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: _____

_____

bluecrossmn.com/secureblue

BlueCross BlueShield Minnesota

MINNESOTA ADVANCE HEALTH CARE DIRECTIVE

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

1009016MNMENBSM 06/21

DHS_061720_KK01 DHS Approved 07/06/2020

My primary care physician is: _____

Address: _____

Phone : _____

My primary care physician is: _____

Address: _____

Phone : _____

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

Blue Advantage[SM] and MinnesotaCare
Toll Free 1-800-711-9862, TTY 711

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

ያስተውሉ: ካለምንም ክፍያ ይህንን ዶኩመንት የሚተረጉምሎ አስተርጓሚ ከፈለጉ ከላይ ወደተጻፈው የስልክ ቁጥር ይደውሉ።

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

သတိ။ ဤစွက်စာတမ်းအားအခမဲ့ဘာသာပြန်ပေးခြင်း အကူအညီလိုအပ်ပါက၊ အထက်ပါဖုန်းနံပါတ်ကိုခေါ် ဆိုပါ။

កំណត់សំគាល់ ។ បើអ្នកត្រូវការជំនួយក្នុងការបកប្រែឯកសារនេះដោយឥតគិតថ្លៃ សូមហៅទូរស័ព្ទតាមលេខខាងលើ ។

請注意，如果您需要免費協助傳譯這份文件，請撥打上面的電話號碼。

Attention. Si vous avez besoin d'une aide gratuite pour interpréter le présent document, veuillez appeler au numéro ci-dessus.

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.

ဟ်သူဉ်ဟ်သးဘဉ်တကွ်. ဖဲနမ့ါလိဉ်ဘဉ်တ်မၤစၢၤကလီလၢတ်ကကျိးထံဝဲဒဉ်လ်ာ် တီလ်ာမီတခါအံၤနူဉ်,ကိးဘဉ် လီတဲစိနီါဂ်ါလၢထးအံၤနူဉ်တကွ်.

알려드립니다. 이 문서에 대한 이해를 돕기 위해 무료로 제공되는 도움을 받으시려면 위의 전화번호로 연락하십시오.

ໂປຣດຊາບ. ຖ້າຫາກ ທ່ານຕ້ອງການການຊ່ວຍເຫຼືອໃນການແປເອກະສານນີ້ຟຣີ, ຈົ່ງ ໂທຣໄປທີ່ໝາຍເລກຂ້າງເທິງນີ້.

Hubachiisa. Dokumentiin kun tola akka siif hiikamu gargaarsa hoo feete, lakkoobsa gubbatti kenname bilbili.

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 (afcelinta) 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.

Civil Rights Notice

Discrimination is against the law. Blue Plus does not discriminate on the basis of any of the following:

- race
- color
- national origin
- creed
- religion
- sexual orientation
- public assistance status
- age
- disability (including physical or mental impairment)
- sex (including sex stereotypes and gender identity)
- marital status
- political beliefs
- medical condition
- health status
- receipt of health care services
- claims experience
- medical history
- genetic information

Auxiliary Aids and Services: Blue Plus provides auxiliary aids and services, like qualified interpreters or information in accessible formats, free of charge and in a timely manner to ensure an equal opportunity to participate in our health care programs. Contact Blue Plus at Civil.Rights.Coord@bluecrossmn.com, or call Blue Advantage[SM] and MinnesotaCare Member Services at 1-800-711-9862 (toll free), or your preferred relay services.

Language Assistance Services: Blue Plus provides translated documents and spoken language interpreting, free of charge and in a timely manner, when language assistance services are necessary to ensure limited English speakers have meaningful access to our information and services. Contact Blue Plus at Civil.Rights.Coord@bluecrossmn.com, or call Blue Advantage[SM] and MinnesotaCare Member Services at 1-800-711-9862 (toll free), or your preferred relay services.

Civil Rights Complaints

You have the right to file a discrimination complaint if you believe you were treated in a discriminatory way by Blue Plus. You may contact any of the following four agencies directly to file a discrimination complaint.

U.S. Department of Health and Human Services' Office for Civil Rights (OCR)

You have the right to file a complaint with the OCR, a federal agency, if you believe you have been discriminated against because of any of the following:

- race
- color
- national origin
- age
- disability
- sex
- religion (in some cases)

Contact the **OCR** directly to file a complaint:

U.S. Department of Health and Human Services
Office of Civil Rights
200 Independence Avenue SW
Room 515F
HHH Building
Washington, DC 20201
Customer Response Center: Toll-free: 800-368-1019
TDD 800-537-7697
Email: ocrmail@hhs.gov

Minnesota Department of Human Rights (MDHR)

In Minnesota, you have the right to file a complaint with the MDHR if you believe you have been discriminated against because of any of the following:

- race
- color
- national origin
- religion
- creed
- sex
- sexual orientation
- marital status
- public assistance status
- disability

Contact the **MDHR** directly to file a complaint:

Minnesota Department of Human Rights
540 Fairview Avenue North
Suite 201
St. Paul, MN 55104
651-539-1100 (voice)
800-657-3704 (toll free)
711 or 800-627-3529 (MN Relay)
651-296-9042 (fax)
Info.MDHR@state.mn.us (email)

Minnesota Department of Human Services (DHS)

You have the right to file a complaint with DHS if you believe you have been discriminated against in our health care programs because of any of the following:

- race
- color
- national origin
- creed
- religion
- sexual orientation
- public assistance status
- age
- disability (including physical or mental impairment)
- sex (including sex stereotypes and gender identity)
- marital status
- political beliefs
- medical condition
- health status
- receipt of health care services
- claims experience
- medical history
- genetic information

Complaints must be in writing and filed within 180 days of the date you discovered the alleged discrimination. The complaint must contain your name and address and describe the discrimination you are complaining about. After we get your complaint, we will review it and notify you in writing about whether we have authority to investigate. If we do, we will investigate the complaint.

DHS will notify you in writing of the investigation's outcome. You have the right to appeal the outcome if you disagree with the decision. To appeal, you must send a written request to have DHS review the investigation outcome. Be brief and state why you disagree with the decision. Include additional information you think is important.

If you file a complaint in this way, the people who work for the agency named in the complaint cannot retaliate against you. This means they cannot punish you in any way for filing a complaint. Filing a complaint in this way does not stop you from seeking out other legal or administrative actions.

Contact **DHS** directly to file a discrimination complaint:

Civil Rights Coordinator
Minnesota Department of Human Services
Equal Opportunity and Access Division
P.O. Box 64997
St. Paul, MN 55164-0997
651-431-3040 (voice) or use your preferred relay service

Blue Plus Complaint Notice

You have the right to file a complaint with Blue Plus if you believe you have been discriminated against because of any of the following:

- Medical Condition
- Health Status
- Receipt of Health Care Services
- Claims Experience
- Medical History
- Genetic Information
- Disability (including mental or physical impairment)
- Marital Status
- Age
- Sex (including sex stereotypes and gender identity)
- Sexual Orientation
- National Origin
- Race
- Color
- Religion
- Creed
- Public Assistance Status
- Political Beliefs

You can file a complaint and ask for help in filing a complaint in person or by mail, phone, fax, or email at:

Nondiscrimination Civil Rights Coordinator
Blue Cross and Blue Shield of Minnesota and Blue Plus
M495
PO Box 64560
Eagan, MN 55164-0560
Toll Free: 1-800-509-5312
TTY: 711
Fax: 651-662-9478
Email: Civil.Rights.Coord@bluecrossmn.com

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 elders 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.

1031603MNMMLBSM 02 21 DHS_022421_KK01 DHS Approved 02/25/2021

MINNESOTA ADVANCE HEALTH CARE DIRECTIVE

This form helps you document how you want to be treated if you get very sick and can no longer make your own medical decisions.

If you fill out this form, you meet 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, but you can choose to review this with your attorney. It is your decision 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, or 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 sign and date the form.

→ 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 page 3**
- **If you only want to record your health care choices, go to page 6**
- **If you want both, go to page 3 and page 6**
- **Always sign the form on page 11**

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 or 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 you want**

PART 1: CHOOSE YOUR HEALTH CARE AGENT

If I am too sick to make my medical decisions, I want:

☐ One health care agent to make my medical decisions for me

☐ Two health care agents to jointly make my medical decisions for me

1. _____
Name Date Relationship

_____
Address City State ZIP code

( ) ( ) ( )
Home phone number Work phone number Cellphone number

2. _____
Name Date Relationship

_____
Address City State ZIP code

( ) ( ) ( )
Home phone number Work phone number Cellphone number

If the health care agent(s) listed above is/are not available, please contact:

_____
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 page 6**
- **To sign this form, go to page 11**

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 page 11**

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 _____

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

Printed Name _____ Signature (of person asked to sign for me) _____

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 _____

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.