MINNESOTA MENTAL HEALTH POWER OF ATTORNEY FORM

IMPORTANT INFORMATION

This power of attorney authorizes another person (your agent) to make decisions for you (the principal). Your agent will be able to make decisions and act on your behalf, whether or not you are able to act for yourself.

This power of attorney does not authorize the agent to make health care decisions for you. Such powers are governed by applicable laws for Advance Directives.

You should select someone you trust to serve as your agent. Unless you specify otherwise, generally the agent's authority will continue until you die or revoke the power of attorney or the agent resigns or is unable to act for you.

If your agent is unable or unwilling to act for you, your power of attorney will end unless you have named a successor agent. You may also name a second successor agent.

This power of attorney becomes effective immediately unless you state otherwise in the Special Instructions.

If you have questions about the power of attorney or the authority you are granting to your agent, you should seek legal advice before signing this form.

The following forms are available from the National Resource Center on Psychiatric Advance Directives.

MINNESOTA STATUTE § 145C
HEALTH CARE DIRECTIVE
OF

_____
_____

(Your Name)

I, _____, understand this document allows me to do
ONE OR BOTH of the following:

Part I: Name another person (called the health care agent) to make health care decisions for me if I am unable to decide or speak for myself. My health care agent must make health care decisions for me based on the instructions I provide in this document (Part II), if any, the wishes I have made known to him or her, or must act in my best interest if I have not made my health care wishes known .

AND/OR

Part II: Give health care instructions to guide others making health care decisions for me. If I have named a health care agent, these instructions are to be used by the agent. These instructions may also be used by my health care providers, others assisting with my health care, and my family, in the event I cannot make decisions for myself.

Part I: Appointment of Health Agent

This is who I want to make health care decisions for me if I am unable to decide or speak for myself (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 I blank and go to Part II.

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

Relationship of my health care agent to me: _____ Telephone number of my health care agent: _____

Address of my health care agent: _____
_____
_____

(Optional) Appointment of Alternate Health Care Agent: If my health care agent is not reasonably available, I trust and appoint _____ to be my health care agent instead.

Relationship of alternate health care agent to me: _____ Telephone number of my alternate health care agent: _____ Address of my alternate health care agent: _____
_____
_____

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

(I know I can change these choices)

My health care agent is automatically given the powers listed below in (A) through (D). My health care agent must follow my health care instructions in this document or any other instructions I have given to my agent. If I have not given health care instructions, then my agent must act in my best interest.

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

(A) Make any health care decision for me. This includes the power to give, refuse, or withdraw consent to any care, treatment, service, or procedures. This includes deciding whether to stop or not start health care that is keeping me or might keep me alive, and deciding about intrusive mental health treatment.

(B) Choose my health care providers .

(C) Choose where I live and receive care and support when those choices relate to my health care needs.

(D) Review my medical records and have the same rights that I would have to give my medical records to other people.

If I DO NOT want my health care agent to have a power listed above in (A) through (D) OR if I want to LIMIT any power in (A) through (D), I MUST say that here: _____
_____
_____
_____
_____

My health care agent is NOT automatically given the powers listed below in (1) and (2). If I WANT my agent to have any of the powers in (1) and (2), I must INITIAL the line in front of the power; then my agent WILL HAVE that power .

(1) To decide whether to donate any parts of my body, including organs, tissues, and eyes, when I die.

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

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

_____
_____
_____

Part II: Health Care Instructions

NOTE: Complete this Part II if you wish to give health care instructions. If you appointed an agent in Part I, completing this Part II is optional but would be very helpful to your agent. However, if you chose not to appoint an agent in Part I, you MUST complete some or all of this Part 11 if you wish to make a valid health care directive.

These are instructions for my health care when I am unable to decide or speak for myself. These instructions must be followed (so long as they address my needs). THESE ARE MY BELIEFS AND VALUES ABOUT MY HEALTH CARE (I know I can change these choices or leave any of them blank)

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

1. My goals for my health care:_____
   _____
   _____

2. My fears about my health care:_____
   _____
   _____

3. My spiritual or religious beliefs and traditions:_____
   _____
   _____

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

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

_____

6. (For a woman of childbearing age) My thoughts about how my health care should be handled in the event I am pregnant: _____

_____

_____

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

(I know I can change these choices or leave any of them blank)

Many medical treatments may be used to try to improve my medical condition or to prolong my life. Examples include artificial breathing by a machine connected to a tube in the lungs, artificial feeding or fluids through tubes, attempts to start a stopped heart, surgeries, dialysis, antibiotics, and blood transfusions . Most medical treatments can be tried for a while and then stopped if they do not help.

I have these views about my health care in these situations:
(NOTE: You can discuss general feelings, specific treatments, or leave any of them blank)

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

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

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

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

5. 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:_____
_____
_____

There are other things that I want or do not want for my health care, if possible:

1. Who I would like to be my doctor:_____

_____ 2.

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

_____

3. Where I would like to die and other wishes I have about dying:_____

_____

_____

4. My wishes about donating parts of my body when I die:_____

_____

_____ 5.

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

_____

_____

6. Any other things:_____

_____

_____

_____

Part III: Making The Document Legal

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

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

_____

_____ _ My signature

If I cannot sign my name, I can ask someone to sign this document for me.

Date signed: _____ Date of birth : _____

Address: _____

_____

_____

_____

_____

Signature of person who I asked to sign this document for me

Printed name of person who I asked to sign this document for me

Option 1: Notary Public

In my presence on _____ (date), _____(name) 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 .

Subscribed and sworn to before me this
_____ day of _____, _____.

_____ Notary
Public

Option 2: Two Witnesses

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

Witness One:

(i) In my presence on _____ (date), _____(name) acknowledged his/her signature on this document or acknowledged that he/she authorized the person signing this document to sign on his/her behalf. (ii) I am at least 18 years of age.

(iii) I am not named as a health care agent or an alternate health care agent in this document.

(iv) If I am a health care provider or an employee of a health care provider giving direct care to the person listed above in (i), I must initial this box: [ ]

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

_____
_____ (Signature of Witness One)

Address:
_____
_____

_____
_____

_____
_____

Witness Two:

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

(ii) I am at least 18 years of age.

(iii) I am not named as a health care agent or an alternate health care agent in this document.

(iv) If I am a health care provider or an employee of a health care provider giving direct care to the person listed above in (i), I must initial this box: [ ]

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

_____
_____ (Signature of Witness Two)

Address:
_____
_____

_____
_____

_____
_____

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