DOWNLOAD COVERSHEET:

This is a standard advance directive for your state, made available to you as a courtesy by Lifecare Directives, LLC. You should be aware that extensive research has demonstrated that there are significant drawbacks to using a very brief state-standard document. As one researcher has noted, "the development of statutory forms occurs in the legislative arena, [so] their content is the result of a political rather than a 'scientific' process." Because of "political compromise, ...many of the forms ultimately passed by the legislatures are not optimal from a consumer perspective" (see: Hoffmann, Diane E; Zimmerman, S; Tompkins, C. The dangers of directives, or the false security of forms. *Journal of Law, Medicine & Ethics*. 1996;24(1) (Spring):5-17).

American Bar Association concurs, noting that "The statutory advance directive is not necessarily the exclusive, or even the best, pathway for individuals to follow," and suggesting that revised and enhanced documents "may be especially helpful as a...replacement for statutory forms where restrictions in a statutory directive prevents the individual from fully expressing his or her wishes" (see: American Bar Association. (1991). *Patient Self Determination Act State Law Guide*. Government printing office, Washington, DC).

Lifecare Directives staff have reviewed more than 6,000 medical, legal, academic, and news media articles on advance directives, as well as reviewing hundreds of document forms. They have also conducted formal research with scores of medical, legal, and academic processionals along with more than 1,000 lay public participants. From this process, more than 30 additional key living will and medical power of attorney enhancements have been identified that should be included in any living will (or "health care instruction" or "declaration") and medical power of attorney (or "proxy") forms that you may use.

Please consider obtaining the *Lifecare Advance Healthcare Directive* to obtain these important additions and benefits. To better understand the important enhancements available through this combined living will and medical power of attorney, you may wish to obtain the booklet, "*Should I Use a Shorter Standard Directive?*" available through Lifecare Directives, LLC.

If you have any other questions about this document or other Lifecare resources, please do not hesitate to contact our staff who will make every effort to fully respond your inquiries and address any questions you may have. We can be reached at the following:

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~ Lifecare Directives ~

Advance Health Care Directive

For

South Dakota Residents

Statutory Compliant Advance Directive for Health Care Choices

~ Lifecare Directives ~

Advance Health Care Directive

For

South Dakota Residents

Statutory Compliant Advance Directive for Health Care Choices

Important Notice:

An advance directive is not a substitute for medical, legal or other necessary advice or direction. This document should not be construed as offering counseling, medical, legal, financial, or estate planning or advice, nor any other similar guidance or direction. Such counsel should be obtained from qualified, certified, and licensed professionals in your locale who are experienced in the specific areas of concern. Completion of this document constitutes acceptance of its content both in whole and in part, as well as a determination of its utility for the purposes indicated. Lifecare Directives, LLC, and all involved in this document's design, publication, and distribution assume no liability for its use, including that which may arise from omissions, technical inaccuracies, and typographical errors. Diligent efforts notwithstanding, this document is not warrantied to be in compliance with state and local laws. All warranties, including those of merchantability, fitness for a particular purpose, and non-infringement are expressly disclaimed. The utilizer agrees to seek appropriate outside review prior to completion. The utilizer and all heirs, assigns, designees, devisees, representatives, and all others involved, agree to assume all liability for its use and any subsequent outcomes, and to release and hold harmless all involved in its design, publication, advertising and distribution. The utilizer also agrees that any physician, health care provider, agent, proxy, surrogate, representative, mediator, court officer, and all others relying on the document's content are similarly free of all liability, when they act in good faith and with due diligence to follow the recorded wishes and directions.

Advance Health Care Directive
For South Dakota Residents

________________________________ ________________________________
Print Full Name *Date of Birth*

Your right *(when age 18 or older): To Document Your Personal Wishes,*
and to have these wishes followed ~~

The South Dakota legislature has provided statutes guiding the construction of both a Living Will and a Power of Attorney for Health Care for use by the public. Collectively, these documents are known as "advance directives." As the content of these documents was designed by your state government, each should be in compliance with all applicable statutes and laws.

There is an introduction to each that summarizes the scope and purpose of the documents, as well as providing further directions for completion. Read them carefully to ensure that your advance directives are fully and properly filled out.

Understanding Your Directive

To make the *best* choices for your medical care, your physician needs to know *your* wishes. In fact, the law requires doctors to seek your permission before giving you *any* treatment. However, if you are ever unable to make decisions due to severe illness or injury, this may not be possible. Completing this Directive will help your family and physicians know who should speak for you, and understand what you want if you cannot make this known yourself.

You can **revoke** (cancel) this directive at ***any*** time by: **1**) writing "revoked" across the front of the directive, followed by your signature and date, and the signature of at least one witness aged 18 years or older ; or **2**) by completing a Notice of Revocation; or **3**) by *telling* an adult witness that you want it revoked (who must then sign and date a statement, which becomes effective only when given to your doctor or health care provider); or **4**) *by simply completing a new directive* in which you state that any prior directive is no longer valid (as is already stated in this directive).

You can **limit** your directive and the authority of anyone named in it, but *no changes are recommended after the document is witnessed*. Any scope-of-authority or content changes needed *after* your directive has been witnessed should be made by completing a new directive. First-time changes can be made by lining out anything in the directive and writing "deleted" beside that clause or section (or initialing above any word(s) you have lined out), followed by your signature, and the signature of at least one of the persons serving as a witness to this document, placed in the margin immediately beside the change.

If you are **unable to write**, you may tell your directive witnesses what you want to have excluded, limited, or added to this directive. They must then sign, date, witness and/or notarize

the statement of the limitations and exclusions as you have described them. Remember, unless you direct otherwise, this directive will **only** be used to guide your family and doctors if you are unable to make and communicate medical treatment decisions for yourself.

Instructions for Completing the Directive:

This directive is written in two parts. While it is best if you fill out the whole document, you may choose to complete only ***Section I***, leaving just a statement of your values and wishes. Or you may complete only ***Section II***, just naming someone to speak for you. However, this may leave your family and others without any evidence to support your wishes in the future, or leave them unsure who is to make decisions and speak for you. Thus, omitting either section may cause your loved ones difficulty if they must eventually make medical choices in your behalf. So, you are strongly encouraged to complete the entire directive.

To complete each document, you should ***initial*** in the underlined spaces provided beside all the questions that are asked, and fill in any blank lines as directed. Feel free to write "No," "None," or "Does Not Apply" in areas that would otherwise be left blank.

SECTION I:

LIVING WILL DECLARATION

and Personal Instructions

(*Pursuant SDCL Title 34; Ch.12D: §34-12D-1 to §34-12D-29*)

1. INTRODUCTION: *The South Dakota Living Will was designed to assist those wishing to refuse life-sustaining treatment in a terminal or permanently unconscious condition (§34-12D-1(8)). A* ***terminal condition*** *is defined as, "an incurable and irreversible condition that...will cause death within a relatively short time if life-sustaining treatment is not administered"(§34-12D-1(8)). A* ***permanently unconscious condition*** *is defined as "a coma or other condition of permanent unconsciousness that...will last indefinitely without significant improvement and in which the individual...demonstrates no purposeful movement or motor ability, and is unable to interact purposefully with environmental stimulation"(§34-12D-1(8)).* ***Life-sustaining treatment*** *is, "any medical or surgical intervention that...will serve only to postpone the moment of death or to maintain...a condition of permanent unconsciousness"(§34-12D-1(4)). Such treatment does not include "the provision of appropriate care to maintain comfort, hygiene and human dignity, the oral administration of food and water, or the administration of any medication or other medical procedure deemed necessary to alleviate pain"(§34-12D-1(4)).*

LIVING WILL DECLARATION

Notice: This is an important legal document. This document directs the medical treatment you are to receive in the event you are unable to participate in your own medical decisions and you are in a terminal condition. This document may state what kind of treatment you want or do not want to receive. This document can control whether you live or die. Prepare this document carefully. If you use this form, read it completely. You may want to seek professional help to make sure the form does what you intend and is completed without mistakes.

This document will remain valid and in effect until and unless you revoke it. Review this document periodically to make sure it continues to reflect your wishes. You may amend or revoke this document at any time by notifying your physician and other health-care providers. You should give copies of this document to your physician and your family. This form is entirely optional. If you choose to use this form, please note that the form provides signature lines for you, the two witnesses whom you have selected and a notary public.

TO MY FAMILY, PHYSICIANS, AND ALL THOSE CONCERNED WITH MY CARE

2. Be it hereby known that I, ____,
~~ do willfully and voluntarily make this declaration as a directive to be followed if I am in a terminal condition and become unable to participate in decisions regarding my medical care.

3. With respect to any life-sustaining treatment, I direct the following: (*initial only one of the following optional directives if you agree. If you do not agree with any of the following directives, space is provided below for you to write your own directives*)

   A) _____ NO LIFE-SUSTAINING TREATMENT. I direct that no life-sustaining treatment be provided. If life-sustaining treatment is begun, terminate it.

   B) _____ TREATMENT FOR RESTORATION. Provide life-sustaining treatment only if and for so long as you believe treatment offers a reasonable possibility of restoring to me the ability to think and act for myself.

   C) _____ TREAT UNLESS PERMANENTLY UNCONSCIOUS. If you believe that I am permanently unconscious and are satisfied that this condition is irreversible, then do not provide me with life-sustaining treatment, and if life-sustaining treatment is being provided to me, terminate it. If and so long as you believe that treatment has a reasonable possibility of restoring consciousness to me, then provide life-sustaining treatment.

   D) _____MAXIMUM TREATMENT. Preserve my life as long as possible, but do not provide treatment that is not in accordance with accepted medical standards as then in effect.

4. With respect to artificial nutrition and hydration, I wish to make clear that:
(*Artificial nutrition and hydration is food and water provided by means of a tube or tubes inserted into the stomach, intestines, or veins. If you do not wish to receive this form of treatment, you must initial the statement "A" below: "I intend to include this treatment, among the 'life-sustaining treatment' that may be withheld or withdrawn.*")

(*initial only <u>one</u>*)

A) _____ I intend to *<u>include</u>* this treatment among the "life-sustaining treatment" that may be withheld or withdrawn.

B) _____ I do *<u>not</u>* intend to include this treatment among the "life-sustaining treatment" that may be withheld or withdrawn.

C) _____ Personal Statement of Wishes (*If you do not agree with any of the above printed directives and would rather write your own, or if you want to write directives <u>in addition</u> to the printed provisions, or if you want to express some of your other thoughts, you can do so here*): ________________________________

____

____

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5. Signed:____________________________________ Date: ________________________

Residence Address: ____

Statement of Witnesses

6. The declarant voluntarily signed this document in my presence. It appears that the principal appears to be of sound mind and under no duress, fraud, or undue influence.

7. 1st Witness: ____
(Signature)

____________________________________ ________________________
(Name Printed) (Date)

____
(Residence Address)

8. 2nd Witness: ____
(Signature)

____________________________________ ________________________
(Name Printed) (Date)

____
(Residence Address)

9. CERTIFICATE OF NOTARY PUBLIC

On this the ____________ day of _________________________________, 20_______,

the declarant, ____

and witness ____

and witness____

~~ personally appeared before the undersigned officer and signed the foregoing instrument in my presence.

____ Notary Seal:

Signature of Notary Public

Date Commission Expires: _____________________

SECTION II:
DURABLE POWER OF ATTORNEY FOR HEALTH CARE
DESIGNATION OF HEALTH CARE AGENT
(*Pursuant to SDCL Title 59: §59-1 to §57-7-9*)

10. INTRODUCTION. *There is no specifically "approved" format for a South Dakota durable power of attorney for health care, nor is there anything "to prevent" the use of any specific form provided it meets state statutory content and witnessing requirements (SD State Medical Association, "Planning for Health Care Decisions," March 1996). This form has been designed using the required statutes. It lets you name a person to make health care decisions for you, if you cannot make them for yourself. The person you name must be at least 18 years of age. If you have questions, you should seek legal advice.*

11. ***Be it known that I***:

Full Legal Name: ______________________________
Date of Birth: ______________________________
Street Address: ______________________________
City: ____________________ County: ____________________
State: ____________________ Zip Code: ____________________

~~ Intend by this document to create a durable power of attorney for health care. This power of attorney shall not be affected by my later disability, incompetency, or incapacity (as the "principal" herein). I am of sound mind, and state that execution of this document is voluntary and without duress. Creation of this power of attorney is for the purpose of designating someone to act as my health care agent (also known as my attorney-in-fact), to act in my place to make medical decisions for me if I become unable to make them for myself . It also grants my agent the authority to make other legal and personal care decisions as outlined in this document. This designation is effective when, in the opinion of my agent herein named and at least one licensed medical doctor who has personally examined me, I am no longer able make personal medical treatment decisions for myself. By creating this document I revoke any prior power of attorney for health care.

12. I understand that I am not required to choose an agent, but recognize that by doing so I may more fully ensure that my wishes are represented and carried out. I recognize that, by South Dakota law, this person may *not* be my health care provider nor an employee of my health care provider, unless related to me by blood, marriage or adoption. The person I have chosen to act as my agent and to whom I give **full** authority to make all medical and health care decisions for me at any time during which I am unable to make them for myself, is:

13. **Name of Agent**: ______________________________
Address: ______________________________
Telephone: Home:____________________Work:____________________
Cell Phone or Pager: ____________________ E-mail: ____________________

14. If for any reason I revoke the authority of my agent (above), or this individual is unavailable, unable, unwilling, or otherwise ineligible to make decisions for me, the following individuals (*to act alone and successively, in order of priority as listed*) are authorized to serve as alternate agents:

15. **Name of Alternate Agent #1:**_______________________________________
Address: ____
Telephone: Home:_____________________Work:______________________
Cell Phone or Pager: ___________________ E-mail: _____________________

16. **Name of Alternate Agent #2:** _______________________________________
Address: ____
Telephone: Home:_____________________Work:______________________
Cell Phone or Pager: ___________________ E-mail: _____________________

17. Each alternate successor designated shall be vested with the same power and duties as if originally named as my health care agent. These persons, *in priority of the order presented*, are to have binding authority over any and all other persons to make my personal and health care decisions.

SPECIFIC AGENT AUTHORITY AND GENERAL INTENT:

18. My agent shall have the same authority to make health care decisions for me as I would if I had the capacity to make them myself, subject to any limitations imposed through this document. In making decisions in my behalf *if my wishes are not clear*, I direct my agent to act in his/her best understanding of what my wishes would have been. And, where not reasonably sure of what I would have wanted, to act according to his/her belief in my interests as determined from his/her knowledge of my personal and family affairs, and other goals and values in life. The authority of my agent shall not be terminated *unless* it appears that he or she is clearly and obviously not acting in accordance with my known wishes, or is overwhelmingly ignoring my best interests if my wishes are not otherwise known. My intent is to facilitate the management of any and all medical matters necessary to provide for my health care and well-being by my agent in whom I have full faith and confidence, and to avoid costly conservatorship or other legal and court proceedings, where possible.

STATEMENT AND SIGNATURE OF PRINCIPAL/GRANTOR:

19. This document is governed by South Dakota law, although I request that it be honored in any state in which I may be found.

By signing below, I indicate that I am fully informed as to all the contents of this document, and understand its purpose, effect, consequences, and full import. Further, I am of legal age, and I am emotionally and mentally competent to complete this document. I am acting voluntarily and without fraud, duress or undue influence.

20. Signed:________________________________ Date: ______________________

At: (City) ______________________________ (State) _____________________

Qualified Witnesses

21. This Advance Directive for Health Care may not be upheld unless it is: 1) signed by two adult witnesses who are personally present when you sign, or 2) notarized. Notarization is not required, but is recommended, as witnesses may become unavailable in the future. South Dakota statutes offer no qualifying criteria for witnesses. However, typical criteria include the following:

Statement of Witnesses

22. I am at least 18 years of age. I know the principal personally, or I have been provided convincing evidence of identity. The principal has affixed (or caused to have affixed) his/her signature or mark in my presence. It appears that this document is being executed voluntarily, and the principal appears to be of sound mind and under no duress, fraud, or undue influence. I have not signed the principal's signature (above) for or at the direction of the principal. I declare under penalty of perjury that I am not related to the principal by blood, marriage, or adoption, nor am I directly responsible for his or her medical care or costs. I am not the agent or an alternate or successor named in this document. Further, I am not the attending physician or other health care provider, nor an employee of the physician or other health care provider, nor that of a current care facility, nor a party to any parent organization thereof. I am also not the employee of a life or health insurance provider for he principal, and to the best of my knowledge I have no claim against nor am I entitled to any part of the principal's estate upon his or her death under a will or codicil now existing, nor by any other operation of law.

23. 1st Witness: ____
(Signature)

______________________________ ____________________
(Name Printed) (Date)

____
(Residence Address)

24. 2nd Witness: ____
(Signature)

______________________________ ____________________
(Name Printed) (Date)

____
(Residence Address)

CERTIFICATE OF ACKNOWLEDGMENT OF NOTARY PUBLIC:

25. State of South Dakota,

County of______________________ }

On this_______day of ______________________________, in the year______, before me (insert officer name/title): __________________________________, personally appeared (insert name of Principal on line here):______________________________, personally known to me (or proved to me on the basis of satisfactory evidence (describe:________________________)) sworn to and acknowledged before me to be the person(s) whose name(s) is/are subscribed to this/these instrument(s) and acknowledged to me that he/she executed the same in his/her authorized capacity, and that by his/her signature on the instrument(s), executed the instrument(s). I declare that he/she appears of sound mind and not under or subject to duress, fraud, or undue influence, that he/she acknowledges the execution of the same to be his/her voluntary act and deed, and that I am not the agent (attorney-in-fact), proxy, surrogate, or a successor of any such, as designated within this document, nor do I hold any interest in his/her estate through a Will or by other operation of law.

WITNESS my hand and official seal.

____

Signature of Notary Public

Notary Seal:

____

Date Commission Expires