

SOUTH DAKOTA Advance Directive Planning for Important Healthcare Decisions

Caring Connections

1731 King St., Suite 100, Alexandria, VA 22314

www.caringinfo.org

800/658-8898

Caring Connections, a program of the National Hospice and Palliative Care Organization (NHPCO), is a national consumer engagement initiative to improve care at the end of life.

It's About How You LIVE

It's About How You LIVE is a national community engagement campaign encouraging individuals to make informed decisions about end-of-life care and services. The campaign encourages people to:

- L**earn about options for end-of-life services and care
- I**mplement plans to ensure wishes are honored
- V**oice decisions to family, friends and healthcare providers
- E**ngage in personal or community efforts to improve end-of-life care

Note: The following is not a substitute for legal advice. While Caring Connections updates the following information and form to keep them up-to-date, changes in the underlying law can affect how the form will operate in the event you lose the ability to make decisions for yourself. If you have any questions about how the form will help ensure your wishes are carried out, or if your wishes do not seem to fit with the form, you may wish to talk to your health care provider or an attorney with experience in drafting advance directives.

Using these Materials

BEFORE YOU BEGIN

1. Check to be sure that you have the materials for each state in which you may receive healthcare.
2. These materials include:
 - Instructions for preparing your advance directive, please read all the instructions.
 - Your state-specific advance directive forms, which are the pages with the gray instruction bar on the left side.

ACTION STEPS

1. You may want to photocopy or print a second set of these forms before you start so you will have a clean copy if you need to start over.
2. When you begin to fill out the forms, refer to the gray instruction bars — they will guide you through the process.
3. Talk with your family, friends, and physicians about your advance directive. Be sure the person you appoint to make decisions on your behalf understands your wishes.
4. Once the form is completed and signed, photocopy the form and give it to the person you have appointed to make decisions on your behalf, your family, friends, health care providers, and/or faith leaders so that the form is available in the event of an emergency.
5. South Dakota does not maintain an Advance Directive Registry. However you may record a durable power of attorney for health care (Part I of this form) at your county's registry of deeds. Be aware that, if you do record your advance directive, you will also need to record any revocation you make as well.
6. You may also want to save a copy of your form in Google Health, or another online medical records management service that allows you to share your medical documents with your physicians, family, and others who you want to take an active role in your advance care planning. You can read more about Google Health at <http://www.caringinfo.org/googlehealth>.

INTRODUCTION TO YOUR SOUTH DAKOTA ADVANCE DIRECTIVE

This packet contains a legal document, a **South Dakota Advance Directive**, that protects your right to refuse medical treatment you do not want, or to request treatment you do want, in the event you lose the ability to make decisions yourself. You may complete Part I, Part II, or both, depending on your advance-planning needs. You must complete Part III.

Part I contains a **South Dakota Durable Power of Attorney for Health Care**. This part lets you name someone to make decisions about your medical care—including decisions about life-sustaining procedures—if you can no longer speak for yourself. The durable power of attorney for health care is especially useful because it appoints someone to speak for you any time you are unable to make your own medical decisions, not only at the end of life.

Your durable power of attorney for health care goes into effect when your doctor determines that you are no longer able to make or communicate your health care decisions.

Part II contains a **South Dakota Declaration**, which is your state's living will. Your declaration lets you state your wishes about health care in the event that you can no longer make your own health care decisions and you are terminally ill.

Your living will goes into effect when your doctor determines that you are no longer able to communicate your health care decisions, you are terminally ill—which includes permanent unconsciousness—and your death is imminent.

Part III contains the signature and witnessing provisions so that your document will be effective.

Following the advance directive is a **South Dakota Organ Donation Form**.

This form does not expressly address mental illness. If you would like to make advance care plans regarding mental illness, you should talk to your physician and an attorney about an advance directive tailored to your needs.

Note: This document will be legally binding only if the person completing it is an individual of sound mind who is 18 years or older.

COMPLETING YOUR SOUTH DAKOTA ADVANCE DIRECTIVE

How do I make my South Dakota Advance Directive legal?

If you complete part II, the directive, you must sign your document in the presence of two adult witnesses. Although not required, you may also have your document notarized.

While there are no legal requirements for witnessing your signature if you only complete Part I, your durable power of attorney for health care, you should have it witnessed in the manner required for Part II to be sure that your wishes are honored in the event someone challenges your document.

Whom should I appoint as my agent?

Your agent—also called an “attorney-in-fact”—is the person you appoint to make decisions about your health care if you become unable to make those decisions yourself. Your agent may be a family member or a close friend whom you trust to make serious decisions. The person you name as your agent should clearly understand your wishes and be willing to accept the responsibility of making health care decisions for you.

You can appoint a second person as your alternate agent. The alternate will step in if the first person you name as an agent is unable, unwilling, or unavailable to act for you.

Should I add personal instructions to my South Dakota Durable Power of Attorney for Health Care?

One of the strongest reasons for naming an agent is to have someone who can respond flexibly as your health care situation changes and deal with situations that you did not foresee. If you add instructions to this document it may help your agent carry out your wishes, but be careful that you do not unintentionally restrict your agent’s power to act in your best interest. In any event, be sure to talk with your agent about your future medical care and describe what you consider to be an acceptable “quality of life.”

What if I change my mind?

You can revoke Part I, your durable power of attorney for health care, at any time and in any manner that expresses your intent, such as executing a written revocation, destroying all copies of your document, or stating your revocation orally. It is important that you notify your agent of your revocation, as he or she will not be held liable for acting as your agent if he or she is unaware of your revocation.

You can revoke Part II, your declaration, at any time and in any manner that expresses your intent, such as executing a written revocation, destroying all copies of your

document, or stating your revocation orally. Your revocation becomes effective on communication to your health care provider.

What other important facts should I know?

Your agent cannot withhold or withdraw comfort care.

Artificial nutrition and hydration will not be withheld or withdrawn unless you specifically state that you want it withheld or withdrawn in your advance directive or you expressly authorize your agent to direct the withholding of artificial nutrition or hydration.

Life-sustaining treatment and artificial nutrition and hydration will not be withheld from you if you are pregnant, unless it is reasonably medically certain that such treatment will not permit the development and live birth of the unborn child, or will be physically harmful to you, or will prolong severe pain which cannot be alleviated by medication.

SOUTH DAKOTA ADVANCE DIRECTIVE – PAGE 1 OF 5

PART I. DURABLE POWER OF ATTORNEY FOR HEALTH CARE

PRINT YOUR NAME
AND ADDRESS

I, _____, of
(name of principal)

(address)

PRINT THE NAME,
ADDRESS, AND
TELEPHONE
NUMBER OF YOUR
AGENT

hereby appoint _____, of
(name of agent)

(address and telephone number of agent)

As my attorney-in-fact ("agent") to consent to, to reject, or to withdraw consent for medical procedures, treatment or intervention.

2) In the event the person I appoint above is unable, unwilling or unavailable to act as my health care agent, I hereby appoint as my successor agent:

_____, of
(name of successor agent)

(address and telephone number of successor agent)

3) I have discussed my wishes with my agent and my successor agent, and authorize him/her to make all and any health care decisions for me, including decisions to withhold or withdraw any form of life support. I expressly authorize my agent (and successor agent) to make decisions for me regarding the withholding or withdrawal of artificial nutrition and hydration in all medical circumstances.

4) This power of attorney becomes effective when I can no longer make my own medical decisions, and is not affected by physical disability or mental incompetence. The determination of whether I can make my own medical decisions is to be made by my agent, or if he or she is unable, unwilling or unavailable to act, by my successor agent, unless the attending physician determines that I have decisional capacity.

PRINT THE NAME,
ADDRESS AND
TELEPHONE
NUMBER OF
YOUR ALTERNATE
AGENT

ADD OTHER INSTRUCTIONS, IF ANY, REGARDING YOUR ADVANCE CARE PLANS

THESE INSTRUCTIONS CAN FURTHER ADDRESS YOUR HEALTH CARE PLANS, SUCH AS YOUR WISHES REGARDING HOSPICE TREATMENT, BUT CAN ALSO ADDRESS OTHER ADVANCE PLANNING ISSUES, SUCH AS YOUR BURIAL WISHES

ATTACH ADDITIONAL PAGES IF NEEDED

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I give the following instructions to help guide my agent:

This image shows a single sheet of white paper with horizontal blue or grey ruling lines. The lines are evenly spaced and run across the width of the page. There are no margins, text, or other markings on the paper.

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Palliative Care
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PART II. DECLARATION

Notice

This is an important legal document. A living will directs the medical treatment you are to receive in the event you are in a terminal condition and are unable to participate in your own medical decisions. This living will may state what kind of treatment you want or do not want to receive.

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 family, your physician and your health care facility. 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.

NOTICE

SOUTH DAKOTA ADVANCE DIRECTIVE - PAGE 4 OF 5

PRINT YOUR NAME

TO MY FAMILY, HEALTH CARE PROVIDER, AND ALL THOSE CONCERNED
WITH MY CARE:

I, _____,
direct that you follow my wishes for care if I am in a terminal condition, my
death is imminent, and I am unable to communicate my decisions about my
medical care.

With respect to any life-sustaining treatment, I direct the following:

*(Initial only one of the following optional options. If you do not agree with
either of the following options, space is provided below for you to write
your own instructions).*

_____ If my death is imminent, I choose not to prolong my life. If life
sustaining treatment has been started, stop it, but keep me comfortable
and control my pain.

_____ Even if my death is imminent, I choose to prolong my life.

_____ I choose neither of the above options, and here are my instructions
should I become terminally ill and my death is imminent:

With respect to artificial nutrition and hydration, I direct the following

*(Artificial nutrition and hydration means food and water provided by means
of a tube inserted into the stomach or intestine or needle into a vein.)*

(initial only one):

_____ If my death is imminent, I do not want artificial nutrition and
hydration. If it has been started, stop it.

_____ Even if my death is imminent, I want artificial nutrition and
hydration.

INITIAL ONLY ONE

INITIAL ONLY ONE

SOUTH DAKOTA ADVANCE DIRECTIVE - PAGE 5 OF 5

SIGN, DATE, AND
PRINT YOUR NAME
AND ADDRESS

IF YOU COMPLETED
PART II, YOU MUST
HAVE YOUR
SIGNATURE
WITNESSED

IN ANY EVENT IT IS
A GOOD IDEA TO
HAVE YOUR
SIGNATURE
WITNESSED, EVEN
IF YOU HAVE
COMPLETED ONLY
PART I

YOUR WITNESSES
MUST SIGN, DATE,
AND PRINT THEIR
NAMES AND
ADDRESSES HERE

THIS OPTIONAL
SECTION IS TO BE
COMPLETED BY A
NOTARY PUBLIC

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PART III. EXECUTION

Signature: _____ Date: _____

Printed Name: _____

Address: _____

WITNESSES

The declarant voluntarily signed this document in my presence.

Witness Signature: _____ Date: _____

Printed Name: _____

Address: _____

Witness Signature: _____ Date: _____

Printed Name: _____

Address: _____

NOTARY (OPTIONAL)

On this the _____ day of _____, _____, the declarant,
_____, and

witnesses _____ and _____,

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

Dated this _____ day of _____, _____.

Notary Public

My Commission expires: _____

Courtesy of Caring Connections
1731 King St., Suite 100, Alexandria, VA 22314
www.caringinfo.org, 800/658-8898

SOUTH DAKOTA ORGAN DONATION FORM - PAGE 1 OF 1

ORGAN DONATION
(OPTIONAL)

INITIAL THE
OPTION THAT
REFLECTS YOUR
WISHES

ADD NAME OR
INSTITUTION (IF
ANY)

PRINT YOUR NAME,
SIGN, AND DATE
THE DOCUMENT

YOUR
WITNESSES
MUST SIGN AND
PRINT THEIR
ADDRESSES

AT LEAST ONE
WITNESS MUST BE
A DISINTERESTED
PARTY

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Initial the line next to the statement below that best reflects your wishes. You do not have to initial any of the statements. If you do not initial any of the statements, your attorney for health care, proxy, or other agent, or your family, may have the authority to make a gift of all or part of your body under South Dakota law.

_____ I do not want to make an organ or tissue donation and I do not want my attorney for health care, proxy, or other agent or family to do so.

_____ I have already signed a written agreement or donor card regarding organ and tissue donation with the following individual or institution:

Name of individual/institution: _____

_____ Pursuant to South Dakota law, I hereby give, effective on my death:

_____ Any needed organ or parts.

_____ The following part or organs listed below:

For (initial one):

_____ Any legally authorized purpose.

_____ Transplant or therapeutic purposes only.

Declarant name: _____

Declarant signature: _____, Date: _____

The declarant voluntarily signed or directed another person to sign this writing in my presence.

Witness _____ Date _____

Address _____

I am a disinterested party with regard to the declarant and his or her donation and estate. The declarant voluntarily signed or directed another person to sign this writing in my presence.

Witness _____ Date _____

Address _____

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You Have Filled Out Your Health Care Directive, Now What?

1. Your South Dakota Advance Directive is an important legal document. Keep the original signed document in a secure but accessible place. Do not put the original document in a safe deposit box or any other security box that would keep others from having access to it.
2. Give photocopies of the signed original to your agent and alternate agent, doctor(s), family, close friends, clergy, and anyone else who might become involved in your healthcare. If you enter a nursing home or hospital, have photocopies of your document placed in your medical records.
3. Be sure to talk to your agent(s), doctor(s), clergy, family, and friends about your wishes concerning medical treatment. Discuss your wishes with them often, particularly if your medical condition changes.
4. South Dakota does not maintain an Advance Directive Registry. However you may record a durable power of attorney for health care (Part I of this form) at your county's registry of deeds. Be aware that, if you do record your advance directive, you will also need to record any revocation you make as well.
5. You may also want to save a copy of your form in Google Health, or another online medical records management service that allows you to share your medical documents with your physicians, family, and others who you want to take an active role in your advance care planning. You can read more about Google Health at <http://www.caringinfo.org/googlehealth>.
6. If you want to make changes to your documents after they have been signed and witnessed, you must complete a new document.
7. Remember, you can always revoke your South Dakota document.
8. Be aware that your South Dakota document will not be effective in the event of a medical emergency. Ambulance and hospital emergency department personnel are required to provide cardiopulmonary resuscitation (CPR) unless they are given a separate directive that states otherwise. These directives called "prehospital medical care directives" or "do not resuscitate orders" are designed for people whose poor health gives them little chance of benefiting from CPR. These directives instruct ambulance and hospital emergency personnel not to attempt CPR if your heart or breathing should stop.

Currently not all states have laws authorizing these orders. We suggest you speak to your physician if you are interested in obtaining one. **Caring Connections does not distribute these forms.**