Minnesota
Catholic Health Care Directive

Approved by the Catholic Bishops of Minnesota
December 6, 2006

Resurrection of the body is a foundational belief in the Roman Catholic Church.
Catholics declare this belief publicly every Sunday as part of Liturgy of the Word and Eucharist.

Death the final experience of every living person on earth is a reality. Questions and concerns about death may be frightful, intimidating, and even avoided.

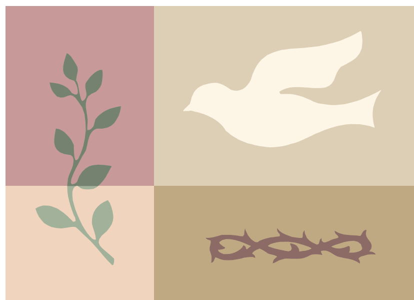
Who will speak for me when I cannot speak for myself? How can I make sure the decisions made about my health care are morally right? These are questions being asked with increasing frequency.

People often avoid questions like these until faced with having to make a decision. Many of us believe that only the sick or dying need to think about such matters. However, these are questions we all must ask and be able to answer—whether we are young or old, sick or healthy. There could come a time in any person's life where he or she may not be able to communicate his or her wishes.

For the past several decades, the increase of life-prolonging technologies, pharmaceuticals, early diagnoses of disease, detection of potential life-threatening conditions, and successful rehabilitation of traumatic injuries have contributed to addressing the end of life issues.

The compassionate caring of hospice staff, the peaceful and supportive environment of hospice facilities and units, the rise of movements of self-determination, personal responsibility and informed conscience in moral decision making have added motivation toward end of life conversations.

To assist Catholics of the state who wish to have an advance directive, the Minnesota Catholic Conference comprised of the Minnesota Catholic Bishops has prepared a **Catholic Health Care Directive** that meets the state's legal requirements and reflects Church's teaching and the recommendations of church, health care, and community leaders. The Conference has also prepared a Guide to answer some basic questions about the law, church teaching, and completing a health care directive.



MINNESOTA CATHOLIC HEALTH CARE DIRECTIVE

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 CARE 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 my alternate health care agent to me: ____

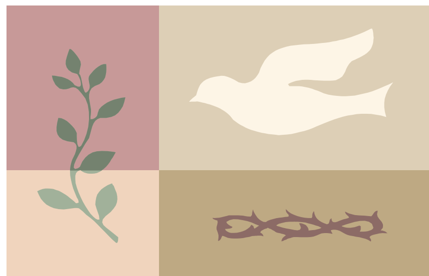
Telephone number of my alternate health care agent: ____

Address of my alternate health care agent: ____

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 II 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

My Wishes

This is what I want my health care agent - or if I have no health care agent, whoever will make decisions regarding my care - to do if I am unable to make and communicate health care decisions for myself. Most of what I state here is general in nature since I cannot anticipate all the possible circumstances of a future illness. If I have not given specific instructions, then my agent must decide consistent with my wishes and beliefs.

As a Catholic, I believe that God created me for eternal life in union with Him. I understand that my life is a precious gift from God and that this truth should inform all decisions with regards to my health care. I have a duty to preserve my life and to use it for God's glory. Suicide, euthanasia, and acts that intentionally and directly would cause my death by deed or omission, are never morally acceptable. However, I also know that death, being conquered by Christ, need not be resisted by any and every means and that I may refuse any medical treatment that is excessively burdensome or would only prolong my imminent death. Those caring for me should avoid doing anything that is contrary to the moral teaching of the Catholic Church. I ask that decisions be thus made respectful of and according to the following principles:

- Medical treatments may be foregone or withdrawn if they do not offer a reasonable hope of benefit to me or are excessively burdensome.
- There should be a presumption in favor of providing me with nutrition and hydration if they are of benefit to me.
- In accord with the teachings of my Church, I have no moral objection to the use of medication or procedures necessary for my comfort even if they may indirectly and unintentionally shorten my life.
- If my death is imminent, I direct that there be forgone or withdrawn treatment that will only maintain a precarious and burdensome prolongation of my life, unless those responsible for my care judge at that time that there are special and significant reasons why I should continue to receive such treatment.
- If I fall terminally ill, I ask that I be told of this so that I might prepare myself for death, and I ask that efforts be made that I be attended by a Catholic priest and receive the Sacraments of Reconciliation, Anointing, and Eucharist as viaticum.

Making an Anatomical Gift (Optional)

So long as it is consistent with Catholic moral teaching, I would like to be an organ donor at the time of my death. I wish to donate the following (initial one statement):

[ ] Any needed organs and tissue.

[ ] Only the following organs and tissue: ____

"My Wishes" in the section above completes my health care directive. ☐ **Yes** _________(initials)

☐ **No, in addition to the "My Wishes" section, above,** I would like you to know these further things about me to help you make decisions about my health care:

Believing none of the following directives conflicts with the teachings of my Catholic faith or the directives listed above, I add the following directives: *(You do not need to complete this section. If you do, you can use an extra sheet, if needed and you may make changes to these choices or leave any of them blank)*

My goals for my health care: ____

My fears about my health care: ____

My spiritual or religious beliefs and traditions: ____

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

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

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*)

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

If I were dying and 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 ___________________________________

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

Who I would like to be my doctor: ____

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

Where I would like to die and other wishes I have about dying: ___________________________________

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

Any other things: ____

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.

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 III: MAKING THE DOCUMENT LEGAL

This document must be signed by me. It also must either be verified 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 Date signed

Date of birth: _______________

Address: ____________________________________

____

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

____

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

____

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

This health care directive will not be valid unless it is notarized or signed by two qualified witnesses who are present when you sign or acknowledge your signature. If you have attached any additional pages to this form, you must date and sign each of the additional pages at the same time you date and sign this health care directive.

If notarized: The person notarizing this document may be an employee of a health care or long-term care provider providing your care. If witnessed: At east one witness to the execution of the document must not be a health care or long-term care provider providing you with direct care or an employee of the health care or long-term care provider providing you with direct care.

None of the following may be used as a notary or witness:
1. A person you designate as your agent or alternate agent;
2. Your spouse;
3. A person related to you by blood, marriage, or adoption;
4. A person entitled to inherit any part of your estate upon your death; or
5. A person who has, at the time of executing this document, any claim against your estate

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.

____
(Signature of Notary) (Notary Stamp)

Option 2: Two Witnesses

Two witnesses 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
(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 (A), I must initial this box [ ]
I certify that the information in (i) through (iv) is true and correct.

____
(Signature of Witness One)

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
(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 (A), I must initial this box [ ]
I certify that the information in (i) through (iv) is true and correct.

____
(Signature of Witness Two)

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.