

**SOUTH DAKOTA**  
**Advance Directive**  
**Planning for Important Healthcare Decisions**

*Caring Connections*  
*1731 King St., Suite 100, Alexandria, VA 22314*  
[www.caringinfo.org](http://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.

Caring Connections tracks and monitors all state and federal legislation and significant court cases related to end-of-life care to ensure that our advance directives are up to date.

**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

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## 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

3. You may want to photocopy these forms before you start so you will have a clean copy if you need to start over.
4. When you begin to fill out the forms, refer to the gray instruction bars - they will guide you through the process.
5. 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.
6. 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, healthcare providers and/or faith leaders so that the form is available in the event of an emergency.

## INTRODUCTION TO YOUR SOUTH DAKOTA ADVANCE DIRECTIVE

This packet contains two legal documents that protect 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:

1. The **South Dakota Durable Power of Attorney for Health Care** lets you name someone to make decisions about your medical care – including decisions about life support – 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.
2. The **South Dakota Living Will Declaration** lets you state your wishes about medical care in the event that you can no longer make your own medical decisions and are diagnosed to be in a terminal condition. Your Living Will goes into effect if it is determined by your attending physician that you are in a terminal condition, death is imminent and you are no longer able to communicate decisions about your medical care.

*Note: These documents will be legally binding only if the person completing them is a competent adult.*

## **COMPLETING YOUR SOUTH DAKOTA DURABLE POWER OF ATTORNEY FOR HEALTH CARE**

### **Whom should I appoint as my attorney-in-fact?**

“Attorney-in-fact” does not refer to a lawyer. Your attorney-in-fact is the person you appoint to make decisions about your medical care if you become unable to make those decisions yourself. Your attorney-in-fact can be a family member or a close friend whom you trust to make serious decisions. The person you name as your attorney-in-fact must be an adult who clearly understands your wishes and is willing to accept the responsibility of making medical decisions for you. (An attorney-in-fact may also be called an “agent” or “proxy.”)

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

### **How do I make my South Dakota Durable Power of Attorney for Health Care legal?**

The law requires that you have your Durable Power of Attorney for Health Care witnessed. You can do this in either of two ways:

1. Have your signature witnessed by a notary public,

Or

2. sign your document, or direct another to sign it, in the presence of two adult witnesses, who must also sign the document to affirm that they know you, that you signed or acknowledged the document in their presence, and that you appear to be of sound mind and under no duress, fraud, or undue influence.

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

One of the strongest reasons for naming an attorney-in-fact is to have someone who can respond flexibly as your medical situation changes and deal with situations that you did not foresee. If you add instructions to this document, you might unintentionally restrict your attorney-in-fact’s power to act in your best interest.

Talk with your attorney-in-fact about your future medical care and describe what you consider to be an acceptable “quality of life.” If you want to record your wishes about specific treatments or conditions, you should use your South Dakota Living Will Declaration.

## **COMPLETING YOUR SOUTH DAKOTA DURABLE POWER OF ATTORNEY FOR HEALTH CARE (CONTINUED)**

### **What if I change my mind?**

You can revoke your South Dakota Durable Power of Attorney for Health Care at any time. You may revoke your document orally, in writing, or by destroying the document. You must then notify your attorney-in-fact or doctor of your intent to revoke your document.

### **What other important facts should I know?**

- Your state law restricts your attorney-in-fact's power to make decisions to withhold or withdraw comfort care. In addition, your state law generally restricts your attorney-in-fact's power to withhold or withdraw artificial nutrition and hydration unless you express in your Durable Power of Attorney for Health Care that artificial nutrition or hydration is to be withheld, or expressly authorize your attorney-in-fact to direct the withholding of artificial nutrition or hydration.
- Due to further restrictions in the state law, your attorney-in-fact cannot authorize the withholding or withdrawal of life-sustaining treatment and artificial nutrition and hydration if you are pregnant, unless your doctor and one other doctor certify that such treatment will not permit the development and live birth of the unborn child, or will be physically harmful to you or prolong severe pain which cannot be alleviated by medication.

## **COMPLETING YOUR SOUTH DAKOTA LIVING WILL DECLARATION**

### **How do I make my South Dakota Living Will legal?**

The law requires that you sign your document, or direct another to sign it, in the presence of two adult witnesses.

### **Can I add personal instructions to my Living Will?**

Yes. You can add personal instructions in the part of the document called "Other directions."

If you have appointed an attorney-in-fact, it is a good idea to add the following statement to your Living Will Declaration: "Any questions about how to interpret or when to apply my Declaration are to be decided by my attorney-in-fact."

### **What if I change my mind?**

You may revoke your Living Will Declaration at any time and in any manner, regardless of your mental or physical condition. Your revocation goes into effect once you notify your doctor or other healthcare provider, who must then make the revocation part of your medical record.

### **What other important facts should I know?**

- Due to restrictions in the state law, life-sustaining treatment and artificial nutrition and hydration must be provided to you if you are pregnant, unless your doctor and one other physician certify in writing that the continued application of life-sustaining treatment will not allow for the live birth of the unborn child, or will be physically harmful to you or cause you to suffer prolonged severe pain which cannot be alleviated by medicine.
- If an individual has executed both a declaration and a durable power of attorney, the later executed document will control to the extent that there are conflicting provisions.

**SOUTH DAKOTA DURABLE POWER OF ATTORNEY  
FOR HEALTH CARE – PAGE 1 OF 3**

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INSTRUCTIONS

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 attorney-in-fact)

-----  
(address and telephone number of attorney-in-fact)

As my attorney-in-fact 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:

\_\_\_\_\_, of  
(name of successor attorney-in-fact)

-----  
(address and telephone number of successor attorney-in-fact)

3) I have discussed my wishes with my attorney-in-fact and my successor attorney-in-fact, 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 attorney-in-fact, or if he or she is unable, unwilling or unavailable to act, by my successor attorney-in-fact, unless the attending physician determines that I have decisional capacity.

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**SOUTH DAKOTA DURABLE POWER OF ATTORNEY  
FOR HEALTH CARE — PAGE 2 OF 3**

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PRINT YOUR NAME  
AND THE DATE

I, \_\_\_\_\_, of  
the principal, sign my name to this instrument this \_\_\_\_\_ day of  
(date)  
\_\_\_\_\_, 20\_\_\_\_\_, and being first duly sworn, do  
(month) (year)

hereby declare to the undersigned authority that I sign it willingly (or  
willingly direct another to sign for me), that I execute it as my free and  
voluntary act for the purposes therein expressed, and that I am eighteen  
years of age or older, of sound mind, and under no constraint or undue  
influence.

SIGN THE  
DOCUMENT

\_\_\_\_\_  
(signature of principal)

WITNESSING  
PROCEDURE

A NOTARY  
PUBLIC MUST  
COMPLETE THIS  
SECTION

**NOTARY**

The State of South Dakota  
The County of \_\_\_\_\_

Subscribed, sworn to, and acknowledged before me by \_\_\_\_\_

\_\_\_\_\_, the principal, this \_\_\_\_\_ day of

\_\_\_\_\_, 20\_\_\_\_\_.

(Seal)

\_\_\_\_\_  
(notary public)

OR

TWO WITNESSES  
MUST SIGN YOUR  
DOCUMENT ON  
THE NEXT PAGE

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**SOUTH DAKOTA DURABLE POWER OF ATTORNEY  
FOR HEALTH CARE — PAGE 3 OF 3**

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WITNESSES MUST  
SIGN AND PRINT  
THEIR NAMES,  
ADDRESSES AND  
TELEPHONE  
NUMBERS

**OR**

**WITNESS STATEMENT**

I declare that the person who signed or acknowledged this Durable Power of Attorney for Health care is personally known to me, that he/she signed or acknowledged 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.

Witness #1

Witness #1:

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

Print Name: \_\_\_\_\_ Telephone Number: \_\_\_\_\_

Residence Address: \_\_\_\_\_  
-----

Witness #2

Witness #2:

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

Print Name: \_\_\_\_\_ Telephone Number: \_\_\_\_\_

Residence Address: \_\_\_\_\_  
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**SOUTH DAKOTA LIVING WILL DECLARATION – PAGE 1 OF 4**

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INSTRUCTIONS

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.

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

PRINT YOUR NAME

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.

INITIAL THE STATEMENT THAT REFLECTS YOUR WISHES ABOUT LIFE-SUSTAINING TREATMENT

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**SOUTH DAKOTA LIVING WILL DECLARATION - PAGE 2 OF 4**

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ADD PERSONAL  
INSTRUCTIONS  
(IF ANY)

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

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

With respect to artificial nutrition and hydration, I direct the following  
(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 THE  
STATEMENT THAT  
REFLECTS YOUR  
WISHES ABOUT  
ARTIFICIAL  
NUTRITION AND  
HYDRATION

**ORGAN DONATION (OPTIONAL)**

ORGAN DONATION  
(OPTIONAL)

Under South Dakota law, any individual 18 or older or an emancipated minor, by signing a written document, may donate all or any part of his body, the gift to take effect upon death.

The donor may amend or revoke a gift by: (1) A writing signed by the donor; or (2) Any other writing used to identify the individual as refusing to make an anatomical gift. During a terminal illness or injury, the refusal may be an oral statement or other form of communication if the statement is addressed to at least two adults, one of whom is disinterested.

Initial the line next to the statement below that best reflects your wishes. If you do not complete this section, your agent will have the authority to make a gift of a part of your body pursuant to law unless you give them notice that you do not want a gift made. The donation elections you make below survive your death.

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**SOUTH DAKOTA LIVING WILL DECLARATION - PAGE 3 OF 4**

\_\_\_\_\_ In the hope that I may help others, I hereby make this organ and tissue gift, if medically acceptable, to take effect upon my death. The words and marks (or notations) below indicate my desires. **Default** choice is (a).

I give:

- (a) \_\_\_\_\_ any needed organ or tissue
- (b) \_\_\_\_\_ only the following organs or tissues:

My donated organs and tissues may be used for:

- \_\_\_\_\_ any legal purpose;
- \_\_\_\_\_ transplantation or therapy,
- \_\_\_\_\_ medical research;
- \_\_\_\_\_ education

(c) \_\_\_\_\_ my body for anatomical study if needed.

\_\_\_\_\_ I do not want to make an organ or tissue donation and I do not want my 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/organization: \_\_\_\_\_

\_\_\_\_\_ (your signature) \_\_\_\_\_ (date)

-----  
(your address)

-----

-----  
(type or print your signature)

INITIAL THE STATEMENT THAT REFLECTS YOUR WISHES

NAME OF INDIVIDUAL/ ORGANIZATION

SIGN AND DATE THE DOCUMENT THEN PRINT YOUR ADDRESS AND NAME

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**SOUTH DAKOTA LIVING WILL DECLARATION - PAGE 4 OF 4**

WITNESSING  
PROCEDURE

WITNESSES  
MUST SIGN AND  
PRINT THEIR  
ADDRESSES

THIS SECTION IS  
TO BE COMPLETED  
BY A NOTARY  
PUBLIC

The declarant voluntarily signed this document in my presence.

Witness: \_\_\_\_\_

Address: \_\_\_\_\_

\_\_\_\_\_

Witness: \_\_\_\_\_

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: \_\_\_\_\_

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## **You Have Filled Out Your Advance Directive, Now What?**

1. Your South Dakota Durable Power of Attorney for Healthcare and South Dakota Living Will Declaration are important legal documents. Keep the original signed documents in a secure but accessible place. Do not put the original documents in a safe deposit box or any other security box that would keep others from having access to them.
2. Give photocopies of the signed originals to your attorney-in-fact and alternate attorney-in-fact, 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 documents placed in your medical records.
3. Be sure to talk to your attorney-in-fact and alternate, doctor(s), clergy, and family and friends about your wishes concerning medical treatment. Discuss your wishes with them often, particularly if your medical condition changes.
4. If you want to make changes to your documents after they have been signed and witnessed, you must complete new documents.
5. Remember, you can always revoke one or both of your South Dakota documents.
6. Be aware that your South Dakota documents will not be effective in the event of a medical emergency. Ambulance personnel are required to provide cardiopulmonary resuscitation (CPR) unless they are given a separate order that states otherwise. These orders, commonly called "non-hospital do-not-resuscitate orders," are designed for people whose poor health gives them little chance of benefiting from CPR. These orders must be signed by your physician and instruct ambulance personnel not to attempt CPR if your heart or breathing should stop.

Currently not all states have laws authorizing non-hospital do-not-resuscitate orders. We suggest you speak to your physician for more information. **Caring Connections does not distribute these forms.**