SANFORD HEALTH

Advanced Care Plan

တၢ်ကွၢ်ထွဲတၢ်တိၵ်ကျဲၤလၢတၢ်ကတဲၵ်ကတီၤဆိပာ်အီၤ

My Advance Care Plan

ယတၢ်ကွၢ်ထွဲတၢ်တိၵ်ကျဲၤလၢတၢ်ကတဲၵ်ကတီၤဆိပာ်အီၤ

I have completed this Advance Directive with much thought. This document gives my treatment choices and preferences, and/or appoints a Health Care Agent (also known as Health Care Power of Attorney) to speak for me if I cannot communicate or make my own health care decisions. My Health Care Agent, if named, is able to make medical decisions for me, including the decision to refuse treatments that I do not want.

ယမၤပွဲၤလံ တၢ်နဲၵ်လီၤဆိ်းတၢ်ဆိကမိၵ်အဂ့ၤကတၢ်နှၵ်လီၤ. လံာ်တိလံာ်မိအံၤဟ့ၵ်လီၤယတၢ်ကူစါယါဘျါတၢ်ယုထၢတဖ့ၵ်ိ်းတၢ်ဘၵ်သးတဖ့ၵ်. ိ်း/မ့တမ့ၢ် ဟ့ၵ်လီၤမူ ါဆူတၢ်အိၵ်ဆူၵ်အိၵ်ချ့တၢ်ကွၢ်အပှၤခၢၵ်စး (ဘၵ်တၢ်သ့ၵ် ညါစ့ၢ်ကီးအီၤိ်တၢ်အိၵ်ဆူၵ်အိၵ်ချ့တၢ်ကွၢ်ထွဲပိၢ်ရိတၢ်စံၵ်ညီၵ်ဆၢတဲာ်တၢ်ခွဲးယာ်) လၢကကတီၤတၢ်လၢယဂိၢ် ဖဲယဆဲးကျိးဆဲးကျိးတၢ်မ့ၢ်တသ့ မ့တမ့ၢ် မၤယနိၢ်ကစၢ် တၢ်အိၵ်ဆူၵ်အိၵ်ချ့တၢ်ကွၢ်ထွဲတၢ်ဆၢတဲာ်တဖ့ၵ်တသ့ဘၵ်နှၵ်လီၤ. ယတၢ်အိၵ်ဆူၵ်အိၵ်ချ့တၢ်ကွၢ်ထွဲပှၤခၢၵ်စး. မ့ၢ်ယၢၤထိၵ်အမံၤ, မၤကသံၵ်ကသိတၢ်ကူစါယါဘျါတၢ်ဆၢတဲာ်လၢယဂိၢ်သ့. ပၵ်ယုာ်ိ်းတၢ်ဆၢတဲာ်လၢကဂ့ၢ်လိာ် တၢ်ကူစါယါဘျါလၢယတအဲာ်ိ်းအီၤနှၵ်လီၤ.

This document will replace any previous advance directive.

လံာ်တိလံာ်မိအံၤကဆိတလဲတၢ်နဲၵ်လီၤဆိပာ်စၢၤတၢ်လၢအပူၤကွံာ်တခါ လၢ်လ့ၢ်နှၵ်လီၤ.

My name *(ယမံၤ)*: _____

Date *(နံၤသိ)*: _____

My date of birth *(ယတၢ်အိၵ်ဖျိၵ်မ့ၢ်နံၤ)*: _____

My address *(ယလိၢ်အိၵ်ဆိးထံး)*: _____

My telephone numbers: (home) *(ယလိတဲစိနိၵ်ဂ်ၢ်တဖၵ် – (ဟံၵ်))* _____

(cell.) *(ဖဲလ)* _____

☐ My initials here indicate a professional medical interpreter helped me complete this document.

ယတၢ်ဆဲးလီၤမံၤဖဲအံၤဒုးနဲၵ်ပာ်ဖျါထိၵ် ပှၤစဲၵ်နီၤလၢအတဲကျိးထံတၢ်လၢကသံၵ်ကသိ တကပၤ မၤစၢၤယၤလၢယကမၤပွဲၤလံာ်တိလံာ်မိအံၤနှၵ်လီၤ.

The ACP of *(ကွဲးလီၤမံၤ)*_____(print name)

Birth Date *(ဆတၢ်မၤဆိတၢ်ကွၢ်ထွဲ တၢ်ရဲၵ်တၢ်ကျဲၤ (ACP) အိၵ်ဖျိၵ်)* အိၵ်ဖျိၵ် နံၤသို_____ Completion Date *(ဝံၤအမ့ၢ်နံၤ)*_____

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Part 1: My Health Care Agent

(Also Known as Health Care Power of Attorney)

အကူၵ် 1 – ယတၢ်အိၵ်ဆူၵ်အိၵ်ချ့တၢ်ကွၢ်ထွဲပှၤခၢၵ်စး

(ဘၵ်တၢ်သ့ၵ်ညါစ့ၢ်ကိးအီၤ် တၢ်အိၵ်ဆူၵ်အိၵ်ချ့တၢ်ကွၢ်ထွဲပိၢ်ရိတၢ်စံၵ်ညီၵ်ဆၢတဲၵ်တၢ်ခွဲးယဝ်)

If I cannot communicate my wishes and health care decisions due to illness or injury, or if my health care team determines that I cannot make my own health care decisions, I choose the person named below to communicate my wishes and make my health care decisions. My health care agent must:

- Follow my health care instructions in this document
- Follow any other health care instructions I have given to him or her
- Make decisions in my best interest and in accordance with accepted medical standards

ယဆဲးကျိးတဲသကိးယတၢ်အဲၵ်ိဳးတဖဉ် ိဳးတၢ်အိၵ်ဆူၵ်အိၵ်ချ့တၢ်ကွၢ်ထွဲတၢ်ဆၢ တဲၵ်တဖဉ် မ့ၢ်လၢတၢ်ဆူးတၢ်ဆါ မ့တမ့ၢ် တၢ်ဘဉ်ိဘဉ်ထံးအယိ, မ့တမ့ၢ် ဖဲ ယတၢ်အိၵ်ဆူၵ်အိၵ်ချ့ကရူၢ်မ့ၢ်ဆၢတဲၵ်လၢ ယမၤယတၢ်အိၵ်ဆူၵ်အိၵ်ချ့တၢ်ကွၢ်ထွဲတၢ်ဆၢ တဲၵ်လၢယနိၢ်ကစၢ်ိဳၵ်ယဲမ့ၢ်တသ့ဘဉ်နူဉ်, ယယုထၢပှၤအမံၤလၢလ်ာ်လၢ ကဆဲးကျိး တဲသကိးယအဲဉ်ိဳးမၤယတၢ်အိၵ်ဆူၵ်အိၵ်ချ့တၢ်ကွၢ်ထွဲတၢ်ဆၢတဲၵ်တဖဉ် သ့နူဉ်လီၤ. ယတၢ်အိၵ်ဆူၵ်အိၵ်ချ့တၢ်ကွၢ်ထွဲပှၤခၢၵ်စးကဘဉ်–

- *မၤပိာ်ထွဲယတၢ်အိၵ်ဆူၵ်အိၵ်ချ့တၢ်ကွၢ်ထွဲတၢ်နဉ်ကျဲတဖဉ်လၢလံာ်တိလံာ်မိအံၤ အပူၤ*
- *မၤပိာ်ထွဲတၢ်အိၵ်ဆူၵ်အိၵ်ချ့တၢ်ကွၢ်ထွဲတၢ်နဉ်ကျဲအဂၤတမံၤလ်ာ်လ်ာလၢ ယဟ့ဉ်လီၤ ဆူအဝဲအအိၵ်*
- *မၤတၢ်ဆၢတဲၵ်တဖဉ်လၢယတၢ်သးစဲအဂ့ၤကတၢ်အပူၤ ိဳးိ ကသံဉ်ကသိအတီၤ ပတိၢ်လၢတၢ်တူၢ်လိာ်အီၤအပူၤ*

The ACP of *(ကွဲးလီၤမံၤ)*_____(print name)

Birth Date *(ဆတၢ်မၤဆိတၢ်ကွၢ်ထွဲ တၢ်ရဲဉ်တၢ်ကျဲၤ (ACP) အိဉ်ဖျဲဉ် အိဉ်ဖျဲဉ် နံၤသ့ါ*_____ Completion Date *(ဝံၤအမ့ၢ်နံၤ)*_____

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Requirements for Who May Be an Agent or Health Care Power of Attorney Under State Law

တၢ်လိၵ်ဘၣ်တဖၣ်လၢပှၤလၢအကဲပှၤခၢဉ်စး မ့တမ့၊ တၢ်အိဉ်ဆူဉ်အိဉ်ချ့တၢ်ကွၢ်ထွဲပိၢ်ရီတၢ်စံဉ်ညီဉ်ဆၢတဲၵ်တၢ်ခွဲးယာ် လၢကိၢ်စဲဉ်သဲစးတၢ်သိဉ်တၢ်သီအဖီလာ်

Iowa: My agent cannot be a health care provider caring for me on the date I sign this document. My agent also cannot be an employee of a health care provider unless related to me by blood, marriage, or adoption within the third degree of relation.

အဲဉ်အိဝ၊် (Iowa)– *ယပှၤခၢဉ်စးနူဉ် ကဲပှၤဟ့ဉ်တၢ်အိဉ်ဆူဉ်အိဉ်ချ့တၢ်ကွၢ်ထွဲလၢအကွၢ်ထွဲယၤ တသ့ ဖဲမ့ၢ်နံၤလၢဃဆဲးလီၤမံၤလၢလံာ်တီလံာ်မိအံၤအဖိခိဉ်တသ့ဘဉ်. ယပှၤခၢဉ်စးနူဉ် ကဲပှၤဟ့ဉ်တၢ်အိဉ်ဆူဉ်အိဉ်ချ့တၢ်ကွၢ်ထွဲတၢ်မၤစၢၤအပှၤမၤတၢ်ဖိ တသ့ မ့တမ့၊်လၢဘဉ်ထွဲဘဉ်ဃးဒီးယၤ ခီဖျိသွံဉ်. တၢ်ဖျိ. မ့တမ့၊် တၢ်လ့ၢ်ဖိလၢ အအိဉ်လၢတၢ်ဘဉ်ထွဲဒီးလၢအမၤကမဉ်ကွၢ်မ့ဉ်အစၢ်ကတၢ်တပတိၢ်နူဉ်လီၤ.*

Minnesota: My agent must be an adult. My agent cannot be a health care provider or employee of a health care provider giving me direct care unless I am related to that person by blood or marriage, registered domestic partnership, or adoption or unless I have specified otherwise in this document (Specify here: _____). In addition, a person appointed to determine my capacity to make decisions cannot be my agent.

မံဉ်နံဉ်စိထဉ် (Minnesota)– *ယပှၤခၢဉ်စးနူဉ် ကဘဉ်မ့၊်ပှၤနီၤ်ဒိဉ်လၢအဒိဉ်တုာ်ခိဉ်ပွဲၤနူဉ်လီၤ. ယပှၤခၢဉ်စးနူဉ်ကဲ ပှၤဟ့ဉ်တၢ်အိဉ်ဆူဉ်အိဉ်ချ့တၢ်ကွၢ်ထွဲတၢ်မၤစၢၤ မ့တမ့၊် ပှၤဟ့ဉ် တၢ်အိဉ်ဆူဉ်အိဉ်ချ့တၢ်ကွၢ်ထွဲတၢ်မၤစၢမအပှၤမၤတၢ်ဖိလၢဟ့ဉ်ယၤတၢ်ကွၢ်ထွဲ လီၤ လီၤ တသ့ မ့၊်လၢဃဘဉ်ထွဲဒီးပှၤအဝဲနူဉ် ခီဖျိသွံဉ် မ့တမ့၊် တၢ်ဖျိ. မါဝၤတၢ်ဘဉ်ထွဲ လိာ်သးလၢအဆဲးလီၤမံၤ. မ့တမ့၊် တၢ်လ့ၢ်ဖိ မ့တမ့၊်ဘဉ်လၢ ယဒုးနဲဉ်ဟ်ဖျါထိဉ် လၢ လံာ်တီလံာ်မိအံၤအပူၤဘဉ် (ဟ်ဖျါထိဉ် ဖဲအံၤ –_____).*

ဒ်နူဉ်အသိး. ပှၤလၢတၢ်ဟ့ဉ်လီၤအီၤမူဒါလၢကဆၢတဲာ် ယတၢ်သ့တၢ်ဘဉ် လၢ တၢ်မၤတၢ်ဆၢတဲာ်တဖၣ်နူဉ် ကဲယပှၤခၢဉ်စးတသ့ဘဉ်.

North Dakota: My agent must be an adult. My agent cannot be: 1) my health care provider; 2) someone who is an employee of my health care provider but is not related to me; 3) my long term care services provider; or 4) someone who is an employee of my long term care services provider but is not related to me.

နီး(သ)ဒ်ခါဓဉ် (North Dakota)– *ယပှၤခၢဉ်စးနူဉ် ကဘဉ်မ့၊်ပှၤနီၤ်ဒိဉ်လၢအဒိဉ်တုာ်ခိဉ်ပွဲၤနူဉ်လီၤ. ယပှၤခၢဉ်စးကဲ ၁) ယပှၤဟ့ဉ်တၢ်အိဉ်ဆူဉ်အိဉ်ချ့တၢ်ကွၢ်ထွဲတၢ်မၤစၢၤ. ၂) ပှၤတဂၤဂၤလၢအမ့၊် ယပှၤဟ့ဉ်တၢ်အိဉ်ဆူဉ်အိဉ်ချ့တၢ်ကွၢ်ထွဲတၢ်မၤစၢၤအပှၤမၤတၢ်ဖိ ဘဉ်ဆဉ်တဘဉ်ထွဲဒီး ယၤ. ၃) ယပှၤဟ့ဉ် ကတိၤ်ယံာ်တၢ်ကွၢ်ထွဲတၢ်ဖံးတၢ်မၤတၢ်မၤစၢၤ. မ့တမ့၊် ၄) ပှၤတ ဂၤဂၤလၢအမ့၊် ယ ပှၤဟ့ဉ်ကတိၤ်ယံာ်တၢ်ကွၢ်ထွဲတၢ်ဖံးတၢ်မၤတၢ်မၤစၢၤအပှၤမၤတၢ်ဖိ ဘဉ်ဆဉ်တဘဉ် ထွဲဒီးယၤဘဉ်နူဉ်လီၤ.*

South Dakota: My agent must be an adult.

ကလံၤထံးဒ်ခါဓဉ် (South Dakota)– *ယပှၤခၢဉ်စးနူဉ် ကဘဉ်မ့၊်ပှၤနီၤ်ဒိဉ်လၢအဒိဉ်တုာ်ခိဉ်ပွဲၤနူဉ်လီၤ.*

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My Primary (Main) Health Care Agent Is:

ယဂ်ၢ်ခီၣ်ထံး (အရှဒိၣ်) တၢ်အိၣ်ဆူၣ်အိၣ်ချုတၢ်ကွၢ်ထွဲပှၤခၢၣ်စးမ့ၢ်ဝဲ –

Name *(မံၤ)*: _____ Relationship *(တၢ်ဘၣ်ထွဲ)*: _____

Telephone numbers: (H) *လိတဲစိနီၣ်ဂ်ၢ်တဖၣ် – (H)*_____ (C *(C)*)_____

(W *(W)*)_____

Full address *(လီၤအိၣ်ဆိးထံးအလၢအပှဲၤ)*: _____

If my primary agent is not willing, able, or reasonably available to make health care decisions for me, I choose an alternate Health Care Agent.

ယဂ်ၢ်ခီၣ်ထံးပှၤခၢၣ်စးမ့ၢ်တအဲၣ်ဒိး, မၤဝဲတသ့, မ့တမ့ၢ် တအိၣ်ဝဲလၢအကြား အဘၣ်လၢကမၤတၢ်အိၣ်ဆူၣ်အိၣ်ချုတၢ်ကွၢ်ထွဲတၢ်ဆၢတဲၵ်လၢယဂီၢ်ဘၣ်နူၣ်, ယဃုထၢတၢ်အိၣ်ဆူၣ်အိၣ်ချုတၢ်ကွၢ်ထွဲပှၤခၢၣ်စးအဂၤတဂၤလီၤ.

My Alternate Health Care Agent Is:

ယတၢ်အိၣ်ဆူၣ်အိၣ်ချုတၢ်ကွၢ်ထွဲပှၤခၢၣ်စးအဂၤတဂၤမ့ၢ်ဝဲ –

Name *(မံၤ)*: _____ Relationship *(တၢ်ဘၣ်ထွဲ)*: _____

Telephone numbers: (H) *လိတဲစိနီၣ်ဂ်ၢ်တဖၣ် – (H)*_____ (C *(C)*)_____

(W *(W)*)_____

Full address *(လီၤအိၣ်ဆိးထံးအလၢအပှဲၤ)*: _____

Powers of My Health Care Agent:

ယတၢ်အိၣ်ဆူၣ်အိၣ်ချုတၢ်ကွၢ်ထွဲပှၤခၢၣ်စးအတၢ်စိတၢ်ကမီၤ–

My Health Care Agent automatically has all the following powers when I do not have the capacity to make decisions and/or I am unable to communicate for myself:

ယတၢ်အိၣ်ဆူၣ်အိၣ်ချုတၢ်ကွၢ်ထွဲပှၤခၢၣ်စးနူၣ် အိၣ်ဒီးတၢ်စိတၢ်ကမီၤပိာ်ထွဲလၢ လာ်ခဲလၢာ်အဂီၢ်တဘျိယိ ဖဲယတအိၣ်ဒီးတၢ်သ့တၢ်ဘၣ်လၢကမၤတၢ်ဆၢတဲၵ်တဖၣ် ဒီး/မ့တမ့ၢ် ယတဲတၢ်လၢယနီၢ်ကစၢ်ဒၣ်ဝဲအဂီၢ်မ့ၢ်တသ့ဘၣ်အခါ –

A. Agree to, refuse, or cancel decisions about my health care. This includes tests, medications, surgery, withdrawing or starting artificial nutrition and hydration (such as tube feedings or IV (intravenous) fluids), and other decisions related to treatments. If treatment has already begun, my agent can continue it or stop it based on my instructions.

အၢဉ်လီၤတူၢ်လိာ်, ဂ့ၢ်လိာ်, မ့တမ့ၢ် ဆိကတိၢ်တၢ်ဆၢတဲၵ်ဘၣ်ယးဒိးယတၢ်အိၣ် ဆူၣ်အိၣ်ချုတၢ်ကွၢ်ထွဲ. တၢ်အံၤပဉ်ယုဉ်ဒိးတၢ်မၤကွၢ်, ကသံဉ် ကသိ, တၢ်ကူးကွဲးယါဘျါ, တၢ်ဆိကတိၢ် မ့တမ့ၢ် စးထိဉ်တၢ်အိဉ်နူၤ်ဂ်ၢ်နူၤ်ဘါဒိးတၢ်ထံတၢ်နိလၢတၢ်ဟုဉ်အိၤလၢပိၤဘိတဖၣ် (ဒ်အမ့ၢ် တၢ်ဟုဉ်တၢ်အိလၢပိၤဘိ မ့တမ့ၢ် IV (တၢ်ဆဲးကသံဉ်လၢသွံဉ်ကျိၤ) တၢ်အထံအနိ), ဒီးတၢ်ဆၢတဲၵ်အဂၤလၢအဘဉ်ထွဲဒီးတၢ်ကူစါယါဘျါတဖၣ်နူဉ်လီၤ. တၢ်ကူစါယါဘျါမ့ၢ်စးထိဉ် လံအသးတခီ, ယပှၤခၢၣ်စးဆဲးမၤဝဲတၢ်အံၤ မ့တမ့ၢ် ပတုာ်တၢ်အံၤဒိးသနူၤထိဉ်အသးလၢယတၢ်နဲၣ်ကျဲအဖိခီဉ်သ့နူဉ်လီၤ.

The ACP of *(ကွဲးလီၤမံၤ)*_____(print name)

Birth Date *(ဆတၢ်မၤဆိတၢ်ကွၢ်ထွဲ တၢ်ရဲၣ်တၢ်ကျဲၤ (ACP) အိၣ်ဖျိၣ်) အိၣ်ဖျိၣ် နံၤသ္ဂီ*_____ Completion Date *(ဝံၤအမ့ၢ်နံၤ)*_____

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B. Interpret any instruction in this document based on his or her understanding of my wishes, values and beliefs.

တဲဖျါထိဉ်တၢ်နဲဉ်ကျဲတမံၤလၢ်လၢ်လၢၤလံာ်တီလံာ်မိအံၤအပူၤ ဒိးသနူၤထိဉ် အ သးလၢအဝဲအတၢ်နၢ်ပၢၢ်လၢယတၢ်အဲဉ်ဒိး. တၢ်ပာ်လုၢ်ပာ်ပူၤတဖဉ်ဒိးတၢ်နာ် တဖဉ် အဖိခိဉ်နူဉ်လီၤ.

C. Review and release my medical records and personal files as needed for my health care, as stated in the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

ကွၢ်က ါကၢၤီးထုးထိဉ်ရၤလီၤယကသံဉ်ကသိတၢ်မၤနီဉ်မၤယါတဖဉ် ီးနီ၊ ကစၢ်လံာ်ကြံာ်တဖဉ်ီအလိဉ်အိဉ်အသိးလၢယတၢ်အိဉ်ဆူဉ်အိဉ်ချ့တၢ်ကွၢ်ထွဲအဂီ၊ ီဘဉ် တၢ်ပာ်ဖျါအီၤလၢတၢ်အိဉ်ဆူဉ်အိဉ်ချ့တၢ်အုဉ်ကီၤလၢတၢ်ဆိတလဲအီၤသ့ညီ ီးတၢ်သ့ဟံးမူ ါတၢ်သိဉ်တၢ်သိ ၁၉၉၆ (HIPAA) အဖိခိဉ်လီၤ.

D. Arrange for my health care and treatment in a location he or she thinks is appropriate.

ရဲဉ်ကျဲၤလၢယတၢ်အိဉ်ဆူဉ်အိဉ်ချ့တၢ်ကွၢ်ထွဲီးတၢ်ကူစါယါဘျါအဂီ၊ လၢတၢ်လိ၊ တၢ်ကျဲလၢအဝဲဆိကမိဉ်လၢကြားဝဲဘဉ်ဝဲအပူၤနူဉ်လီၤ.

E. Decide which health care providers and organizations provide my health care.

ဆၢတဲာ်လၢတၢ်အိဉ်ဆူဉ်အိဉ်ချ့တၢ်ကွၢ်ထွဲပှၤဟ့ဉ်တၢ်မၤစၢၤတဖဉ်ီး တၢ်ကရၢက ရိတဖဉ်ဟ့ဉ်လီၤယတၢ်အိဉ်ဆူဉ်အိဉ်ချ့တၢ်ကွၢ်ထွဲနူဉ်လီၤ.

F. Make decisions about organ and tissue donation according to my instructions in Part 2 of this document.

မၤတၢ်ဆၢတဲာ်ဘဉ်ယးီးတၢ်ဟ့ဉ်မၤဘူဉ်နီၢ်ခိကွၢ်ဂီၤ့ ီးထံးရှူတဖဉ် ယ တၢ်နဲဉ်ကျဲဟဲဝဲလၢ လံာ်တီလံာ်မိအံၤအကူာ် ၂ အပူၤအသိးနူဉ်လီၤ.

Comments or limits on the above *(တၢ်ဟ့ဉ်ကူဉ် မ့တမ့၊ တၢ်ပာ်ပနီဉ်လၢထး)*– _____

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The ACP of *(ကွဲးလီၤမံၤ)*_____(print name)

Birth Date *(ဆတၢ်မၤဆိတၢ်ကွၢ်ထွဲ တၢ်ရဲဉ်တၢ်ကျဲၤ (ACP) အိဉ်ဖျါဉ်) အိဉ်ဖျါဉ် နံၤသ့ါ*_____ Completion Date *(ဝံၤအမ့ၢ်နံၤ)*_____

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Additional Powers of My Health Care Agent:

ယတၢ်အိၵ်ဆူၵ်အိၵ်ချုတၢ်ကွၢ်ထွဲ အပှၤခၢၵ်စးအတၢ်စိကမီၤအဂၤတဖၣ်

My initials below indicate I also authorize my health care agent to:

ယတၢ်ဆဲးလီၤမံၤလၢလာ် ပာ်ဖျါထိၵ်လ၊ ယဟ့ၵ်စိဟ့ၵ်ကမီၤစ့ၢ်ကီး ယတၢ်အိၵ်ဆူၵ်အိၵ်ချုတၢ်ကွၢ်ထွဲ အပှၤခၢၵ်စးလၢက–

☐ Make decisions about the care of my body after death.
မၤတၢ်ဆၢတဲာ်ဘၵ်ယး တၢ်ကွၢ်ထွဲယနီၢ်ခိမိၢ်ပှၢ်ဖဲယစူးကွံာ်သးဝံၤအလိၢ်ခံနှၵ်လီၤ.

If I live in North Dakota or Minnesota, my initials below indicate I also authorize my health care agent to:

ယမ့ၢ်အိၵ်လ၊ ကလံၤစီးဇၢ်ခိထၣ်(North Dakota) မ့တမ့ၢ် မံၵ်နှၵ်စိထၣ် (Minnesota) အဃိ, ယတၢ်ဆဲးလီၤမံၤ လၢလာ် ကပာ်ဖျါထိၵ်လ၊ ယဟ့ၵ်တၢ်စိတၢ်ကမီၤဆူ ယတၢ်အိၵ်ဆူၵ်အိၵ်ချု, တၢ်ကွၢ်ထွဲခၢၵ်စးလၢက–

☐ Continue as my health care agent even if our marriage or domestic partnership is legally ending or has been ended.

ဆဲးမၤတၢ်ဒ်ယတၢ်အိၵ်ဆူၵ်အိၵ်ချုတၢ်ကွၢ်ထွဲအပှၤခၢၵ်စး ဖဲတၢ်မၤကတၢ်၊ ပတၢ်ဒိးတ့ဒိးဖျိသး မ့တမ့ၢ် တၢ်အိၵ်ယှာ်သကိး တပူၤယီလၢဟံာ်ပူၤဒ်မါဝၤအသိးအဖၢမ့ၢ် မ့တမ့ၢ် ကတၢၢ်ကွံာ်လံအခါနှၵ်လီၤ.

☐ Make health care decisions for me even if I am able to decide or speak for myself, if I so choose.

မၤတၢ်အိၵ်ဆူၵ်အိၵ်ချုတၢ်ကွၢ်ထွဲအတၢ်ဆၢတဲာ်လၢယဂီၢ်ဖဲ ယဆၢတဲာ် မ့တမ့ၢ် တဲတၢ်လၢယနီၢ်ကစၢ် ဒၣ်ယဲအဂီၢ်သ့အခါ, ဒီးယယုထၢလၢယကပျဲအီၤအခါနှၵ်လီၤ.

The ACP of (ကွဲးလီၤမံၤ)_____(print name)
Birth Date (ဆတၢ်မၤဆိတၢ်ကွၢ်ထွဲ တၢ်ရဲၵ်တၢ်ကျဲၤ (ACP) အိၵ်ဖျါၵ် အိၵ်ဖျါၵ် နံၤသျိ)_____ Completion Date (ဝံၤအမ့ၢ်နံၤ)_____

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Part 2: My Health Care Instructions

အကျဉ် ၂– ယတၢ်အိဉ်ဆူဉ်အိဉ်ချ့တၢ်ကွၢ်ထွဲအတၢ်နဲဉ်လီၤတဖဉ်

My choices and preferences for health care are indicated below. I ask my Health Care Agent to communicate these choices, and my health care team to honor them, if I cannot communicate or make my own choices.

ယမၤယတၢ်အိဉ်ဆူဉ်အိဉ်ချ့တၢ်ကွၢ်ထွဲ အပှၤခၢဉ်စးလၢ ကတဲနုးသ့ဉ်ညါ တၢ်ယုထၢတဖဉ်အံၤ, ဒီးယပှၤကွၢ်ထွဲတၢ်အိဉ်ဆူဉ်အိဉ်ချ့ တၢ်မၤကရူၢ် ကဘဉ် လူၤဟိဉ်မၤထွဲအဂီၤ. ဖဲယတဲတၢ်ဒီးအဝဲသ့ဉ် မ့ၢ်တသ့ မ့တမ့ၢ် မၤယနီၢ်ကစၢ်အတၢ်ယုထၢမ့ၢ်တသ့အခါနူဉ်လီၤ.

I have initialed a box below for the option I prefer for each situation.

ယဆဲးလီၤမံၤဖဲတၢ်ဟ်ပနီဉ်အလိၢ်လၢလာ်အံၤလၢ တၢ်ယုထၢလၢယအဲဉ်ဒီးမၤအီၤလၢ တၢ်အိဉ်ဆူဉ်အိဉ်ချ့ တခါစုဉ်စုဉ်အဂိၢ်နူဉ်လီၤ.

Note: You do not need to write instructions about treatments to extend your life, but it is helpful to do so. If you do not have written instructions, your agent will make decisions based on your spoken wishes, or in your best interest if your wishes are unknown

တိၢ်နီဉ်– *နတလိဉ်ဘဉ်လၢ ကကွဲးတၢ်နဲဉ်လီၤဘဉ်ထွဲ တၢ်ကူစါယါဘျါလၢ ကမၤထိထိဉ်နသးသမူ, ဘဉ်ဆဉ် ကဲထိဉ်တၢ်မၤစၢၤလၢ တၢ်ကမၤအီၤအဂိၢ်လီၤ. နမ့ၢ်တအိဉ်ဒီး တၢ်နဲဉ်လီၤလၢ တၢ်ကွဲးဟ်လီၤအီၤတဖဉ်အယိ, နပှၤခၢဉ်စးကမၤတၢ်ဆၢတဲဉ်တဖဉ်လၢ အဒီးသနူၤထိဉ်အသးလၢ နတၢ်မိဉ်နူၢ်သးလီလၢ နတဲတ့ၢ်အီၤတဖဉ်, မ့တမ့ၢ် တၢ်မ့ၢ်တသ့ဉ်ညါ နတၢ်မိဉ်နူၢ်သးလီတဖဉ်အယိ တၢ်ကမၤအီၤလၢ နတၢ်သးစဲအဂ့ၤကတၢ်လၢနဂိၢ်လီၤ.*

A. Cardiopulmonary Resuscitation: A Decision for the Present

တၢ်မၤကဒၢကွၤဒ်သိးသးဖျၢဉ်ဒီးပသိဉ်ကမၤကွၤတၢ်အဂိၢ်* (Cardiopulmonary Resuscitation) *တၢ်ဆၢတဲဉ်လၢ ကတိၢ်အံၤအဂိၢ်

This decision refers to a treatment choice I am making today based on my current health. **Section C below (Treatments to Prolong My Life: A Decision for the Future)** indicates treatment choices I want if my health changes in the future and I cannot communicate for myself.

တၢ်ဆၢတဲဉ်အံၤ တၢ်ကဘဉ်ကွၢ်သတြဲၤအီၤဒီး တၢ်ကူစါယါဘျါအတၢ်ကွၢ်ထွဲလၢ ယမၤအီၤတနံၤအံၤ လၢအဒီးသနူၤထိဉ်အသးလၢ ယတၢ်အိဉ်ဆူဉ်အိဉ် ချ့တၢ်အိဉ်သးခဲအံၤအဖိခိဉ်လီၤ. ***အကျဉ် ဂ လၢလဉ် (တၢ်ကူစါယါဘျါလၢ ကမၤထိထိဉ်ယသးသမူ– တၢ်ဆၢတဲဉ်လၢ ခါဆူညါအဂိၢ်) ဟ်ဖျါထိဉ် တၢ်ကူစါယါဘျါအတၢ်ယုထၢလၢတဖဉ်လၢ ယလိဉ်ဘဉ်အီၤ ဖဲယတၢ်အိဉ်ဆူဉ်အိဉ်ချ့ဆီတလဲသးလၢ ခါဆူညါဒီး ယတဲယတၢ်လိဉ်ဘဉ်လၢ ယနီၢ်ကစၢ်ဒဉ်ယဲတသ့ဘဉ် အခါနူဉ်လီၤ.***

CPR is a treatment used to attempt to restore heart rhythm and breathing when they have stopped. CPR may include chest compressions (forceful pushing on the chest to make the blood circulate), medications, electrical shocks, a breathing tube, and hospitalization.

CPR နူဉ် မ့ၢ်တၢ်ကူစါယါဘျါလၢ တၢ်စူးကါအီၤလၢ ကမၤစံဉ်ထိဉ်ကဒၢကွၤယသးဒီး ယတၢ်သါထိဉ်သါလီၤ ဖဲအအိဉ်ပတုဉ်ကွံဉ်အလိၢ်ခံနူဉ်လီၤ. ***အပူၤကပဉ်ဃုဉ်ဒီး တၢ်ဆိဉ်တံၢ်လီၤဖဲသးနါပှၤ် (တၢ်ဆိဉ်တံၢ်လီၤသးနါပှၤ်ဒ်သိး ကမၤလဲၤတရံး သွံဉ်အတၢ်လဲၤတၢ်ကွၤ), ကသံဉ်ကသီ, တၢ်ထိးဒီးအံဉ်လဲးြ ထံး, တၢ်ထၢနှာ်လီၤတၢ်ကသါကျိဘိ, ဒီးတၢ်ဘဉ်ထိဉ်တၢ်ဆါဟံဉ်တဖဉ်နူဉ်လီၤ.***

I understand that CPR can save a life but does not always work. I also understand that CPR does not work as well for people who have chronic (long-term) diseases or impaired functioning, or both. I understand that recovery from CPR can be painful and difficult.

ယနၢ်ပၢၢ်လၢ CPR နူဉ် မၤစၢၤသးသမူသ့ ဘဉ်ဆဉ် တမၤတၢ်ထိဘိဘဉ်နူဉ်လီၤ. ယသ့ဉ်ညါစုၢ်ကီးလၢ CPR နူဉ် တမၤတၢ်လၢ ပှၤလၢအိဉ်ဒီးတၢ်ဆါထၢ (ကတိၢ်ထိ) တၢ်ဆူးတၢ်ဆါ မ့တမ့ၢ် အနီၢ်ခိတၢ်မၤကျိၤကျဲတဘဉ်လိာ်ဘဉ်စး, မ့တမ့ၢ် ခံမံၤလၢာ်အဂိၢ်ဂ့ၤဂ့ၤဘဉ်နူဉ်လီၤ. ယနၢ်ပၢၢ်လၢ တၢ်ကိညၢ်ထိဉ်က့ၤဖဲတၢ်မၤ CPR ဝံၤအလိၢ်ခံ ကဆါဒီးကိခဲဝဲသ့နူဉ်လီၤ.

The ACP of *(ကွဲးလီၤမံၤ)*_____(print name)
Birth Date *(ဆတၢ်မၤဆိတၢ်ကွၢ်ထွဲ တၢ်ရဲဉ်တၢ်ကျဲၤ (ACP) အိဉ်ဖျဲဉ် အိဉ်ဖျဲဉ် နံၤသ)*_____ Completion Date *(ဝံၤအမ့ၢ်နံၤ)*_____

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Therefore (initial one)

လၢတၢ်နှၣ်အဃိ (ဃုထၢဆဲးလီၤမံၤတခါ)

☐ I want CPR attempted if my heart or breathing stops.
ယသးလီလၢ တၢ်ကမၤကွၢ်ယၤ CPR ဖဲယသးဖျၢ်ဉ် မ့တမ့်၊ တၢ်ကသါပတုာ်အခါနှၣ်လီၤ.

Or *(မ့တမ့်၊)*

☐ I want CPR attempted if my heart or breathing stops based on my current state of health. However, in the future if my health has changed, then my agent or I (if I am able) should discuss CPR with my health care team. My choices in **Section B: Treatment Preferences and Section C: Treatments to Prolong My Life** below should be considered when making this decision. Examples of when my health has changed include:

ယသးလီလၢ တၢ်ကမၤကွၢ်ယၤ CPR ဖဲယသးဖျၢ်ဉ် မ့တမ့်၊ တၢ်ကသါ ပတုာ် ဒိးသန့ၤ ထိဉ် အသးလၢ ယတၢ်အိဉ်ဆူဉ်အိဉ်ချ့တၢ်အိဉ်သးခဲအံၤနှၣ်လီၤ. CPR ဒ်လဲဉ်ဂ့ၤ, ယတၢ်အိဉ်ဆူဉ်အိဉ်ချ့ဖဲခါဆူညါ မ့ၢ်ဆိတလဲအသးအဃိ, ယပှၤခၢဉ်စး မ့တမ့်၊ ယၤ (ယမၤမ့ၢ်သ့) ကြၢးတဲသကိး အဂ့ၢ်ဒီး ယတၢ်အိဆူဉ်အိဉ်ချ့တၢ်ကွၢ်ထွဲကချ့ၢ်နှၣ်လီၤ. ယတၢ်ယုထၢလၢ ***အကျိ ခ အပူၤ– တၢ်ကူစါယါဘျါအတၢ်ဘဉ်သးဒီး အကျိ ဂ–*** *တၢ်ကြၢးဆိကမိဉ်တၢ်ဂ့ၢ်လၢလာ် ဖဲတၢ်မၤတၢ်ဆၢတဲာ် အခါလီၤ.*

- have an incurable illness or injury and am dying
  ယအိဉ်ိးတၢ်ဆူးတၢ်ဆါ မ့တမ့်၊ တၢ်ဘဉ်ိဘဉ်ထံးလၢ တၢ်ကူစါယါဘျါအီၤတသ့ိး ဘူးယကသံ
- have no reasonable chance of survival if my heart or breathing stops
  ယတအိဉ်ိး တၢ်မ့ၢ်လၢအကြားအဘဉ်လၢ ယကအိဉ်မူဖဲယသးဖျၢ်ဉ် မ့တမ့်၊ ယတၢ်သါထိဉ်သါလီၤ ပတုာ်အခါ
- have little chance of long-term survival if my heart or breathing stops and CPR would cause significant suffering
  ယအိဉ်ိးတၢ်ခွဲးတၢ်ယာ်ထဲတဖဲးဖိလၢ ယကအိဉ်မူလၢကတိၢ်ထိုဖဲယသးဖျၢ်ဉ် မ့တမ့်၊ ယတၢ်သါထိဉ်သါလီၤ ပတုာ်အခါိး CPR ကုၤ်းအိဉ်ထိဉ် တၢ်တူၢ်ဘဉ်လၢအိဉ်အမ့ၢ်

Or *(ချ)*

☐ I do not want CPR attempted if my heart or breathing stops. I want to allow a natural death. I understand if I choose this option I should see my health care provider about writing a Do Not Resuscitate (DNR) order.
ယသးဖျၢ်ဉ် မ့တမ့်၊ ယတၢ်သါထိဉ်သါလီၤမ့ၢ်ပတုာ်အဃိ ယတသးလိ CPR ဘဉ်. ယအဲဉ်ိးပျဲတၢ်သံ့ိန့ဆၢဉ်အသိးလီၤ. ယနၢ်ပၢၢ်လၢ ယမ့ၢ်ယုထၢတၢ်ယုထၢအံၤနှၣ် ယကြၢးထံဉ်လိာ်သးိ ပှၤလၢအဟ့ဉ်ဃၤ တၢ်အိဉ်ဆူဉ်အိဉ်ချ့တၢ်ကွၢ်ထွဲဘဉ်ဃး တၢ်ကွဲး တလိဉ် မၤကသါထိဉ်ကၢ်တၢ် (Do Not Resuscitate (DNR)) အတၢ်နဲဉ်လီၤအဂိၢ်နှၣ်လီၤ.

The ACP of *(ကွဲးလီၤမံၤ)*_____(print name)
Birth Date *(ဆတၢ်မၤဆိတၢ်ကွၢ်ထွဲ တၢ်ရဲဉ်တၢ်ကျဲၤ (ACP) အိဉ်ဖျဲဉ်) အိဉ်ဖျဲဉ် နံၤသ့ိ*_____ Completion Date *(ဝံၤအမ့ၢ်နံၤ)*_____

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B. Treatment Choices: My Health Condition

တၢ်ကူစါယါဘျါအတၢ်ယုထၢတဖၣ်– ယတၢ်အိၣ်ဆူၣ်အိၣ်ချုတၢ်အိၣ်သး

My treatment choices for my specific health condition(s) are written here. With any treatment choice, I understand I will continue to receive pain and comfort medicines, as well as food and liquids by mouth if I am able to swallow.

ယတၢ်ကူစါယါဘျါအတၢ်ယုထၢလၢ ယတၢ်အိၣ်ဆူၣ်အိၣ်ချုတၢ်အိၣ်သး(တဖၣ်)အဂီၢ်နူၣ် ဘၣ်တၢ်ကွဲးလီၤအီၤဖဲအံၤနူၣ်လီၤ. ဖဲယယုထၢ တၢ်အိၣ်ဆူၣ်အိၣ် ချုတၢ်ယုထၢ ထိရိၤတမံၤနူၣ်, ယနၢ်ပၢၢ်လၢ ယကဆဲးမၤနူၢ် ကသံၣ်ဖိၣ်လၢ တၢ်ဆူးတၢ်ဆါဒီး တၢ်မၤမုာ်ထိၣ်ကှၤတၢ်အဂီၢ်, တကတိၢ်ယိ တၢ်ကဒုးအိၣ်ဒုးအီယၤ တၢ်အိၣ်တၢ်အီဒီးတၢ်ထံတၢ်နိ ဖဲယယူၢ်လီၤတၢ်မ့ၢ်နူၢ်အခါနူၣ်လီၤ.

_____

_____

_____

_____

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_____

☐ My initials here indicate additional documents are attached.

ယတၢ်ဆဲးလီၤမံၤဖဲအံၤဟ်ဖျါလၢ တၢ်ဘျးစဲယှာ်ဒီးလံာ်တိလံာ်မိတဖၣ်လီၤ.

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C. Treatments to Prolong My Life: A Decision for the Future

တၢ်ကူစါယါဘျါလၢ ယထုးယံာ်ထိၣ်ယသးသမူ– တၢ်ဆၢတဲာ်လၢခါဆူညါအဂီၢ်

If I can no longer make decisions for myself, and my health care team and agent believe I will not recover my ability to know who I am, I want (Initial One):

ယမၤတၢ်ဆၢတဲာ်လၢယနီၢ်ကစၢ်အဂီၢ်မ့ၢ်တသ့လၢၤဘၣ်အဃိ, ယတၢ်အိၣ်ဆူၣ်အိၣ်ချ့တၢ်ကွၢ်ထွဲ အကရူၢ်ဒီး ပှၤခၢၣ်စးမ့ၢ်နာ်လၢ ယတမၤန့ၢ်ကဒၢကှၤ ယတၢ်သ့တၢ်ဘၣ်လၢ ကသ့ၣ်ညါလၢယမ့ၢ်မတၤအဃိ, ယအဲၣ်ဒိး (ယုထၢဆဲးလီၤမံၤတခါ)–

NOTE: With either choice, I understand I will continue to receive pain and comfort medicines, as well as food and liquids by mouth if I am able to swallow.

တိၢ်နီၣ်– ဖဲယဃုထၢ တၢ်ဃုထၢ ထိရီၤတမံၤန့ၣ်, ယနၢ်ပၢၢ်လၢ ယကဆဲးမၤန့ၢ် ကသံၣ်ဖိၣ်လၢ တၢ်ဆူးတၢ်ဆါဒိး တၢ်မၤမ့ာ်ထိၣ် ကှၤတၢ်အဂီၢ်, တကတီၢ်ဃီ တၢ်ကနုးအိၣ်နုးအီယၤ တၢ်အိၣ်တၢ်အီဒိးတၢ်ထံတၢ်နိ ဖဲယယူၢ်လီၤတၢ်မ့ၢ်နၢ်အခါန့ၣ်လီၤ.

☐ **To stop or withhold all treatments** that may extend my life. This includes but is not limited to artificial nutrition and hydration (for example, tube feedings and IV (intravenous) fluids), respirator/ventilator (breathing machine), cardiopulmonary resuscitation (CPR), dialysis, and antibiotics.

*ကဘဉ် **ပတုာ် မ့တမ့ၢ် တြီဃာ် တၢ်ကူစါယါဘျါခဲလၢာ်** လၢ ကထုးယံာ်ထိၣ် ယသးသမူန့ၣ်လီၤ. တၢ်အံၤကပၣ်ယုာ် ဘၣ်ဆၣ် တၢ်တဟ်ပနီၣ် အိၤလၢ ကဘဉ်မ့ၢ် တၢ်အိၣ်နၢ်ဂံၢ်နၢ်ဘါ မ့တမ့ၢ် တၢ်ထံတၢ်နိလၢ အယိၢ် (အဒိ, တၢ်ဟ့ၣ်နုးအိၣ်တၢ်အိၣ်တၢ်အီခီဖျိကျိဘိဒိး* IV *(ခီဖျိသွံၣ်ကျိ) အထံ), တၢ်ကသါဒၢ/ တၢ်ကသါစဲးအပီးလိ (စဲးကသါစၢၤတၢ်), တၢ်မၤကဒၢကှၤ ဒ်သိးသးဖျၢၣ်ဒိးပသိၣ်ကမၤကှၤတၢ်အဂီၢ်* (CPR), *တၢ်သ့ကလ့ၢ်, ဒိးကသံၣ်မၤသံတၢ်ဆါယၢ်တဖၣ်နၣ်လီၤ.*

Or *(မ့တမ့ၢ်)*

☐ **All treatments recommended** by my health care team. This includes but is not limited to artificial nutrition and hydration (for example, tube feedings, IV (intravenous) fluids), respirator/ventilator (breathing machine), cardiopulmonary resuscitation (CPR), dialysis, and antibiotics. I want treatments to continue until my health care team and agent agree such treatments are harmful or no longer helpful.

တၢ်ကူစါယါဘျါလၢ တၢ်ဟ့ၣ်ကူၣ်အီၤခဲလၢာ် *ခီဖျိလၢပှၤလၢအကွၢ်ထွဲ ယတၢ်အိၣ်ဆူၣ်အိၣ်ချ့, ကရူၢ် နၣ်လီၤ. တၢ်အံၤကပၣ်ယုာ် ဘၣ်ဆၣ် တၢ်တဟ်ပနီၣ်အီၤလၢ ကဘဉ်မ့ၢ် တၢ်အိၣ်နၢ်ဂံၢ်နၢ်ဘါ မ့တမ့ၢ် တၢ်ထံတၢ်နိလၢ အယိၢ် (အဒိ, တၢ်ဟ့ၣ်နုးအိၣ်တၢ်အိၣ်တၢ်အီခီဖျိကျိဘိဒိး* IV *(ခီဖျိသွံၣ်ကျိ) အထံ), တၢ်ကသါဒၢ/ တၢ်ကသါစဲးအပီးလိ (စဲးကသါစၢၤတၢ်), တၢ်မၤကဒၢကှၤ ဒ်သိးသးဖျၢၣ်ဒိးပသိၣ်ကမၤကှၤတၢ်အဂီၢ်* (CPR), *တၢ်သ့ကလ့ၢ်, ဒိးကသံၣ်မၤသံတၢ်ဆါယၢ်တဖၣ်နၣ်လီၤ. ယအဲၣ်ဒိးလၢ တၢ်ကဆဲးကူစါယ့ဘျိယၤတုၤလၢ ယ ပှၤလၢအကွၢ်ထွဲ ယတၢ်အိၣ်ဆူၣ်အိၣ်ချ့, ကရူၢ်ဒိး ပှၤခၢၣ်စးမ့ၢ်အၢၣ်လီၤတူၢ်လိာ်ဝဲလၢ တၢ်ကွၢ်ထွဲဒ်နၣ်တဖၣ် မ့ၢ်တကဲထိၣ်တၢ်မၤစၢၤလၢၤဘၣ်အယိ နၣ်လီၤ.*

Comments or directions to my health care team:

တၢ်ဟ့ၣ်ကူၣ် မ့တမ့ၢ် တၢ်နဲၣ်လီၤဆူယ ပှၤလၢအကွၢ်ထွဲ ယတၢ်အိၣ်ဆူၣ်အိၣ်ချ့, ကရူၢ်အအိၣ်–

_____

_____

_____

The ACP of *(ကွဲးလီၤမံၤ)*_____(print name)

Birth Date *(ဆတၢ်မၤဆိတၢ်ကွၢ်ထွဲ တၢ်ရဲၣ်တၢ်ကျဲၤ (ACP) အိၣ်ဖျဲၣ်) အိၣ်ဖျဲၣ် နံၤသ့ါ*_____ Completion Date *(ဝံၤအမ့ၢ်နံၤ)*_____

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D. Organ Donation (Initial One)

ဃ. တၢ်ဟ့ဉ်မၤဘူဉ်လီၤက့ၢ်ဂီၤဒွဲ (ဃုထၢဆဲးလီၤမံၤတခါ)

☐ I want to donate my eyes, tissues and/or organs, if able. My Health Care Agent may start and continue treatments or interventions needed to maintain my organs, tissues and eyes until donation has been completed. My specific wishes (if any) are:

မ့ၢ်သ့. ယအဲဉ်ဒိးဟ့ဉ်မၤဘူဉ်လီၤယမဲာ်ချိ. ညဉ်ထံးရှူဒိး/မ့တမ့ၢ် က့ၢ်ဂီၤဒွဲ. ယတၢ်အိဉ်ဆူဉ်အိဉ်ချ့တၢ်ကွၢ်ထွဲအပှၤခၢဉ်စး ကစးထိဉ်ဒိးဆဲးမၤ တၢ်ကူစါယါဘျါ မ့တမ့ၢ် နှဉ်လီၤတဲစၢၤတၢ်ဖဲအလိဉ်ဘဉ်လၢ ကပၢၤယာ် ယက့ၢ်ဂီၤဒွဲ. ထံးရှူဒိးမဲာ်ချိတ့ၤလၢ တၢ်ဟ့ဉ်မၤဘူဉ်လီၤတၢ်ဝံၤတစုနှဉ်လီၤ. ယတၢ်ဆၢမ့ၢ်လၢ်လီၤတိၢ်လီၤဆိ (မ့ၢ်အိဉ်တမံၤမံၤ) နှဉ်မ့ၢ်ဝဲ–

_____

_____

☐ I do not want to donate my eyes, tissues and/or organs.
ယတအဲဉ်ဒိး ဟ့ဉ်မၤဘူဉ်လီၤယမဲာ်ချိ. ညဉ်ထံးရှူဒိး/မ့တမ့ၢ် က့ၢ်ဂီၤဒွဲတဖဉ်ဘဉ်.

Or *(မ့တမ့ၢ်)*

☐ My Health Care Agent can decide.
ယတၢ်အိဉ်ဆူဉ်အိဉ်ချ့တၢ်ကွၢ်ထွဲအပှၤခၢဉ်စးဆၢတဲာ်ဝဲသ့လီၤ.

E. Autopsy (Initial One)

တၢ်သမံသမိးတၢ်အစိဉ် (ယုထၢဆဲးလီၤမံၤတခါ)

☐ I want my agent to make decisions about an autopsy of my body.
ယအဲဉ်ဒိးလၢ ယပှၤခၢဉ်စး ကမၤတၢ်ဆၢတဲာ်ဘဉ်ယး တၢ်သမံသမိးကွၢ် ယစိဉ်အဂီၢ်နှဉ်လီၤ.

☐ I do not want an autopsy unless required by law.
ယတအဲဉ်ဒိး တၢ်သမံသမိးကွၢ်ယစိဉ် မ့တမ့ၢ်လၢတၢ်လိဉ်ဘဉ်အီၤလၢသဲစးဂ့ၢ်ဝိအယိဘဉ်နှဉ်လီၤ.

The ACP of *(ကွဲးလီၤမံၤ)*_____(print name)
Birth Date *(ဆတၢ်မၤဆိတၢ်ကွၢ်ထွဲ တၢ်ရဲဉ်တၢ်ကျဲၤ (ACP) အိဉ်ဖျဲဉ် အိဉ်ဖျဲဉ် နံၤသ့ါ*_____ Completion Date *(ဝံၤအမ့ၢ်နံၤ)*_____

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F. Comments or Directions to My Health Care Team

တၢ်ဟ့ဉ်ကူဉ် မ့တမ့ၢ် တၢ်နဲၵ်လီၤဆူဃ ပှၤလၢအကွၢ်ထွဲ ယတၢ်အိဉ်ဆူဉ်အိဉ်ချ့ ကရူၢ်အအိဉ်

You may use this space to write any additional instructions or messages to your health care team which have not been covered in this directive, or to elaborate on a point for clarification. You may also leave this space blank.

နစူးကါတၢ်လိၢ်အံၤလၢ ကကွဲးအါထိဉ် တၢ်နဲၵ်လီၤ မ့တမ့ၢ် တၢ်ကစိဉ်တမံၤမံၤလၢ နအဲဉ်ဒိးဟ့ဉ် တၢ်အိဉ်ဆူဉ်အိဉ်ချ့တၢ်ကွၢ်ထွဲကရူၢ် လၢအတပဉ်ဃုာ်လၢ တၢ်နဲၵ်လီၤအံၤအပူၤ. မ့တမ့ၢ် အဲဉ်ဒိး တဲနၢ်ပၢၢ်အါထိဉ် တၢ်ဂ့ၢ်တၢ်ကျိၤ တခါသ့လီၤ. နပာ်တိၢ်လီၤဟိတၢ်လိၢ်အံၤသ့စ့ၢ်ကိးလီၤ.

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☐ My initials here indicate additional documents are attached.

ယတၢ်ဆဲးလီၤမံၤဖဲအံၤဟာ်ဖျါလၢ တၢ်ဘျးစဲယုာ်ဒီးလံာ်တီလံာ်မိတဖဉ်လီၤ.

The ACP of *(ကွဲးလီၤမံၤ)*_____(print name)

Birth Date *(ဆတၢ်မၤဆိတၢ်ကွၢ်ထွဲ တၢ်ရဲဉ်တၢ်ကျဲၤ **(ACP)** အိဉ်ဖျဲဉ် အိဉ်ဖျဲဉ် နံၤသ့)*_____ Completion Date *(ဝံၤအမ့ၢ်နံၤ)*_____

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Part 3: My Hopes and Wishes (Optional)

အကျဉ် ၃– ယတၢ်မ့ၢ်လ့ၢ်ဒီးတၢ်လၢယဆၢမ့ၢ်လ့ၢ်တဖဉ် (တၢ်ဃုထၢအဂီၤသ့)

I want my loved ones to know my following thoughts and feelings.

ယအဲၵ်ဒီးလၢပှၤလၢယအဲၵ်အဂီၤတဖဉ် ကသ့ဉ်ညါ ယတၢ်ဆိကမိဉ်ဒီးတၢ်တူၢ်ဘဉ်လၢလာ်တဖဉ်အံၤလီၤ. /

The things that make life most worth living to me are:

တၢ်လၢအနုးကၢကိဉ်ယၤအဒိဉ်ကတၢ်လ၊ ယကအိဉ်မူအိဉ်ဂဲၤအဂီၢ်တဖဉ်နှဉ်မ့ၢ်ဝဲ–

_____

_____

My beliefs about when life would be no longer worth living:

ယတၢ်နာ်ဘဉ်ထွဲ တၢ်ဆၢကတီၢ်ဖဲ တကၢကိဉ်လ၊၊လ၊ ယကအိဉ်မူအိဉ်ဂဲၤအဂီၢ် နှဉ်မ့ၢ်ဝဲ–

_____

_____

My thoughts about specific medical treatments, if any:

ယတၢ်နာ်ဘဉ်ယး တၢ်အိဉ်ဆူဉ်အိဉ်ချ့တၢ်ကွၢ်ထွဲတနီၤ, မ့ၢ်အိဉ်တမံၤမံၤ–

_____

_____

My thoughts and feelings about how I would like to die and where I would like to die:

ယတၢ်ဆိကမိဉ်ဒီး တၢ်တူၢ်ဘဉ် ဘဉ်ယးယအဲၵ်ဒီးသံဒ်လဲဉ်ဒီး ယအဲၵ်ဒီးသံဖဲလဲဉ်–

_____

_____

If I am nearing my death, I want my loved ones to know that I would appreciate the following for comfort and support (rituals, prayers, music, etc.):

ယမ့ၢ်ဘူးကသံနှဉ်, ယအဲၵ်ဒီးလ၊ ပှၤလၢယအဲၵ်အဂီၤတဖဉ် ကသ့ဉ်ညါလ၊ ယကသးခုဖဲနမ့ၢ်မၤတၢ်သ့ဉ် တဖဉ်အံၤဒ်သိး ယသးကမ့ာ်ထိဉ်ဒီး ကဆိဉ်ထွဲမၤစ၊၊ယၤအဂီၢ် (တၢ်လ့ၢ်တၢ်လ့ၢ်အမူး, တၢ်ထုကဖဉ်, တၢ်ဒုတၢ်အူ, အဂၤတဖဉ်.) –

_____

_____

Religious affiliation:

တၢ်ဘူဉ်တၢ်ဘါအတၢ်ဘဉ်ထွဲတဖဉ်–

I am of the *(ယတၢ်စူၢ်တၢ်နာ်မ့ၢ်ဝ)* _____ faith, and am a member of *(ဒီးမ့ၢ်ကရၢဖိလ၊)*

_____ in (city) *တၢ်စူၢ်တၢ်နာ် အပှၤတဝၢဖဲ (ဝ့ၢ်)* _____ faith community အပူၤန့ဉ်လီၤ.

I would like my Health Care Agent to notify my faith community of my death and arrange for them to provide my funeral/memorial/burial.

ယအဲၵ်ဒီးလ၊ ယတၢ်အိဉ်ဆူဉ်အိဉ်ချ့တၢ်ကွၢ်ထွဲခၢဉ်စးကရ၊ ကဘီးဘဉ်သ့ဉ်ညါ ယတၢ်စူၢ်တၢ်နာ် အပှၤတဝ၊ ဘဉ်ယးယတၢ်သံအဂ့ၢ်ဒီး ရဲဉ် ကျဲၤန့ၢ်တၢ်လ၊ အဝဲသ့ဉ်အဂီၢ်လ၊ ကမၤန့ၢ်ယၤ တၢ်ဟ်လီၤပှၤသံ/တၢ်သ့ဉ်နီဉ်/ တၢ်ခူဉ်လီၤဘါလီၤအတၢ်ရဲဉ်တၢ်ကျဲၤန့ဉ်လီၤ.

The ACP of *(ကွဲးလီၤမံၤ)*_____(print name)

Birth Date *(အတၢ်မၤဆိတၢ်ကွၢ်ထွဲ တၢ်ရဲဉ်တၢ်ကျဲၤ **(ACP)** အိဉ်ဖျဲဉ်) အိဉ်ဖျဲဉ် နံၤသါ*_____ Completion Date *(ဝံၤအမ့ၢ်နံၤ)*_____

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I would like my funeral to include, if possible, the following (people, music, rituals, etc.):

မ့ၢ်သ့နူၣ်, လၢတၢ်ခူၣ်လီၤဘါလီၤတၢ်အပူးအပူၤ, ယအဲၣ်ဒီးလၢ တၢ်သ့ၣ်တဖၣ်အံၤကပၣ်ဃုာ် *(ပှၤကညီ, တၢ်ဒ့တၢ်အူ, တၢ်လုၢ်တၢ်လၢ်အမူး, ဒီးအဂၤတဖၣ်)*

_____

_____

Other wishes and instructions:

တၢ်ဆၢမ့ၢ်လၢ်ဒီးတၢ်နဲၣ်ကျဲအဂၤတဖၣ်–

_____

_____

☐ My initials here indicate additional documents are attached:

ယတၢ်ဆဲးလီၤမံၤဖဲအံၤဟ်ဖျါလၢ တၢ်ဘျးစဲယုာ်ဒီးလံာ်တိလံာ်မိတဖၣ်လီၤ–

Part 4: Legal Authority

အကူဉ် ၄– သဲးအပှၤဟ့ၣ်စိဟ့ၣ်ကမီၤ

Do not sign unless the witnesses or notary are present.

မ့တမ့ၢ်လၢအိၣ်ဒီး ပှၤအုၣ်ကီၤသး မ့တမ့ၢ် ကမျၢ်အပိၢ်ရီတဖၣ်အဃိ တဘဉ်ဆဲးလီၤမံၤတဂ့ၤ.

Note: This document must be notarized or witnessed. [See individual state requirements on page 16]. Two witnesses OR a Notary Public must verify your signature and the date.

တိၢ်နီၣ်– *လံာ်တိလံာ်မိအံၤ ကဘဉ်တၢ်အၢဉ်လီၤဟ်ပနီၣ်အီၤလၢ ပိၢ်ရီ မ့တမ့ၢ် ပှၤအုၣ်အသးတဖၣ်လီၤ. \[ကွၢ်ကိၢ်စဲၣ်တဘ့ၣ်စုာ်စုာ် အတၢ်လိၣ်ဘဉ်ဖဲ ကဘျုံးပၤ ၁၆ အပူၤတကွၢ်]. ပှၤအုၣ်သးခံဂၤ မ့တမ့ၢ် ကမျၢ်အပိၢ်ရီ ကဘဉ်အုၣ်သးလၢနတၢ်ဆဲးလီၤမံၤဒီး မ့ၢ်နံၤမ့ၢ်သိအဖိခိၣ်လီၤ.*

I have made this document willingly. I am thinking clearly. This document states my wishes about my future health care decisions:

ယကွဲးဒုးအိၣ်ထိၣ် လံာ်တိလံာ်မိအံၤလၢ ယတၢ်သးအိၣ်အဖိခိၣ်လီၤ. ယဆိကမိၣ်တၢ်သ့ၣ်ရဲၤပျိပျိလီၤ. လံာ်တိလံာ်မိအံၤဟ်ဖျါ ယတၢ်မိၣ်နူၤ်သးလီဘဉ်ယး ယတၢ်အိၣ် ဆူၣ်အိၣ်ချုတၢ်ကွၢ်ထွဲ တၢ်ဆၢတဲာ်ဆူညါတဖၣ်လီၤ–

Signature *(ဆဲးလီၤမံၤ)*_____ *Date (မ့ၢ်နံၤ)*_____

If I cannot sign my name, I ask the following person to sign for me:

ယဆဲးလီၤမံၤ မ့ၢ်တနူၤ်အဃိ, ယမၢပှၤလၢလာ်လၢ ကဆဲးလီၤမံၤလၢယဂီၢ်လီၤ–

Signature (of person asked to sign) *ဆဲးလီၤမံၤ (ပှၤလၢတၢ်မၢအဆဲးလီၤမံၤ)*_____

*Date (မ့ၢ်နံၤ)*_____

Printed Name *ကွဲးလီၤမံၤ*_____

The ACP of *(ကွဲးလီၤမံၤ)*_____(print name)

Birth Date *(ဆတၢ်မၤဆိတၢ်ကွၢ်ထွဲ တၢ်ရဲၣ်တၢ်ကျဲၤ (ACP) အိၣ်ဖျိၣ်) အိၣ်ဖျိၣ် နံၤသ္ဂီ*_____ Completion Date *(ဝံၤအမ့ၢ်နံၤ)*_____

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Option 1: Notary Public

တၢ်ဃုထၢ ၁– ကမျၢ်ပီၢ်ရီ

_____ State of *(ကီၢ်စဲၵ်)* _____ County of *(ခီဆံၵ်ဟိၵ်ကဒိၤ)*

In my presence on *(ပာ်ဖျါထိၵ်သးဖဲယမဲာ်ညါဖဲ)* _____ (date) *(နံၤသီ)*.

_____ (name) *(မံၤ)* acknowledged his or her signature on this document, or acknowledged that he or she authorized the person signing this document to sign on his or her behalf. *(ပာ်ဂၢ်ပာ်ကျၢၤ အတၢ်ဆဲးလီၤမံၤ ဖဲလံာ်တိလံာ်မိအံၤအပူၤ. မ့တမ့ၢ် ပာ်ဂၢ်ပာ်ကျၢၤလၢ အဝဲဟ့ဉ်စိဟ့ဉ်ကမီၤ ပှၤလၢအဆဲးလီၤမံၤလၢ လံာ်တိလံာ်မိအံၤအပူၤ ကဆဲးလီၤမံၤလၢအခၢဉ်စးန္ဉာ်လီၤ.)*

Signature of Notary *(ပီၢ်ရီဆဲးလီၤမံၤ)* _____

Notary Seal *(ပီၢ်ရီတၢ်စဲပနီဉ်)*_____

My commission expires *(ယခိဉ်မံးရှၢဉ် အမ့ၢ်နံၤကတၢ်ဖဲ)*– _____

Or *(မ့တမ့ၢ်)*

Option 2: Statement of Witnesses

တၢ်ဃုထၢ ၂– ပှၤအုဉ်ကီၤသးအတၢ်ပာ်ဖျါ

Witness 1: In my presence on *(**ပှၤအုဉ်သး** ၁– ပာ်ဖျါထိၵ်သးဖဲယမဲာ်ညါဖဲ)* _____ *(date)* *(နံၤသီ)*.

_____ (name) *(နံၤသီ)*, voluntarily signed this document (or authorized the person signing this document to sign on his or her behalf. *ဆဲးလီၤမံၤ ဖဲလံာ်တိလံာ်မိအံၤ အပူၤ လၢ အနိၢ်ကစၢ်အတၢ်သးဆူဉ်အဖိခိဉ် (မ့တမ့ၢ် ဟ့ဉ်စိဟ့ဉ်ကမီၤ ပှၤလၢအဆဲးလီၤမံၤလၢ လံာ်တိလံာ်မိအံၤအပူၤ ကဆဲးလီၤမံၤလၢအခၢဉ်စးန္ဉာ်လီၤ.*

Signature *(ဆဲးလီၤမံၤ)*_____ Date *(မ့ၢ်နံၤ)*_____

Printed Name *(ကွဲးလီၤမံၤ)*_____

***Witness 2:** In my presence on **(ပှၤအုဉ်သး** ၂– ပာ်ဖျါထိၵ်သးဖဲယမဲာ်ညါဖဲ)* _____ *(date)* *(နံၤသီ)*. _____ (name) *(နံၤသီ)*, voluntarily signed this document (or authorized the person signing this document to sign on his or her behalf. *ဆဲးလီၤမံၤ ဖဲလံာ်တိလံာ်မိအံၤ အပူၤ လၢ အနိၢ်ကစၢ်အတၢ်သးဆူဉ်အဖိခိဉ် (မ့တမ့ၢ် ဟ့ဉ်စိဟ့ဉ်ကမီၤ ပှၤလၢအဆဲးလီၤမံၤလၢ လံာ်တိလံာ်မိအံၤအပူၤ ကဆဲးလီၤမံၤလၢအခၢဉ်စးန္ဉာ်လီၤ.*

Signature *(ဆဲးလီၤမံၤ)*_____ Date *(မ့ၢ်နံၤ)*_____

Printed Name *(ကွဲးလီၤမံၤ)*_____

SANFORD HEALTH

Advanced Care Plan / တၢ်ကွၢ်ထွဲတၢ်တိၵ်ကျဲၤလၢတၢ်ကတဲၵ်ကတီၤဆိပၢ်အဂီၤ

Requirements for Witnesses by State

ကျိၤစဲၵ်တဘုၵ်စုၵ်စုၵ်အဖီခိၵ် အတၢ်လိၵ်ဘၵ်လၢ အ လီၤဆီလိၵ်သးလၢ ပှၤအုၵ်သးတဖၣ်အဂီၢ်

Iowa: Notary Public or 2 adult witnesses are required. A witness cannot be: (1) a provider attending the principal on the date this document is signed; (2) an employee of the provider attending the principal on the date this document is signed; (3) the Health Care Agent named in this document; and (4) at least one witness cannot be related to the principal by blood, marriage, or adoption within the third degree of relation.

အဲၵ်အိဝ်ၢ် (Iowa)– *တၢ်ကလိၵ်ဘၵ် ကမျၢ်အပိၢ်ရီ မ့တမ့ၢ် ပှၤနီၣ်ဂ်လၢ အအုၵ်သးသ့ 2 ဂၤလိၤ. ပှၤအုၵ်သးတဂၤ တဘၵ်မ့ၢ်– (၁) ပှၤဟ့ၵ် တၢ်မၤစၢၤတၢ်မၤလၢ အကွၢ်ထွဲပှၤတဂၤအံၤဖဲမ့ၢ်နံၤလၢ တၢ်ဆဲးလိၤလံာ်တိလံာ်မိအံၤ. (၂) ပှၤဟ့ၵ်တၢ်မၤစၢၤတၢ်မၤ အပှၤမၤတၢ်ဖိလၢ အကွၢ်ထွဲပှၤတဂၤအံၤ ဖဲမ့ၢ်နံၤလၢ တၢ်ဆဲးလိၤ လံာ်တိလံာ်မိအံၤ. (၃) တၢ်အိၵ်ဆူၵ်အိၵ်ချ့တၢ်ကွၢ်ထွဲအပှၤခၢဂ်စးလၢ တၢ်ယၢၤထိဉ်အမံၤလၢ လံာ်အံၤအပူၤ. ီး (၄) အစုၤကတၢ်၊ ပှၤအုၵ် အသးအကျါတဂၤ တဘၵ်ဘၵ်ထွဲီး ပှၤတဂၤအံၤလၢ သွံဉ်ထံစၢၤသွဲဉ်, ခီဖျိတၢ်တ့တၢ်ဖျိ, မ့တမ့ၢ် တၢ်လုၢ်ဖိအီၤလၢ တၢ်ဘဉ်ထွဲလိာ်သးသၢပတိၢ်တပတိၢ်အပူၤဘဉ်နူဉ်လီၤ.*

Minnesota: Notary Public or 2 adult witnesses are required. A witness cannot be the Health Care Agent or alternate Health Care Agent. Of the two witnesses, only one can be a health care provider or an employee of a provider giving direct care on the date the document is signed.

မံဉ်နံဉ်စိထဉ် (Minnesota)– *တၢ်ကလိၵ်ဘၵ် ကမျၢ်အပိၢ်ရီ မ့တမ့ၢ် ပှၤနီၣ်ဂ်လၢ အအုၵ်သးသ့ ၂ ဂၤလိၤ. ပှၤအုၵ်သးတဂၤ တဘၵ်မ့ၢ် တၢ်အိၵ်ဆူၵ်အိၵ် ချ့တၢ်ကွၢ်ထွဲအပှၤခၢဂ်စး မ့တမ့ၢ် တၢ်အိၵ်ဆူၵ်အိၵ်ချ့ တၢ်ကွၢ်ထွဲ အပှၤခၢဂ်စးလၢတၢ်ယုထၢအီၤသ့အဂၤတဂၤဘဉ်.လၢပှၤအုၵ်သးခံဂၤအကျါ, ထဲဉ်ပှၤတဂၤ ကဘဉ်မ့ၢ်ပှၤဟ့ၵ်တၢ်အိၵ်ဆူၵ်အိၵ်ချ့ တၢ်ကွၢ်ထွဲ မ့တမ့ၢ် အပှၤမၤတၢ်ဖိလၢအဟ့ၵ်တၢ်ကွၢ်ထွဲလီၤလီၤ ဖဲမ့ၢ်နံၤလၢ တၢ်ဆဲးလိၤလံာ်တိလံာ်မိအံၤ အမ့ၢ်နံၤနူဉ်လီၤ.*

North Dakota: Notary Public or 2 adult witnesses are required. A witness cannot be: (1) the Health Care Agent; (2) the principal's spouse or heir; (3) a person related to the principal by blood, marriage, or adoption; (4) a person entitled to any part of the Estate of the principal upon the death of the principal under a will or deed; (5) any other person who has any claims against the Estate of the principal; (6) a person directly financially responsible for the principal's medical care; or (7) the principal's attending physician. In addition, at least one witness may not be a health care or long term care provider providing direct care to the principal on the date this document is signed or an employee of a health care or long term care provider providing direct care to the principal on the date this document is signed.

"ဒ (North Dakota): *တၢ်ကလိၵ်ဘၵ် ကမျၢ်အပိၢ်ရီ မ့တမ့ၢ် ပှၤနီၣ်ဂ်လၢ အအုၵ်သးသ့ ၂ ဂၤလိၤ. ပှၤအုၵ်သးတဂၤ တဘၵ်မ့ၢ်– ၁) တၢ်အိၵ်ဆူၵ်အိၵ်ချ့တၢ်ကွၢ်ထွဲအပှၤခၢဂ်စး, (၂) ပှၤတဂၤလၢအကွဲးဆိတၢ်ကွၢ်ထွဲ တၢ်ရဲၵ်တၢ်ကျဲၤ အမါဝၤ မ့တမ့ၢ် အဖိ, (၃) ပှၤတဂၤလၢ အဘဉ် ထွဲီးပှၤတဂၤအံၤလၢသွံဉ်ထံတၢ်လိၤစၢၤ. တၢ်တ့တၢ်ဖျိ, မ့တမ့ၢ် တၢ်လုၢ်ဖိ, (၄) ပှၤတဂၤလၢအိၵ်ီး အတၢ်နူၣ်သါလၢ ပှၤတဂၤလၢအကွဲးဆိတၢ်ကွၢ်ထွဲ တၢ်ရဲၵ် တၢ်ကျဲၤ အတၢ်စုလိၢ်ခိၵ်ခိၵ် ဖဲပှၤတဂၤအံၤစူးကွံာ်အသး လၢအအိၵ်လၢ တၢ်ကွဲးဟ့ၵ်တ့ၢ်တၢ်ဟ့ၵ်သါ မ့တမ့ၢ် တၢ်မၤလံာ်တိလံာ်မိတဖၣ်အပူၤ. (၅) ီးပှၤအဂၤတဂၤလၢ်လၢ်လၢ အအိၵ်ီးတၢ်ဆိုးထိဉ်တၢ်သးတမံလၢ ပှၤတဂၤလၢအကွဲးဆိတၢ်ကွၢ်ထွဲ တၢ်ရဲၵ်တၢ်ကျဲၤ အတၢ်စုလိၢ်ခိၵ်ခိၵ်အဖိခိၵ်, (၆) ပှၤတဂၤ လၢ အိၵ်ီးကျိၵ်စုဂ့ၢ်ဝိမူ ါလိၤလိၤလၢ ပှၤတဂၤအံၤအတၢ်အိၵ်ဆူၵ်အိၵ်ချ့တၢ်ကွၢ်ထွဲအပူၤ, မ့တမ့ၢ် (၇) ကသံဉ်သရ့ဉ်လၢ အကွၢ်ထွဲပှၤတဂၤအံၤ. အါနူၣ်အနူဉ်, အစုၤကတၢ်၊ ပှၤအုၵ်သးအကျါတဂၤ တဘၵ်မ့ၢ် ပှၤလၢအဟ့ၵ်တၢ်အိၵ်ဆူၵ်အိၵ်ချ့တၢ်ကွၢ်ထွဲ မ့တမ့ၢ် ပှၤဟ့ၵ်ကတီၢ်ထိတၢ်ကွၢ်ထွဲလၢအဟ့ၵ် တၢ်ကွၢ်ထွဲလီၤလီၤဆူ ပှၤတဂၤလၢအကွဲးဆိတၢ်ကွၢ်ထွဲ တၢ်ရဲၵ်တၢ်ကျဲၤ ဖဲမ့ၢ်နံၤလၢတၢ်ဆဲးလိၤမံၤ မ့တမ့ၢ် ပှၤလၢအဟ့ၵ်တၢ်အိၵ်ဆူၵ်အိၵ်ချ့တၢ်ကွၢ်ထွဲ မ့တမ့ၢ် ပှၤဟ့ၵ် ကတီၢ်ထိတၢ်ကွၢ်ထွဲလၢအဟ့ၵ် တၢ်ကွၢ်ထွဲလီၤလီၤအပှၤမၤတၢ်ဖိ ဖဲမ့ၢ်နံၤလၢတၢ်ဆဲးလိၤမံၤ နူဉ်လီၤ.*

South Dakota: Notary Public or 2 adult witnesses are required.

*ကလံၤထံးီခိထဉ် **(South Dakota)***– *တၢ်ကလိၵ်ဘၵ် ကမျၢ်အပိၢ်ရီ မ့တမ့ၢ် ပှၤနီၣ်ဂ်လၢ အအုၵ်သးသ့ ၂ ဂၤလိၤ.*

The ACP of *(ကွဲးလီၤမံၤ)*_____(print name)

Birth Date *(အတၢ်မၤဆိတၢ်ကွၢ်ထွဲ တၢ်ရဲၵ်တၢ်ကျဲၤ **(ACP)** အိဉ်ဖျဲဉ်) အိဉ်ဖျဲဉ် နံၤသ့ါ*_____ Completion Date *(ဝံၤအမ့ၢ်နံၤ)*_____

SANFORD HEALTH

Advanced Care Plan / *တၢ်ကွၢ်ထွဲတၢ်တိၵ်ကျဲၤလၢတၢ်ကတဲၵ်ကတီၤဆိပာ်အဂီၤ*

After Completing the Advance Care Plan

ဖဲတၢ်မၤပုၤ တၢ်ပာ်လီၤဆိတၢ်ကွၢ်ထွဲအတၢ်ရဲၵ်တၢ်ကျဲၤဝံၤအလိၢ်ခံ

Now that I have completed this document, I will:

ခဲအံၤမ့ၢ်လၢ ယမၤပုၤလံာ်တိလံာ်မိအံၤဝံၤလံအဃိ. ယက–

☐ Keep the original copy of this document where it can be easily found.
ယကပာ်လံာ်တိလံာ်မိအခိဉ်ကျၢ်တဘ့ဉ်အံၤဖဲတၢ်လိၢ်လၢ တၢ်ထံဉ်နှၢ်အီၤသ့ညီကၤဉ်နှဉ်လီၤ.

☐ Make several copies of this document and give to my:
မၤလံာ်တိလံာ်မိအံၤ အလံာ်ကွဲးဒိတဘျူးဘ့ဉ်ဒီး ဟ့ဉ်လီၤအီၤဆူယ–

- Primary and Alternate Health Care Agents
ယတၢ်အိဉ်ဆူဉ်အိဉ်ချ့တၢ်ကွၢ်ထွဲအပှၤခၢဉ်စး အဂံၢ်ခိဉ်ထံးတဂၤဒီးအဂၤတဂၤတဖဉ်အအိဉ်
- Doctor and other health care providers
ကသံဉ်သရဉ်ဒီး ပှၤလၢအဟ့ဉ်ဆူဉ်ချ့တၢ်ကွၢ်ထွဲအဂၤတဖဉ်
- Health care facility (hospital, other) whenever I am admitted, and ask that it be placed in my medical record
တၢ်ကွၢ်ထွဲတၢ်အိဉ်ဆူဉ်အိဉ်ချ့လိၢ် (တၢ်ဆါဟံဉ်. အဂၤ) တၢ်လိၢ်တတီၤတီၤဖဲ ယထိဉ်တၢ်ဆါဟံဉ်. ဒီးမၤအဟ်လၢ ယတၢ်အိဉ်ဆူဉ်အိဉ်ချ့တၢ်ကွဲးနိဉ်အပူၤ

☐ Talk to the rest of my family and close friends who might be involved if I have a serious illness or injury, making sure they know who my Health Care Agent is, and what my wishes are.
တဲသကိးတၢ်ဒီး ယဟံဉ်ဖိယီဖိဒီး တံၤသကိးဘူးတံၢ်လၢအဂၤတဖဉ်လၢ ဘဉ်သ့ဉ်သ့ဉ် အကပဉ်ယုာ်လၢ တၢ်ဆူးတၢ်ဆါ မ့တမ့ၢ် တၢ်ဘဉ်ဒိဘဉ် ထံးလၢအနးအပူၤ. မၤလီၤတံၢ်လၢ အဝဲသ့ဉ် သ့ဉ်ညါလၢ မတၢနှဉ်မ့ၢ် ယပှၤတၢ်အိဉ်ဆူဉ်အိဉ်ချ့အပှၤခၢဉ်စး. ဒီးယတၢ်ဆၢမ့ၢ်လၢ်တဖဉ်မ့ၢ်မနုၤလဲဉ်နှဉ်တက့ၢ်.

The ACP of *(ကွဲးလီၤမံၤ)*_____(print name)
Birth Date *(ဆတၢ်မၤဆိတၢ်ကွၢ်ထွဲ တၢ်ရဲၵ်တၢ်ကျဲၤ (ACP) အိဉ်ဖျဲဉ် အိဉ်ဖျဲဉ် နံၤသ့ါ)*_____ Completion Date *(ဝံၤအမ့ၢ်နံၤ)*_____

SANFORD HEALTH

Advanced Care Plan / တၢ်ကွၢ်ထွဲတၢ်တိၵ်ကျဲၤလၢတၢ်ကတဲၵ်ကတီၤဆိပာ်အဂီၤ

When to Review Your Advance Care Plan

နကဘဉ်ဖးကွၢ်ကဒါက့ၤ နတၢ်ပာ်လီၤဆိတၢ်အိဉ်ဆူဉ်အိဉ်ချ့အတၢ်ရဲဉ်တၢ်ကျဲၤအခါဖဲလဲဉ်

It is common to review and update an advance care plan regularly. You may want to review it with your annual physical exam or whenever any of the "Five D's" occur.

တၢ်ညီနၢ်ကဲထိဉ်အသးလၢ တၢ်ကဖးကွၢ်ကဒါက့ၤဒီး ဘိဘဉ်က့ၤတၢ်ပာ်လီၤဆိတၢ်အိဉ်ဆူဉ်အိဉ်ချ့ တၢ်ရဲဉ်တၢ်ကျဲၤထိဘိလီၤ. ဘဉ်သ့ဉ် သ့ဉ် နကဏဲဉ်ဒီးကွၢ်ကဒါက့ၤအီၤဖဲနမၤတနံဉ်တဘျိ တၢ်သမံသမိးကွၢ်နီၢ်ခိ မ့တမ့ၢ် ဖဲ *"Five D's"* (ဒ်ၤယ်ၢဖျၢဉ်) အိဉ်ထိဉ်တဘျိလ်လ်အခါနူဉ်လီၤ.

- **Decade:** when you start each new decade of your life.
  ဆဲဖိုဉ်နံဉ် (Decade): *ဖဲနတၢ်အိဉ်မူအဆဲဖိုဉ်နံဉ် စးထိဉ်တဘျိစုဉ်စုဉ်အခါ.*
- **Death:** whenever you experience the death of a loved one.
  တၢ်သံတၢ်ပှၢ် (Death): *ဖဲနလဲၤခိဖျိဘဉ် ပှၤလၢနဏဲဉ်အီၤတဂၤစူးကွံဉ်အသးအခါ.*
- **Divorce:** when you experience a divorce or other major family change.
  တၢ်မၤလံာ်လီၤဖှဉ် (Divorce): *ဖဲနလဲၤခိဖျိဘဉ် တၢ်လီၤမူၢ်လီၤဖးမၤလံာ်လီၤဖှဉ် မ့တမ့ၢ် ဟံဉ်ဖိယိဖိ အတၢ်ဆိတလဲအခါ.*
- **Diagnosis:** when you are diagnosed with a serious health condition.
  တၢ်ဃုထံဉ်သ့ဉ်ညါ တၢ်ဆူးတၢ်ဆါ (Diagnosis): *ဖဲတၢ်ဃုထံဉ်သ့ဉ်ညါလၢ နအိဉ်ဒီး တၢ်ဆူးတၢ်ဆါ လၢ အနးတမံၤမံၤအခါ.*
- **Decline:** when you experience a significant decline or deterioration of an existing health condition, especially when you are unable to live on your own.
  တၢ်ဆံးလီၤစုၤလီၤ (Decline): *ဖဲနလဲၤခိဖျိဘဉ် နတၢ်ဆံးလီၤစုၤလီၤလၢ ဆူးတၢ်ဆါလၢ အအိဉ်ဟ်စၢၤ မ့တမ့ၢ် တၢ်ဆါနးထိဉ်, လီၤဆိဒဉ် တၢ် ဖဲနအိဉ်ဒဉ်လၢ နကစၢ်တသ့အခါ.*

Copies of This Document Have Been Given To:

တၢ်ဟ့ဉ်လီၤလံာ်တီလံာ်မိအကွဲးဒိတဖဉ်အံၤဆူ–

Primary (main) Health Care Agent

ဂံၢ်ခိဉ်ထံး တၢ်အိဉ်ဆူဉ်အိဉ်ချ့တၢ်ကွၢ်ထွဲအပှၤခၢဉ်စး (ဂံၢ်ခိဉ်သ့ဉ်)

Name *(မံၤ)*: _____ Telephone *(လိတဲစိ)*:_____

Alternate Health Care Agent *(တၢ်အိဉ်ဆူဉ်အိဉ်ချ့တၢ်ကွၢ်ထွဲအပှၤခၢဉ်စးအဂၤ)*

Name *(မံၤ)*: _____ Telephone *(လိတဲစိ)*:_____

Health care Provider/Clinic/Hospital/Family Members

ပှၤဟ့ဉ်တၢ်အိဉ်ဆူဉ်အိဉ်ချ့တၢ်ကွၢ်ထွဲ/ကသံဉ်ဇၢး /တၢ်ဆါဟံဉ်/ဟံဉ်ဖိယိဖိတဖဉ်

Name *(မံၤ)*: _____ Telephone *(လိတဲစိ)*:_____

Name *(မံၤ)*: _____ Telephone *(လိတဲစိ)*:_____

Name *(မံၤ)*: _____ Telephone *(လိတဲစိ)*:_____

Name *(မံၤ)*: _____ Telephone *(လိတဲစိ)*:_____

Name *(မံၤ)*: _____ Telephone *(လိတဲစိ)*:_____

The ACP of *(ကွဲးလီၤမံၤ)*_____(print name)
Birth Date *(ဆတၢ်မၤဆိတၢ်ကွၢ်ထွဲ တၢ်ရဲဉ်တၢ်ကျဲၤ (ACP) အိဉ်ဖျိဉ်) အိဉ်ဖျဲဉ် နံၤသျိ*_____ Completion Date *(ဝံၤအမ့ၢ်နံၤ)*_____

SANFORD HEALTH

Advanced Care Plan / *တၢ်ကွၢ်ထွဲတၢ်တိၵ်ကျဲၤလၢတၢ်ကတဲၵ်ကတီၤဆိပာ်အဒီၤ*

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နတၢ်မိၵ်နှၤ်သးလီမ့ၢ်ဆိတလဲအဃိ. မၤပဲၤလံာ်ကွီဉ်ိအသိတဘ့ဉ်တက့ၢ်. ဟ့ဉ်လံာ်တီလံာ်မီအသိတဘ့ဉ်အကွဲးိဆူ ပှၤကိးဂၤလၢအအိဉ်ိး လံာ်တီလံာ်မီလၢညါတဘ့ဉ် အကွဲးိနှၤ်တက့ၢ်.တဲဘဉ်အဝဲသ့ဉ်လၢ ကမၤဟးဂီၤ အကတတြူၢ်လၢညါတဘ့ဉ်တက့ၢ်.

The ACP of *(ကွဲးလီၤမံၤ)*_____(print name)

Birth Date *(အတၢ်မၤဆိတၢ်ကွၢ်ထွဲ တၢ်ရဲဉ်တၢ်ကျဲၤ (ACP) အိဉ်ဖျိဉ်) အိဉ်ဖျိဉ် နံၤသ့ါ*_____ Completion Date *(ဝံၤအမ့ၢ်နံၤ)*_____