not able to make health care decisions.

Primary Agent Signature \_\_\_\_\_ Date \_\_\_\_\_

Printed Name \_\_\_\_\_

Alternate Agent Signature \_\_\_\_\_ Date \_\_\_\_\_

Printed Name \_\_\_\_\_

**Requirements for Witnesses by State**

**Iowa:** Notary Public 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 Public 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 Public 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 Public or 2 adult witnesses are required.

The ACP of \_\_\_\_\_ (print name) Birth Date \_\_\_\_\_ Completion Date \_\_\_\_\_



# After Completing the Advance Care Plan

Now that I have completed this document, I will:

- Keep the original copy of this document where it can be easily found.
- Make several copies of this document and give to my:
  - Primary and Alternate Health Care Agents
  - Doctor and other health care providers
  - Health care facility (hospital, other) whenever I am admitted, and ask that it be placed in my medical record
- Talk to the rest of my family and close friends who might be involved if I have a serious illness or injury, making sure they know who my Health Care Agent is, and what my wishes are.

## When to Review Your Advance Care Plan

It is common to review and update an advance care plan regularly. You may want to review it with your annual physical exam or whenever any of the “Five D’s” occur.

- **Decade:** when you start each new decade of your life.
- **Death:** whenever you experience the death of a loved one.
- **Divorce:** when you experience a divorce or other major family change.
- **Diagnosis:** when you are diagnosed with a serious health condition.
- **Decline:** when you experience a significant decline or deterioration of an existing health condition, especially when you are unable to live on your own.

## Copies of This Document Have Been Given To:

### Primary (main) Health Care Agent

Name: \_\_\_\_\_ Telephone: \_\_\_\_\_

### Alternate Health Care Agent

Name: \_\_\_\_\_ Telephone: \_\_\_\_\_

### Health care Provider/Clinic/Hospital/Family Members

Name: \_\_\_\_\_ Telephone: \_\_\_\_\_

Name: \_\_\_\_\_ Telephone: \_\_\_\_\_

Name: \_\_\_\_\_ Telephone: \_\_\_\_\_

Name: \_\_\_\_\_ Telephone: \_\_\_\_\_

Name: \_\_\_\_\_ Telephone: \_\_\_\_\_

The ACP of _____ (print name) Birth Date _____ Completion Date _____
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If your wishes change, fill out a new form. Give copies of the new document to everyone who has copies of your previous one. Tell them to destroy the previous version.

# When You Want Help With Advance Care Planning

Advance care planning gives you the chance to talk with others. Health care providers, family members and important others can help you explore options. For more information contact:

## **Bemidji**

Advance Care Planning Program

Phone: (218) 333-6060

Email: [acp.bemidji@sanfordhealth.org](mailto:acp.bemidji@sanfordhealth.org)

## **Fargo**

Advance Care Planning Program

Phone: (701) 234-6980

Email: [acp.fargo@sanfordhealth.org](mailto:acp.fargo@sanfordhealth.org)

## **Bismarck**

Advance Care Planning Program

Phone: (701) 323-1ACP (1227)

Email: [acp.bismarck@sanfordhealth.org](mailto:acp.bismarck@sanfordhealth.org)

## **Sioux Falls**

DeGroot Center

Phone: (605) 312-3520

Email: [acp.siouxfalls@sanfordhealth.org](mailto:acp.siouxfalls@sanfordhealth.org)

