

# South Dakota Living Will Declaration

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 decision and you are in a terminal condition. This document states 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 healthcare 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 those concerned with my care:**

I, (print name) \_\_\_\_\_, 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.

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).

\_\_\_\_\_ **No life-sustaining treatment.** I direct that no life-sustaining treatment be provided. If lifesustaining treatment is begun, terminate it.

\_\_\_\_\_ **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.

\_\_\_\_\_ **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.

\_\_\_\_\_ **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.

(Artificial nutrition and hydration is food and water provided by means of a nasogastric 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 below, which reads: "I intend to include this treatment among the 'life-sustaining treatment' that may be withheld or withdrawn.")

**With respect to artificial nutrition and hydration, I wish to make clear that:**  
(initial only one)

\_\_\_\_\_ **I desire** to receive these treatments under the conditions set forth above.

\_\_\_\_\_ **I do not desire** to receive these treatments under the conditions set forth above.

(If you do not agree with any of the printed directives and want to write your own, or if you want to write directives in addition to the printed provisions, or if you want to express some of your other thoughts, you can do so here.)

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Date: \_\_\_\_\_

\_\_\_\_\_  
(Your signature)

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\_\_\_\_\_  
(Your address)

\_\_\_\_\_  
(Type or print your signature)

The declarant voluntarily signed this document in my presence.

Witness \_\_\_\_\_

Address \_\_\_\_\_

Witness \_\_\_\_\_

Address \_\_\_\_\_

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: \_\_\_\_\_



# South Dakota Health Care Power of Attorney

This is an important legal document. This document designates the person you want to make medical decisions for you in the event you are unable to participate in your own medical decisions.

Prepare this document carefully. 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 in effect until 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 healthcare providers. You should give copies of this document to your physician and family. This form is entirely optional. If you choose to use this form, please note the form provides signature lines for you and either two witnesses or a notary.

## 1. Designation of Health Care Agent

I, \_\_\_\_\_ hereby appoint: \_\_\_\_\_  
(print your name) (Attorney-in-fact's name)

Address \_\_\_\_\_

Home phone \_\_\_\_\_ Work Phone \_\_\_\_\_

As my attorney-in-fact (or "Agent") to make health and personal care decisions for me as authorized in this document.

## 2. Effective Date and Durability

By this document I intend to create a durable power of attorney effective upon, and only during, any period of incapacity in which, in the opinion of my Agent and attending physician, I am unable to make or communicate a choice regarding a particular health-care decision.

## 3. Agent's Powers

I grant to my Agent full authority to make decisions for me regarding my health care. In exercising this authority, my Agent shall follow my desires as stated in this document or otherwise known to my Agent. In making any decision, my Agent shall attempt to discuss the proposed decision with me to determine my desires if am able to communicate in any way. If my Agent cannot determine the choice I would want made, then my Agent shall make a choice for me based upon what my Agent believes to be in my best interest. My Agent's authority to interpret my desires is intended to be as broad as possible, except for any limitations I may state below.

**Accordingly, unless specifically limited by Section 4, below, my Agent is authorized as follows:**

**A.** To consent, refuse or withdraw consent to any and all types of medical care, treatment, surgical procedures, diagnostic procedures, medication, and use of mechanical or other



procedures that affect any bodily function, including (but not limited to) artificial respiration, nutritional support and hydration, and cardiopulmonary resuscitation;

**B.** To have access to medical records and information to the same extent that I am entitled to, including the right to disclose the contents to others;

**C.** To authorize my admission to or discharge (even against medical advice) from any hospital, nursing home, residential care, assisted living or similar facility or service;

**D.** To contact on my behalf for any health care related service or facility on my behalf, without my Agent incurring personal financial liability for such contracts;

**E.** To hire and fire medical, social service and other support personnel responsible for my care;

**F.** To authorize, or refuse to authorize, any medication or procedure intended to relieve pain, even though such use may lead to physical damage, addiction, or hasten the moment of (but not intentionally cause) my death;

**G.** To make anatomical gifts of part or all of my body for medical purposes, authorize an autopsy, and direct the disposition of my remains, to the extent permitted by law;

**H.** To take any other action necessary to do what I authorize here, including (but not limited to) granting any waiver or release from liability required by any hospital, physician, or other health care provider; signing any documents relating to refusals of treatment or the leaving of a facility against medical advice, and pursuing any legal action in my name, and at the expense of my estate to force compliance with my wishes as determined by my Agent, or to seek actual or punitive damages for the failure to comply.

#### **4. Statement of Desires, Special Provisions, and Limitations**

**A.** The powers granted above do not include the following powers or are subject to the following rules or limitations.

**B.** With respect to any Life-Sustaining Treatment, I direct the following: (initial only one of the following paragraphs)

\_\_\_\_\_ Reference To Living Will. I specifically direct my Agent to follow any health care declaration or "living will" executed by me.

\_\_\_\_\_ Grant of Discretion to Agent. I do not want my life to prolonged nor do I want life-sustaining treatment if my Agent believes the burdens of the treatment outweigh the expected benefits. I want my Agent to consider the relief of suffering, the expense involved and the quality as well as the possible extension of my life in making decisions concerning life-sustaining treatment.

\_\_\_\_\_ Directive to Withhold or Withdraw Treatment. I do not want my life to be prolonged and I do not want life-sustaining treatment:

- a.** If I have a condition that is incurable or irreversible and, without the administration of life-sustaining treatment, expected to result in death within a relatively short time; or



b. If I am in a coma or persistent vegetative state, which is reasonably concluded to be irreversible.

\_\_\_\_\_ Directive For Maximum Treatment. I want my life to be prolonged to the greatest extent possible without regard to my condition, the changes I have for recovery, or the cost the procedures

\_\_\_\_\_ Directive In My Own Words.

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(With respect to nutrition and hydration provided by means of a nasogastric tube or tube into the stomach, intestines, or veins, I wish to make clear that . . . (initial only one))

\_\_\_\_\_ I desire these life sustaining procedures. However, I give my agent herein the express authority to later determine to discontinue these procedures should it be in my best interest to do so.

\_\_\_\_\_ I do not desire these life sustaining procedures under the conditions given above.

**5. Successors**

If any Agent named by me shall die, become legally disabled, resign, refuse to act, be unavailable, or (if any Agent is my spouse) be legally separated or divorced from me, I name the following (each to act alone and successively, in the order named) as successors to my Agent:

**A. First Alternate Agent**

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Address \_\_\_\_\_

Telephone \_\_\_\_\_

**B. Second Alternate Agent**

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Address \_\_\_\_\_

Telephone \_\_\_\_\_

**6. Protection of Third Parties Who Rely on My Agent**

No person who relies in good faith upon any representations by my Agent or Successor Agent shall be liable to me, my estate, my heirs or assigns, for recognizing the Agent's authority.

**7. Nomination of Guardian**

If a guardian of my person should for any reason be appointed, I nominate my Agent (or his or her successor), named above.

**8. Administrative Provisions**

**A.** I revoke any prior power of attorney for health care.

**B.** This power of attorney is intended to be valid in any jurisdiction in which it is presented.

**C.** My Agent shall not be entitled to compensation for services performed under this power of attorney, but he or she shall be entitled to reimbursement for all reasonable expenses incurred as a result of carrying out any provision of this power of attorney.

**D.** The powers delegated under this power of attorney are separable, so that the invalidity of one or more powers shall not affect any others. By signing here I indicate that I understand the contents of this document and the effect of this grant of powers to my Agent.

I sign my name to this Health Care Power of Attorney on this

\_\_\_\_\_ Day of \_\_\_\_\_, 20\_\_\_\_.

My current address is: \_\_\_\_\_

X \_\_\_\_\_  
Signature

\_\_\_\_\_  
Print Name

**Witness Statement**

I declare that the person who signed this document is personally known to me, that he/she signed this Durable power of attorney in my presence and that he/she appears to be of sound mind and under no duress, fraud, or undue influence. I am not the person appointed as agent by this document, nor am I the patient's health care provider, or an employee of the patient's health care provider. I further declare that I am not related to the principal by blood, marriage, or adoption, and to the best of my knowledge, I am not a creditor of the principal nor entitled to any part of his/her estate under a will now existing or by operation of law.

\_\_\_\_\_  
Witness

\_\_\_\_\_  
Address

\_\_\_\_\_  
Witness

\_\_\_\_\_  
Address

**OR**

**Notarization**

State Of \_\_\_\_\_

County Of \_\_\_\_\_

On this the \_\_\_\_\_ day of \_\_\_\_\_, 20\_\_\_\_,

The said \_\_\_\_\_, known to me (or satisfactorily proven) to be the person named in the foregoing instrument, personally appeared before me, a Notary Public, within and for the State and County aforesaid, and acknowledged that he or she freely and voluntarily executed the same for the purposes stated therein.

Notary Public \_\_\_\_\_

My Commission Expires \_\_\_\_\_

