BlueCross BlueShield Minnesota

MINNESOTA ADVANCE HEALTH CARE DIRECTIVE

You have the right to make your own health care treatment decisions

Blue Plus Blue Advantage (Prepaid Medical Assistance Program and Minnesota Senior Care Plus) and MinnesotaCare member services **(651) 662-5545** or toll free at **1-800-711-9862**, 8 a.m. to 5 p.m., Monday through Thursday, 9 a.m. to 5 p.m., Friday

Blue Plus SecureBlue (MSHO) member services **(651) 662-6013** or toll free at **1-888-740-6013**, 8 a.m. to 8 p.m., seven days a week

TTY users call **711**

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.

LB3-0001 (3-13)

This information is available in other forms to people with disabilities by calling Blue Plus member services at **(651) 662-5545** (voice), **1-800-711-9862** (toll free), TTY **711**, or through the Minnesota Relay direct access numbers at **1-800-627-3529** (TTY, voice, ASCII, hearing carryover), or **1-877-627-3848** (speech-to-speech).

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 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 health plan primary care provider prior to the referral.

SecureBlue is an HMO SNP plan with a Medicare contract and a contract with the Minnesota Medicaid program. Enrollment in SecureBlue depends on contract renewal.

MINNESOTA ADVANCE HEALTH CARE DIRECTIVE

This form helps you document how you want to be treated if you get very sick.

If you fill out this form, you have met the Minnesota state legal requirements for it to be honored. The health care directive replaces the living will and durable power of attorney for health care.

You do not need to get help from a lawyer to fill out this form.

It is your choice to fill out this form. Even if you don't have a form, doctors will still treat you.

You can cancel or change this form at any time by filling out a new one. You can also cancel parts or all of this form at any time by telling your provider what you want to cancel.

This form has three parts. You can choose to fill out only part 1 or part 2, or both. You must always complete part 3.

- **Part 1: Choose and write down the name of a health care agent.**
  A health care agent is a person who can make medical decisions for you if you choose not to, or are too sick to make them yourself.
- **Part 2: Make your own health care choices.**
  This form lets you choose the kind of health care you want. This way, those who care for you will not have to guess what you want if you are too sick to tell them yourself.
- **Part 3: Sign and date the form.**
  Before it can be used, the form must be signed and dated by you and two witnesses or a notary. If you are physically unable to sign this form yourself, you can ask your witness(es) to sign without your signature.

MINNESOTA ADVANCE HEALTH CARE DIRECTIVE

What do I do with the form after I fill it out?

Share the form with those who care for you:

- doctors
- nurses
- social workers
- family
- friends

What if I change my mind?

- Talk to your health care provider about the changes you want to make
- Update your existing form, or fill out a new form
- Re-sign the document in front of two witnesses or a notary
- Tell those who care for you about your changes

What if I have questions about the form?

- Ask your doctors, nurses, social workers, family or friends to answer your questions

What if I want to make health care choices that are not on this form?

- Write down your choices on page 9
- You could also write your choices on a piece of paper and sign it in front of two witnesses or a notary. Keep the paper with this form.
- Share your choices with those who care for you

NEXT STEPS:

- **If you only want a health care agent, go to part 1**
- **If you only want to record your health care choices, go to part 2**
- **If you want both, fill out part 1 and part 2**
- **Always sign the form in part 3**

PART 1: CHOOSE YOUR HEALTH CARE AGENT

A health care agent is a person who can make medical decisions for you if you are too sick to make them yourself.

Whom should I choose to be my health care agent?

A family member or friend who:

- is at least 18 years old
- knows you well
- can be there for you when you need him or her
- you trust to do what is best for you
- can tell your doctors about the decisions you made on this form

You can choose to have one or more people act together as your health care agent. It is up to you to decide. However, your agent cannot be your doctor or someone who works at your hospital or clinic, unless you explain in writing why you want this person to be your agent. Unless you specifically state that your spouse can serve as your agent regardless of any future events, marriage dissolution or annulment will disqualify him or her from serving as your agent.

What will happen if I do not choose a health care agent?

If you are too sick to make your own decisions and you do not have an agent, your doctors will ask your closest family members to make decisions for you. This is why it is important to name the person you want to be your health care agent.

What kind of decisions can my health care agent make?

Your health care agent can agree to, say no to, change, stop or choose:

- doctors, nurses, social workers
- hospitals or clinics
- medications, tests or treatments
- what happens to your body and organs after you die

PART 1: CHOOSE YOUR HEALTH CARE AGENT

Your agent can make decisions about the following kinds of care for you:

LIFE-SUPPORT TREATMENTS

Medical care to try to help you live longer

- *CPR or cardiopulmonary resuscitation*
  Definition: cardio (heart), pulmonary (lungs), resuscitation (to bring back)

  CPR may involve:

  - pressing hard on your chest to keep your blood pumping
  - electrical shocks to jumpstart your heart
  - medicines in your veins
- *Breathing machine or ventilator*
  The machine pumps air into your lungs and breathes for you. You are not able to talk when you are on the machine
- *Dialysis*
  A machine that cleans your blood if your kidneys stop working
- *Feeding tube*
  A tube used to feed you if you cannot swallow. The tube is placed down your throat into your stomach. It can also be placed during a surgery.
- *Intravenous fluids*
  Puts fluid into your veins so you can stay hydrated and receive nutrients
- *Blood transfusions*
  Puts blood into your veins
- *Surgery*
- *Medicines*
  Such as antibiotics

END-OF-LIFE CARE

To help you be as comfortable as possible, your health care agent can:

- call in a spiritual leader such as a priest, minister or rabbi
- decide where you are cared for (examples: home or hospital)

NEXT STEPS:

- **Show your health care agent this form**
- **Tell your agent what kind of medical care your want**

PART 1: CHOOSE YOUR HEALTH CARE AGENT

I want this person to help make my medical decisions:

☐ I want one health care agent ☐ I want more than one health care agent

1. _____
name date relationship

_____
address city state ZIP code

( ) ( ) ( )
home phone number work phone number cell phone number

2. _____
name date relationship

_____
address city state ZIP code

( ) ( ) ( )
home phone number work phone number cell phone number

Optional: Alternate health care agent

_____
name date relationship

_____
address city state ZIP code

( ) ( ) ( )
home phone number work phone number cell phone number

Optional: Please explain why you have chosen these persons as your health care agent(s)

_____

_____

NEXT STEPS:

- **To make your own health care choices, go to part 2**
- **To sign this form, go to part 3**

PART 2: MAKE YOUR OWN HEALTH CARE CHOICES

Think about what makes your life worth living. Put an 'X' in the box next to all the sentences you most agree with.

My life would not be worth living if I could not:

- ☐ talk to family or friends
- ☐ wake up from a coma
- ☐ feed, bathe, or take care of myself
- ☐ be free from pain
- ☐ live without being hooked up to machines
- ☐ I am not sure

My life is always worth living no matter how sick I am

If I am dying, I would like to be:

- ☐ at home
- ☐ in the hospital
- ☐ I am not sure

What I want people to know about my religion or spirituality: _____

_____

_____

_____

_____

_____

_____

PART 2: MAKE YOUR OWN HEALTH CARE CHOICES

Life-support treatments are used to try to keep you alive. These can be CPR, a breathing machine, feeding tube, dialysis, blood transfusions or medicine.

Put an 'X' in the box next to the sentences you most agree with.

Please read this whole page before you make your choices.

If I am so sick that I may die soon:

☐ Try all life-support treatments that my doctors think might help. If the treatments do not work and there is little hope of getting better, I want to stay on life-support machines.

☐ Try all life-support treatments that my doctors think might help. If the treatments do not work and there is little hope of getting better, I do not want to stay on life-support machines.

☐ Try some life-support treatments that my doctors think might help, but NOT these treatments. (Mark what you do NOT want.)

- ☐ CPR ☐ feeding tube ☐ dialysis ☐ blood transfusion
- ☐ medicine ☐ fluids ☐ breathing machine
- ☐ other treatments (list) _____

_____

☐ I do not want any life-support treatments

☐ I want my health care agent to decide for me

☐ I am not sure

Other things I'd like to have or not have:

_____

_____

My agent cannot make the following types of health care decisions for me:

_____

_____

I want to limit my agent's decision powers in the following ways:

_____

_____

PART 2: MAKE YOUR OWN HEALTH CARE CHOICES

Your doctors may ask about organ donation after you die. Donating (giving) your organs can help save lives.

Put an 'X' in the box next to the sentences you most agree with.

☐ Yes, I want to donate my organs

- ☐ any organs
- ☐ only _____

☐ No, I do not want to donate my organs

☐ I want my health care agent to decide

☐ I am not sure

What my doctors should know about how I want my body to be treated after I die:

_____

_____

_____

_____

_____

_____

NEXT STEPS:

→ **To sign this form, go to part 3**

PART 2: MAKE YOUR OWN HEALTH CARE CHOICES

Other choices I would like my health care agent and people who care for me to know:

PART 3: SIGN THE FORM

INSTRUCTIONS

Before this form can be used, you must:

- sign this form in front of two witnesses or a notary, and
- have your two witnesses or a notary sign the form

WITNESSES

By signing, witnesses are confirming that you have acknowledged your signature on this document or that you've authorized the signee to sign on your behalf

Your witnesses must:

- be over 18 years of age
- know you
- watch you sign this form

Your witnesses cannot:

- be your health care agent
- benefit financially (get any money) after your death
- both be your direct care providers (only one of the witnesses can be your direct care provider)

Witnesses must sign their names on page 11.

NOTARY PUBLIC

- If you do not have witnesses, you need a notary public. A notary public's job is to make sure it is you signing the form.
- Take this form to a notary public and have them sign on page 12

PART 3: SIGN THE FORM

Sign your name and write the date

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

sign your name | date

print your first name | print your last name | date of birth

address | city | state | ZIP code

Have your witnesses sign their names and write the date

Witness #1

sign your name | date

print your first name | print your last name

address | city | state | ZIP code

Witness #2

sign your name | date

print your first name | print your last name

address | city | state | ZIP code

YOU HAVE NOW COMPLETED YOUR ADVANCE HEALTH CARE DIRECTIVE FORM

Give copies of this form to your doctors, nurses, social workers, friends, family and health care agent(s). Talk with them about your choices.

Keep the original form in a safe place. Do not put the completed form in a safe deposit box. Make sure it is easy to find.

PART 3: SIGN THE FORM

Notary Public

Take this form and your photo identification (driver's license, passport, etc.) to a notary public if two witnesses have not signed this form.

Sign your name and write the date.

_____

sign your name date

_____

print your first name print your last name

_____

address city state ZIP code

Certificate of Acknowledgment of Notary Public

State of Minnesota

In my presence on this_____day of_____in the year_____

_____

print name of person completing this form

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.

Notary Seal

_____

signature date

YOU HAVE NOW COMPLETED YOUR ADVANCE HEALTH CARE DIRECTIVE FORM

Give copies of this form to your doctors, nurses, social workers, friends, family and health care agent(s). Talk with them about your choices.

Keep the original form in a safe place. Do not put the completed form in a safe deposit box. Make sure it is easy to find.

My primary care physician is: _____

Address: _____

Phone : _____

BlueCross BlueShield Minnesota

Blue Cross® and Blue Shield® of Minnesota and Blue Plus® are nonprofit independent licensees of the Blue Cross and Blue Shield Association

My primary care physician is: _____

Address: _____

Phone : _____

BlueCross BlueShield Minnesota

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Minnesota Advance Health Care Directive wallet cards

1. **Tear off card**
2. **Fill it out**
3. **Keep it with you**

Important notice to medical personnel
I have an Advance Health Care Directive.
In case of emergency, please consult this document or contact my health care agent.

My health care agent is: _____

Address: _____

Phone: _____

My document is located: _____

_____

Important notice to medical personnel
I have an Advance Health Care Directive.
In case of emergency, please consult this document or contact my health care agent.

My health care agent is: _____

Address: _____

Phone: _____

My document is located: _____

_____

LIVE FEARLESS℠

BlueCross BlueShield Minnesota

As Minnesota's health care leader, we live fearless. We believe good health is for everyone — not just our members. It's a big vision. And that's why we're investing in the communities we serve and empowering individuals to make smart choices about their health. Live fearless with the peace of mind that comes from knowing you're protected by the strength and stability of Blue Cross. We invite you to join us.

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