# Triage Health Estate Planning Toolkit: South Dakota

## Part II: Understanding Estate Planning Documents in Your State

### State Laws About Wills

A will is a legal document that provides instructions for what you would like to have happen to your property upon death. A will is also a place where parents can name a guardian for any minor children or adult children with developmental disabilities.

South Dakota probate courts accept written and holographic wills. To make a valid written will in South Dakota:

1. You need to be in the right state of mind to create a will. This means you need to be:
   - At least 18 years old
   - Of "sound mind" (meaning you know what you're doing)
2. You need to sign the will in front of two witnesses who have watched you sign or authorize someone else to sign the will in your name in front of two witnesses who watched you acknowledge the signature.
3. You need both witnesses to sign the will in your presence.
4. You may also want to make your will "self-proving," or accepted in probate court without the court needing to contact your witnesses. To do this, ask your witnesses to sign a notarized statement that it was your intention to make the will and you did so without undue or coercive influence.

South Dakota allows you to execute your will remotely, so your witnesses can witness you\ sign the will by using video communication technology (e.g., Zoom or Facetime.).

A holographic will is one that is handwritten by you. To make a valid holographic will in South Dakota:

1. You need to be in the right state of mind to create a will. This means you need to be:
   - At least 18 years old
   - Of "sound mind" (meaning you know what you're doing)
2. Your will must be written in your handwriting and you must sign it

If you make a holographic will, it does not need to be signed by witnesses. However, most estate planning experts do not recommend relying on holographic wills because it is more difficult to prove that they are valid in probate court.

To revoke a written or holographic will, you can create a new will that is inconsistent with or revokes the previous one, or you can destroy the previous will such as by burning or tearing it.

### State Laws About Financial Powers of Attorney

A power of attorney for financial affairs is a legal document where you (the principal) name a trusted adult (the agent) who is authorized to make financial decisions on your behalf.

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South Dakota's statutory form for power of attorney allows you to appoint someone to manage your finances, including assets like your property, taxes, and government benefits. You can also appoint an alternate agent, who will take charge separately if the first person cannot act, or who can oversee your finances jointly if you indicate this preference in the "special instructions" section. This person can make all financial decisions for you, including decisions related to your will, or you can limit their powers to specific areas, like filing taxes or banking. Unless you indicate otherwise in the "special instructions" section, this document takes effect immediately after you sign it. In South Dakota, a power of attorney is not "durable," meaning that it does not remain in effect if you become incapacitated unless it explicitly says so using language such as, "This power of attorney shall not be affected by disability of the principal." Note that if your designated agent is your spouse, they will be automatically removed in the case of a divorce.

A valid power of attorney must be signed and notarized.

Part III of this toolkit includes a sample form.

**State Laws About Advance Health Care Directives**

An advance health care directive (AHCD) is a legal document you can use to provide written instructions, or state preferences, about your medical care in case you become unable to communicate. In South Dakota, this document consists of a durable power of attorney for health care and a declaration.

**South Dakota Durable Power of Attorney for Health Care:** This form lets you choose someone (your "health care agent") to make medical decisions for you any time you cannot make them yourself, including decisions about life-sustaining care, and organ donation. You can also appoint an alternate person to make these decisions if the first person you chose isn't available. To guide this agent, you can share directions in the "other directions" section.

A durable power of attorney for health care must be signed and witnessed by two adults or by a notary public. The signing and witnessing of the document can be done using video communication technology. This form takes effect if your doctor determines you are unable to communicate health care decisions.

**South Dakota Declaration:** This is where you state your wishes about life-sustaining care in advance, in case you become unable to make these decisions due to terminal illness or unconsciousness.

To make your declaration legal, you must sign it and have it witnessed by two qualified adult witnesses or by a notary public.

A declaration goes into effect when your doctor determines that you are in a terminal condition, death is imminent, and you are no longer able to communicate decisions about medical care. You can change or revoke your advance health care directive at any time and in any manner (e.g. destroying the document or notifying your doctor). This decision takes effect when you tell your doctor or other health care professional. Your decision to revoke your agent's power takes effect when you notify them.

Part III of this toolkit includes a sample form.

**State Laws About POLST/MOLST**

A physician order for life-sustaining treatment (POLST) is a medical order completed by a seriously ill person and signed by a physician. In South Dakota, this form is called a medical order for scope of treatment (MOST). The MOST does not replace an advance directive. You can complete a MOST form with your doctor. In order to be valid, the MOST must be signed by you and your doctor, nurse practitioner, or physician's assistant.

This form lets you indicate your preferences for:

- Cardiopulmonary resuscitation orders (also known as a "Do not resuscitate," or DNR order)

- Medical Interventions, ranging from all medical and surgical treatments available to prolong your life, selective treatments to restore your health while avoiding burdensome procedures, or comfort-focused treatments to manage symptoms and allow natural death
- Medically-assisted nutrition and hydration, or food and liquids offered through surgically-placed tubes
- Additional orders or instructions for your care

This form will not expire, so it is important for you and your physician to review it regularly to make sure it still reflects your wishes. You may revoke your MOST by destroying it, by a written revocation that is signed and dated, or by an oral revocation in front of an adult witness who signs and dates your revocation in writing. Revocation is effective when it is communicated to your health care provider.

You can find a sample form in Part III of this toolkit.

**State Laws About Funeral Designation Forms**

Funeral designation forms allow you to tell your loved ones what you would like to happen to your remains after you pass away. These forms can be used to choose someone to control what happens to your remains after your death, specify what you would like to have happen, and other wishes depending on your state.

South Dakota's **Directions for the Disposition of My Body** form allows you to indicate your wishes for the disposition of your remains and funeral arrangements.

**State Laws About Death with Dignity**

"Death with Dignity" laws, or physician-assisted dying/aid-in-dying laws, allow certain terminally ill people to voluntarily and legally request and receive a prescription medication from their physician to hasten their death in a peaceful, humane, and dignified way. By adding a voluntary option to the continuum of end-of-life care, these laws can give you dignity, control, and peace of mind during your final days with family and loved ones.

South Dakota does not have a death with dignity law. But, you can indicate other decisions related to end-of-life care through an advance health care directive.

**Federal Law About HIPAA**

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) is a federal law that protects the privacy of your health information. HIPAA does allow your protected health information to be shared with your personal representative who has authority to make health care decisions for you (i.e., your health care agent or proxy.)

To guarantee your agent's access to information, a HIPAA authorization form should be signed and dated by you. Also, it must identify the information to be disclosed, the purpose of the disclosure, the recipients of the information, and an expiration date. This means that any advance health care directives should be clear about the scope of your agent's authority to receive protected health care information.

You can revoke a HIPAA authorization form at any time by notifying your health care provider in writing.

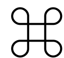
Part III of this toolkit includes a sample HIPAA authorization form. For more information: [www.cdc.gov/phlp/publications/topic/hipaa.html](www.cdc.gov/phlp/publications/topic/hipaa.html).

# Triage Health Estate Planning Toolkit: South Dakota

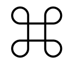
**Part III: Your State's Estate Planning Forms**

- Power of Attorney for Financial Affairs
- Advanced Health Care Directive
- Medical Order for Scope of Treatment (MOST)
- Directions for the Disposition of My Body
- HIPAA Authorization Form

# Triage Health Estate Planning Toolkit



# Part III: Your State's Estate Planning Forms



# Power of Attorney for Financial Affairs

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STATUTORY FORM POWER OF ATTORNEY

IMPORTANT INFORMATION

This power of attorney authorizes another person (your agent) to make decisions concerning your property for you (the principal). Your agent will be able to make decisions and act with respect to your property (including your money) whether or not you are able to act for yourself. The meaning of authority over subjects listed on this form is explained in SDCL chapter 59-12.

This power of attorney does not authorize the agent to make health-care decisions for you.

You should select someone you trust to serve as your agent. Unless you specify otherwise, generally the agent's authority will continue until you die or revoke the power of attorney or the agent resigns or is unable to act for you.

Your agent is entitled to reasonable compensation unless you state otherwise in the Special Instructions.

This form provides for designation of one agent. If you wish to name more than one agent you may name a co-agent in the Special Instructions. Co-agents are required to have a majority to act unless you include otherwise in the Special Instructions.

If your agent is unable or unwilling to act for you, your power of attorney will end unless you have named a successor agent. You may also name a second successor agent.

This power of attorney becomes effective immediately unless you state otherwise in the Special Instructions.

If you have questions about the power of attorney or the authority you are granting to your agent, you should seek legal advice before signing this form.

DESIGNATION OF AGENT

I ________________________________________ name the following person as my agent:

(Name of Principal)

Name of Agent: ____________________________________________

Agent's Address: ____________________________________________

Agent's Telephone Number: __________________________________

DESIGNATION OF SUCCESSOR AGENT(S) (OPTIONAL)

If my agent is unable or unwilling to act for me, I name as my successor agent:

Name of Successor Agent: _____________________________________

Successor Agent's Address: _____________________________________

Successor Agent's Telephone Number: _________________________

1 If my successor agent is unable or unwilling to act for me, I name as my second
2 successor agent:
3 Name of Second Successor Agent: ______________________________
4 Second Successor Agent's Address: ______________________________
5 Second Successor Agent's Telephone Number: ____________________
6 GRANT OF GENERAL AUTHORITY
7 I grant my agent and any successor agent general authority to act for me with
8 respect to the following subjects as defined in the SDCL chapter 59-12:
9 (INITIAL each subject you want to include in the agent's general authority. If you
10 wish to grant general authority over all of the subjects you may initial "All Preceding
11 Subjects" instead of initialing each subject.)
12 (___) Real Property (§ 59-12-26)
13 (___) Tangible Personal Property (§ 59-12-27)
14 (___) Stocks and Bonds (§ 59-12-28)
15 (___) Commodities and Options (§ 59-12-29)
16 (___) Banks and Other Financial Institutions (§ 59-12-30)
17 (___) Operation of Entity or Business (§ 59-12-31)
18 (___) Insurance and Annuities (§ 59-12-32)
19 (___) Estates, Trusts, and Other Beneficial Interests (§ 59-12-33)
20 (___) Claims and Litigation (§ 59-12-34)
21 (___) Personal and Family Maintenance (§ 59-12-35)
22 (___) Benefits from Governmental Programs or Civil or Military Service (§ 59-12-
23 36)
24 (___) Retirement Plans (§ 59-12-37)
25 (___) Taxes (§ 59-12-38)
26 (___) All Preceding Subjects (§§ 59-12-26 through 59-12-38)
27 GRANT OF SPECIFIC AUTHORITY (OPTIONAL)
28 My agent MAY NOT do any of the following specific acts for me UNLESS I have
29 INITIALED the specific authority listed below:
30 (CAUTION: Granting any of the following will give your agent the authority to take
31 actions that could significantly reduce your property or change how your property is
32 distributed at your death. INITIAL ONLY the specific authority you WANT to give your
33 agent.)
34 (___) Create an inter vivos trust or amend, revoke, or terminate a trust

1 ( ) Make a gift, subject to the limitations of § 59-12-39 and any special
2 instructions in this power of attorney
3 ( ) Create or change rights of survivorship
4 ( ) Create or change a beneficiary designation
5 ( ) Authorize another person to exercise the authority granted under this power
6 of attorney
7 ( ) Waive the principal's right to be a beneficiary of a joint and survivor annuity,
8 including a survivor benefit under a retirement plan
9 ( ) Exercise fiduciary powers that the principal has authority to delegate
10 ( ) Access the content of electronic communications
11 ( ) Disclaim or refuse an interest in property, including a power of appointment
12 LIMITATION ON AGENT'S AUTHORITY
13 An agent that is not my ancestor, spouse, or descendant MAY NOT use my property
14 to benefit the agent or a person to whom the agent owes an obligation of support unless
15 I have included that authority in the Special Instructions.
16 SPECIAL INSTRUCTIONS (OPTIONAL)
17 (INITIAL if you wish for the agent to only have authority upon your incapacity
18 instead of
19 immediately.)
20 ( ) My agent(s) shall only have the authority to act upon my later incapacity.
21 You may give additional special instructions on the following lines:
22 ______________________________________________________________
23 ______________________________________________________________
24 ______________________________________________________________
25 EFFECTIVE DATE
26 This power of attorney is effective immediately unless I have stated otherwise in
27 the Special Instructions.
28 NOMINATION OF CONSERVATOR AND/OR GUARDIAN (OPTIONAL)
29 If it becomes necessary for a court to appoint a conservator of my estate, I
30 nominate the following person(s) for appointment:
31 Name of Nominee for conservator of my estate:
32 ______________________________________________________________
33 Nominee's Address: ______________________________________________
34 Nominee's Telephone Number: ____________________________

1 If it becomes necessary for a court to appoint a guardian of my person, I nominate
2 the following person(s) for appointment:
3 Name of Nominee for guardian of my person:
4 ______________________________________________
5 Nominee's Address: ______________________________________________
6 Nominee's Telephone Number: ______________________________
7 RELIANCE ON THIS POWER OF ATTORNEY
8 Any person, including my agent, may rely upon the validity of this power of
9 attorney or a copy
10 of it unless that person knows it has terminated or is invalid.
11 SIGNATURE AND ACKNOWLEDGMENT
12 ______________________________________________ ______________, 2____
13 Your Signature Date
14 ______________________________________________
15 Your Name Printed
16 ______________________________________________
17 Your Address
18 ______________________________________________
19 Your Telephone Number
20 State of ______________________________)
21 )SS.
22 County of ______________________________)
23 This Statutory Form Power of Attorney document was acknowledged before me on
24 ______________________, ____________________2________________________by
25 ______________________________________.
26 (Date) (Name of Principal)
27 ______________________________________________(Seal)
28 Signature of Notary Public
29 My commission expires:
30 IMPORTANT INFORMATION FOR AGENT
31 Agent's Duties
32 When you accept the authority granted under this power of attorney, a special legal
33 relationship is created between you and the principal. This relationship imposes upon you
34 legal duties that continue until you resign or the power of attorney is terminated or
35 revoked. You must:

1 (1) Do what you know the principal reasonably expects you to do with the
2 principal's property or, if you do not know the principal's expectations, act in the principal's
3 best interest;
4 (2) Act in good faith;
5 (3) Do nothing beyond the authority granted in this power of attorney; and
6 (4) Disclose your identity as an agent whenever you act for the principal by writing
7 or printing the name of the principal and signing your own name as "agent" in the following
8 manner:
9 (Principal's Name) by (Your Signature) as Agent under POA dated (Date)
10 Unless the Special Instructions in this power of attorney state otherwise, you must
11 also:
12 (1) Act loyally for the principal's benefit;
13 (2) Avoid conflicts that would impair your ability to act in the principal's best
14 interest;
15 (3) Act with care, competence, and diligence;
16 (4) Keep a record of all receipts, disbursements, and transactions made on behalf
17 of the principal;
18 (5) Cooperate with any person that has authority to make health-care decisions for
19 the principal to do what you know the principal reasonably expects or, if you do not know
20 the principal's expectations, to act in the principal's best interest; and
21 (6) Attempt to preserve the principal's estate plan if you know the plan and
22 preserving the plan is consistent with the principal's best interest.
23 Termination of Agent's Authority
24 You must stop acting on behalf of the principal if you learn of any event that
25 terminates this power of attorney or your authority under this power of attorney. Events
26 that terminate a power of attorney or your authority to act under a power of attorney
27 include:
28 (1) Death of the principal;
29 (2) The principal's revocation of the power of attorney or your authority;
30 (3) The occurrence of a termination event stated in the power of attorney;
31 (4) The purpose of the power of attorney is fully accomplished; or
32 (5) If you are married to the principal, a legal action is filed with a court to end
33 your marriage, or for your legal separation, unless the Special Instructions in this power
34 of attorney state that such an action will not terminate your authority.
35 Liability of Agent

1 The meaning of the authority granted to you is defined in SDCL chapter 59-12. If
2 you violate SDCL chapter 59-12 or act outside the authority granted, you may be liable
3 for any damages caused by your violation.
4 In addition to civil liability, failure to comply with your duties and authority granted
5 under this document could subject you to criminal prosecution for grand theft,
6 embezzlement of property received in trust, among other criminal charges.
7 If the principal is 65 years of age or older, or an adult with a disability, you could
8 also be prosecuted for elder abuse and financial exploitation.
9 If there is anything about this document or your duties that you do not understand,
10 you should seek legal advice.

11 **Section 42.** That a NEW SECTION be added:

12 **59-12-42. Statutory Form--Agent Certification.**

13 The following optional form may be used by an agent to certify facts concerning a
14 power of attorney. The provisions of §§ 43-28-23 and 7-9-1 apply to any power of attorney
15 that is to be recorded with the register of deeds.
16 AGENT'S CERTIFICATION AS TO THE VALIDITY OF POWER OF ATTORNEY AND
17 AGENT'S AUTHORITY
18 State of ________________________)
19 )SS. AFFIDAVIT
20 County of ________________________)
21 I, ________________________________________________________ (Name of Agent),
22 certify under penalty of perjury that
23 ________________________________________________ (Name of Principal) granted me
24 authority as an agent or successor agent in a power of attorney dated
25 ________________________, 2____.
26 I further certify that to my knowledge:
27 (1) The Principal is alive and has not revoked the Power of Attorney or my authority
28 to act under the Power of Attorney and the Power of Attorney and my authority to act
29 under the Power of Attorney have not terminated;
30 (2) If the Power of Attorney was drafted to become effective upon the happening
31 of an event or contingency, the event or contingency has occurred;
32 (3) If I was named as a successor agent, the prior agent is no longer able or willing
33 to serve; and

1 (4) ______________________________________________________________

2 ______________________________________________________________________

3 _________________________________________________________________

4 (Insert other relevant statements)

5 SIGNATURE AND ACKNOWLEDGMENT

6 ___________________________________________________________, 2______

7 Agent's Signature ____________________ Date

8 ___________________________________________

9 Agent's Name Printed

10 Agent's Address ____________________________________________

11 Agent's Telephone Number ____________________________________________

12 State of ______________________________ )

13 )SS.

14 County of ____________________________ )

15 This Agent's Certification as to the Validity of Power of Attorney and Agent's

16 Authority document was acknowledged before me on ______________________, 2______

17 by _____________________________________. (Date) (Name of Agent)

18 ______________________________________________ (Seal)

19 Signature of Notary Public

20 My commission expires:

21 **Section 43.** That a NEW SECTION be added:

22 **59-12-43. Statutory Form--Revocation.**

23 A document substantially in the following form may be used to create a statutory

24 form revocation of power of attorney that has the meaning and effect prescribed by this

25 chapter. The provisions of §§ 43-28-23 and 7-9-1 apply to any power of attorney that is

26 to be recorded with the register of deeds.

27 SOUTH DAKOTA

28 STATUTORY FORM REVOCATION OF POWER OF ATTORNEY

29 IMPORTANT INFORMATION

30 This revocation of power of attorney revokes a previously executed power of

31 attorney including any nominations of guardian or conservator made within that

32 instrument. This revocation does not revoke any power of attorney authorizing the agent

33 to make health-care decisions for you. You should immediately deliver copies of this

34 revocation to any person, institution, or company

1 that has a copy of the original power of attorney.

2 REVOCATION OF POWER OF ATTORNEY

3 I ______________________________ previously executed a Statutory Form

4 Power of

5 (Name of Principal)

6 Attorney with a date of ____________________, 2____ and named the

7 following person as my agent:

8 Name of Agent: ______________________________

9 Agent's Address: ______________________________

10 Agent's Telephone Number: ______________________

11 I also named the following successor agent(s):

12 Name of Successor Agent: ________________________

13 Successor Agent's Address: ________________________

14 Successor Agent's Telephone Number: ____________________

15 Name of Second Successor Agent: ______________________

16 Second Successor Agent's Address: ______________________

17 Second Successor Agent's Telephone Number: ________________

18 I now hereby revoke that Statutory Form Power of Attorney.

19 EFFECTIVE DATE

20 This revocation of power of attorney is effective immediately.

21 SIGNATURE AND ACKNOWLEDGMENT

22 ____________________________________________________, 2____

23 Your Signature Date

24 ________________________________________

25 Your Name Printed

26 ________________________________________

27 Your Address

28 ________________________________________

29 Your Telephone Number

30 State of ___________________________)

31 )SS.

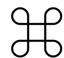
32 County of __________________________)

33 This Statutory Form Revocation of Power of Attorney document was acknowledged

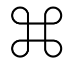
34 before me on ____________________, 2____ by

35 ________________________________.

# Triage Health Estate Planning Toolkit



# Part III: Your State's Estate Planning Forms



# Advance Health Care Directive

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PART I

PRINT YOUR NAME AND ADDRESS

## PART I. DURABLE POWER OF ATTORNEY FOR HEALTH CARE

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:

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

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5) When making health care decisions for me, my agent should think about what action would be consistent with past conversations we have had, my treatment preferences as expressed in this document, my religious and other beliefs and values, and how I have handled medical and other important issues in the past. If what I would decide is still unclear, then my agent should make decisions for me that my agent believes are in my best interest, considering the benefits, burdens, and risks of my current circumstances and treatment options.

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

I give the following instructions to help guide my agent:

______________________________________________________________
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(attach additional pages if needed)

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PART II

## PART II. DECLARATION

NOTICE

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.

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PRINT YOUR NAME

LIFE-SUSTAINING TREATMENT CHOICES

INITIAL ONLY ONE

ARTIFICIAL NUTRITION AND HYDRATION CHOICES

INITIAL ONLY ONE

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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 land hydration. If it has been started, stop it.

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

PART III

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 CaringInfo*
*1731 King St., Suite 100, Alexandria, VA 22314*
*www.caringinfo.org, 800-658-8898*

ORGAN DONATION (OPTIONAL)

## SOUTH DAKOTA ORGAN DONATION FORM - PAGE 1 OF 1

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.

INITIAL THE OPTION THAT REFLECTS YOUR WISHES

_____ 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:

ADD NAME OR INSTITUTION (IF ANY)

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.

PRINT YOUR NAME, SIGN, AND DATE THE DOCUMENT

Declarant name: ______________________________________________________

Declarant signature:______________________________, Date: _______________

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

YOUR WITNESSES MUST SIGN AND PRINT THEIR ADDRESSES

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.

AT LEAST ONE WITNESS MUST BE A DISINTERESTED PARTY

Witness_____________________________________, Date_____________________

Address ____________________________________________________________

____________________________________________________________

*Courtesy of CaringInfo*
*1731 King St., Suite 100, Alexandria, VA 22314*
*www.caringinfo.org, 800-658-8898*

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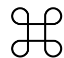
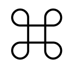
# Triage Health Estate Planning Toolkit



# Part III: Your State's Estate Planning Forms



# Physician Orders for Life Sustaining Treatment (POLST)

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# MEDICAL ORDERS FOR SCOPE OF TREATMENT

## SOUTH DAKOTA MOST

LAST NAME ________________________

FIRST NAME ________________________

MIDDLE INITIAL ____________________

DATE OF BIRTH ____________________ (mm/dd/yyyy)

**FIRST** follow these orders, **THEN** contact medical provider. This is a Medical Order Sheet based on the patient's current medical condition and wishes. Any section that does not include an indication of the patient's or authorized representative's preference, is a directive to health care providers to use all necessary and appropriate medical interventions. The South Dakota MOST complements an advance health care directive and is not intended to replace that document.

Does patient have an advance health care directive? Yes ☐ No ☐

**PATIENT'S DIAGNOSIS OF TERMINAL CONDITION:**

____________________________________________

____________________________________________

____________________________________________

**GOALS OF CARE:**

____________________________________________

____________________________________________

____________________________________________

**Check One**

**A. CARDIOPULMONARY RESUSCITATION (CPR):** PATIENT HAS NO PULSE AND IS NOT BREATHING

☐ CPR/Attempt Resuscitation (requires full intervention in section B)

☐ DNR/Do Not Attempt Resuscitation (Allow Natural Death)

When not in cardiopulmonary arrest, follow orders in B and C

**Check One**

**B. MEDICAL INTERVENTIONS:** PATIENT HAS PULSE AND IS BREATHING, OR HAS PULSE AND IS NOT BREATHING.

☐ Full Intervention: Treatment Goal: Full intervention including life support measures in the intensive care unit. In addition to treatment described in Comfort Measures and Selective Treatment below, use intubation, advanced airway interventions, and mechanical ventilation as indicated. Transfer to hospital and/or intensive care unit if indicated to meet medical needs.

☐ Selective Treatment: Treatment Goal: Stabilization of medical condition. In addition to treatment described in Comfort Measures below, use medical treatment, IV fluids (hydration) and cardiac monitor as indicated to stabilize medical condition. May use basic airway management techniques and non-invasive positive-airway pressure. Do not intubate. Transfer to hospital if indicated to manage medical needs or comfort. Avoid intensive care if possible.

☐ Comfort Measures Only (Allow Natural Death): Treatment Goal: Maximize comfort through symptom management. Relieve pain and suffering through the use of any medication by any route, positioning, wound care and other measures. Use oxygen, suction and manual treatment of airway obstruction as needed for comfort. Patient prefers no transfer to hospital for life-sustaining treatments. Transfer to hospital only if comfort needs cannot be met in current location.

**ADDITIONAL ORDERS:** (e.g. dialysis, etc.)

____________________________________________

____________________________________________

____________________________________________

____________________________________________

**Check One in Each Column**

**C. ARTIFICIALLY ADMINISTERED NUTRITION AND HYDRATION:**

ALWAYS OFFER FOOD AND FLUIDS BY MOUTH AS TOLERATED.

Based on the Provider's medical judgment:

| | YES | NO |
|---|---|---|
| 1. Will artificially administered nutrition and hydration be unable to prolong life? | ☐ | ☐ |
| 2. Will artificially administered nutrition and hydration be more burdensome than beneficial? | ☐ | ☐ |
| 3. Will artificially administered nutrition and hydration cause significant physical discomfort? | ☐ | ☐ |
| 4. Has patient previously expressed a desire to forgo artificially administered nutrition and hydration by tube? | ☐ | ☐ |

In order for artificially administered nutrition and hydration to be withheld, there must be a "YES" answer to one or more of questions 1-4 above.

**Check One**

**D. INFORMED CONSENT DISCUSSION:**

______________________________ had an informed consent discussion with patient or authorized representative.

Name of Medical Provider (MD, DO, NP or PA)

**DISCUSSED WITH:** ☐ Patient ☐ Authorized Representative ______________________________

(Name of Representative)

**Check All That Apply**

**The basis for these orders is:**

☐ Patient's declaration (can be verbal or nonverbal).

☐ Patient's Authorized Representative (patient without capacity).

☐ Patient's Advance Directive (if indicated, patient has completed an additional document that provides guidance for treatment measures if he /she loses medical decision-making capacity).

☐ Resuscitation would be medically non-beneficial.

This form is voluntary and the signatures below indicate that the medical orders are consistent with the patient's medical condition and treatment plan and are the known desires or in the best interests of the patient who is the subject of the document.

| PRINT MEDICAL PROVIDER NAME | MEDICAL PROVIDER SIGNATURE (MANDATORY) | MEDICAL PROVIDER PHONE | DATE (MANDATORY) |
|---|---|---|---|

| PRINT PATIENT OR REPRESENTATIVE NAME | PATIENT OR REPRESENTATIVE SIGNATURE (MANDATORY) | DATE (MANDATORY) |
|---|---|---|

| REPRESENTATIVE RELATIONSHIP | REPRESENTATIVE ADDRESS | REPRESENTATIVE PHONE NUMBER |
|---|---|---|



ENSURE PATIENT HAS THE CURRENT FORM.

PHOTOCOPIES AND FAXES OF SIGNED AND DATED SD MOST FORMS ARE LEGAL AND VALID.

## INFORMATION FOR HEALTH CARE PROVIDERS

Last Name: ______________________________ First Name: _________________________ DOB: ___/____/_____

### COMPLETING SOUTH DAKOTA MOST

a. Must be completed by a physician, nurse practitioner or physician assistant based on patient's preferences and/or best interests, and medical indications.
b. **South Dakota MOST** must be signed and dated by a MD, DO, NP or PA to be valid.
c. **South Dakota MOST** must be signed by the patient or the patient's authorized representative.
d. Use of original form is strongly encouraged. Photocopies and faxes of signed and dated **South Dakota MOST** are legal and valid.

### USING SOUTH DAKOTA MOST (Additional information available at: www.sdaho.org/MOST)

1. Any section that does not include an indication of the patient's or authorized representative's preference, is a directive to health care providers to use all necessary and appropriate medical interventions.

2. Artificial nutrition and hydration is optional when it cannot reasonably be expected to prolong life, would be more burdensome than beneficial, would cause significant physical discomfort, or patient had previously expressed a personal desire to forgo artificial nutrition by tube.

3. The determination of burden refers to the provision of artificial nutrition or hydration itself and not the quality of continued life of the patient.

4. A patient with capacity may revoke the **South Dakota MOST** at any time and request alternate treatment. Additionally, an authorized representative may revoke the MOST only if the MOST was executed by the authorized representative.

5. If there is a conflict between the patient's MOST document and the patient's written directives in any previously executed and unrevoked durable power of attorney or living will, the health care provider will treat the patient in accordance with the instructions in the MOST.

**The duty of medicine is to care for patients even when they cannot be cured. Physicians, nurse practitioners and physician assistants, and their patients must evaluate the use of technology at their disposal based on available information. Judgments about the use of technology to maintain life must reflect the inherent dignity of the patient and the purpose of medical care. Everyone is to be treated with dignity and respect.**

### REVIEWING SOUTH DAKOTA MOST

It is recommended that this **South Dakota MOST** be reviewed periodically, such as when the patient is transferred from one care setting or care level to another, or there is a substantial change in the patient's health status. A patient may revoke a MOST at any time by:

a. Destroying or defacing the MOST with the intent to revoke;
b. A written revocation of the MOST, signed and dated by the patient; or
c. An oral expression of the intent to revoke the MOST, in the presence of a witness 18 years of age or older who signs and dates in writing, confirming that such expression of intent was made.

NOTE: An authorized representative may not revoke a MOST unless the MOST was executed by the authorized representative. Any such revocation by the authorized representative must be in writing.

A revocation is effective upon communication to the health care provider. A health care provider who is informed of a revocation shall record the date and time of the notification of revocation in the patient's medical record.

A new **South Dakota MOST** form should be completed if the patient wishes to make any substantive change to treatment goal(s) (e.g. reversal of prior directive). When completing a new form, the old form must be properly voided and retained in the medical record. To void the **South Dakota MOST** form, draw line through sections A through D and write "VOID" in large letters. This must be signed and dated.

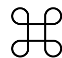
### REVIEW OF THIS SOUTH DAKOTA MOST FORM

| REVIEW DATE AND TIME | REVIEWER | LOCATION OF REVIEW | REVIEW OUTCOME |
|---|---|---|---|
| | | | ☐ No Change<br>☐ Form Voided and New Form Completed |
| | | | ☐ No Change<br>☐ Form Voided and New Form Completed |
| | | | ☐ No Change<br>☐ Form Voided and New Form Completed |

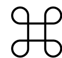


**ENSURE PATIENT HAS THE CURRENT FORM.**
**PHOTOCOPIES AND FAXES OF SIGNED AND DATED SD MOST FORMS ARE LEGAL AND VALID.**

# Triage Health Estate Planning Toolkit



# Part III: Your State's Estate Planning Forms



# Funeral Designation Form

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## State of South Dakota
## Directions for the Disposition of My Body at Death

*as authorized by statute number 34-26-1.*

*This law gives your wishes the highest legal priority, and those may not be overridden by kin. Bear in mind, however, that kin are not obligated to arrange or pay for funeral arrangements that are impossible, impractical, or unaffordable for them.*

I, ______________________________________________________________________, direct that

my body be disposed of in the following manner (you may include, or not, directions for any

associated ceremonies or rites):

______________________________________________________________________________

______________________________________________________________________________

______________________________________________________________________________

______________________________________________________________________________

______________________________________________________________________________

______________________________________________________________________________

______________________________________________________________________________

______________________________________________________________________________

______________________________________________________________________________

______________________________________________________________________________

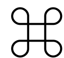
______________________________________________________________________________

______________________________________________________________________________

________________________________ ________________________

(signature) (date)

# Triage Health Estate Planning Toolkit



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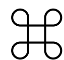

# HIPAA Authorization Form

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## Sample HIPAA Right of Access Form for Family Member/Friend

I, _________________________________, direct my health care and medical services providers and payers to disclose and release my protected health information described below to:

*Name:* *Relationship:*

______________________________ _____________________________________

Contact information: _____________________________________________________

______________________________________________________________________

**Health Information to be disclosed** upon the request of the person named above -- (Check either A or B):

- ☐ A. **Disclose** my complete health record (including but not limited to diagnoses, lab tests, prognosis, treatment, and billing, for all conditions) **OR**
- ☐ B. **Disclose** my health record, as above, **BUT do not disclose** the following (check as appropriate):
  - ☐ Mental health records
  - ☐ Communicable diseases (including HIV and AIDS)
  - ☐ Alcohol/drug abuse treatment
  - ☐ Other (please specify):
    _____________________________
    _____________________________

Form of Disclosure (unless another format is mutually agreed upon between my provider and designee):

- ☐ An electronic record or access through an online portal
- ☐ Hard copy

This authorization shall be effective until (Check one):

- ☐ All past, present, and future periods, OR
- ☐ Date or event:_________________________________________________

unless I revoke it. (NOTE: You may revoke this authorization in writing at any time by notifying your health care providers, preferably in writing.)

_____________________________________________ ____________________
Name of the Individual Giving this Authorization Date of birth

_____________________________________________ ____________________
Signature of the Individual Giving this Authorization Date

Note: HIPAA Authority for Right of Access: 45 C.F.R. § 164.524