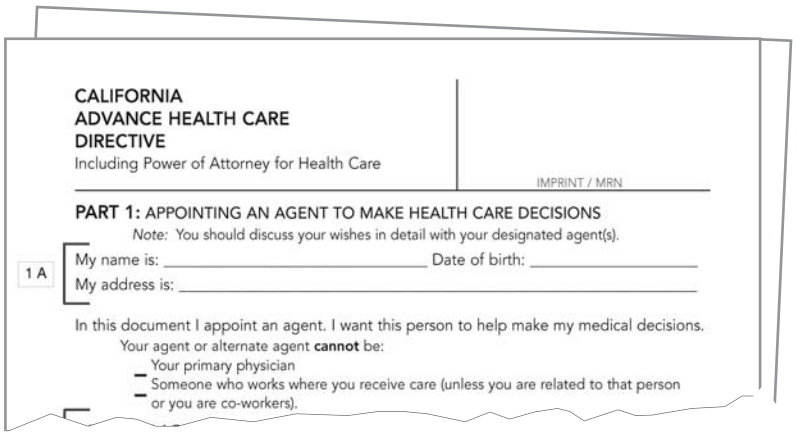
INSTRUCTIONS FOR COMPLETING THE "CALIFORNIA ADVANCE HEALTH CARE DIRECTIVE" LEGAL FORM



CALIFORNIA
ADVANCE HEALTH CARE
DIRECTIVE
Including Power of Attorney for Health Care

IMPRINT / MRN

PART 1: APPOINTING AN AGENT TO MAKE HEALTH CARE DECISIONS

Note: You should discuss your wishes in detail with your designated agent(s).

1 A My name is: _____ Date of birth: _____
My address is: _____

In this document I appoint an agent. I want this person to help make my medical decisions.
Your agent or alternate agent **cannot** be:
- Your primary physician
- Someone who works where you receive care (unless you are related to that person or you are co-workers).

An Advance Health Care Directive has 3 parts:

Part 1: Choose a health care agent.

A health care agent is a person who can make medical decisions for you if you are too sick to make them yourself.

Part 2: Make your own health care choices.

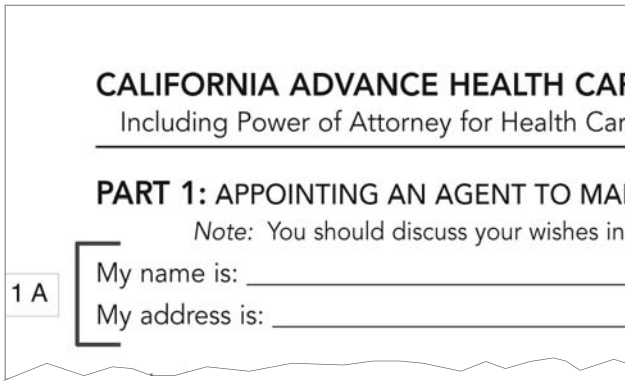
You can have a say about how you want to be treated.

This way, those who care for you will not have to guess what you want if you are too sick to tell them yourself.

Part 3: **Sign the form**.

It must be signed before it can be used.

You can do Part 1, Part 2, or both — whichever you want. But be sure to sign the form in Part 3.



CALIFORNIA ADVANCE HEALTH CA
Including Power of Attorney for Health Car

PART 1: APPOINTING AN AGENT TO MA

Note: You should discuss your wishes in

1 A My name is: _____
My address is: _____

Go to PART 1, page 1:

1 A Print your first name, last name, date of birth, address, city, state, and ZIP code so it is clear who is making this directive.

Choosing your health care agent

Whom should I choose to be my health care agent?

A family member or friend who:

- is at least 18 years old
- knows you well
- can be there for you when you need them
- you trust to do what is best for you
- can tell your doctors about the decisions you made on this form

Your agent cannot be your doctor or someone who works at your hospital or clinic where you get health care, unless they are a family member or your co-worker.

What will happen if I do not choose a health care agent?

- If you are too sick to make your own decisions, your doctors will probably ask your closest loves ones to make decisions for you.
- If there is someone you DON'T want to make your decisions, you can say so in this form.

What kind of decisions can my health care agent make?

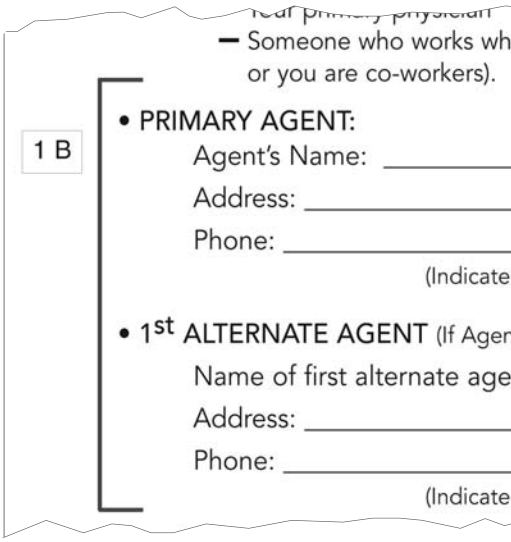
Your agent can agree to, say "no" to, change, stop or choose:

- doctors, nurses, social workers
- hospitals or clinics
- medical treatment, medications, or tests
- what happens to your body and organs after you die

1 B

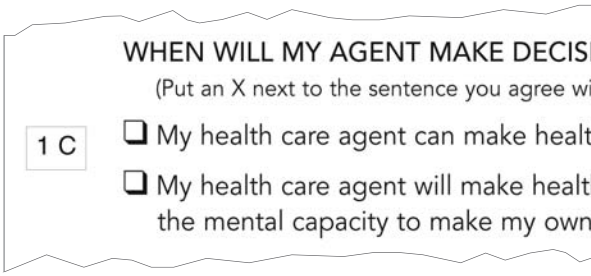
Write in the name of your agent. Your agent is the person who you want to make medical decisions for you if you are too sick to make them yourself.

In case the first person cannot do it, write in who should help make your medical decisions.



Your health care agent can start helping with your medical decisions right away; or you can ask that they get involved only if you cannot make your own decisions.

1 C If you want your agent to start *right away* **or**, *only when you cannot make your own decisions,* place an "X" in the appropriate box and sign your initials in the space.

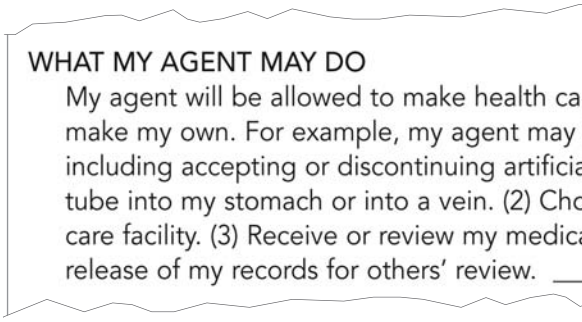

WHEN WILL MY AGENT MAKE DECISI
(Put an X next to the sentence you agree wi
1 C
❑ My health care agent can make healt
❑ My health care agent will make healt
the mental capacity to make my own

Choices about health care treatments

Your agent can make choices about all kinds of medical treatments, such as blood transfusions, surgery and medicines. Your agent can even decide about life support treatments (treatments that try to make you live longer when some part of your body has stopped working).

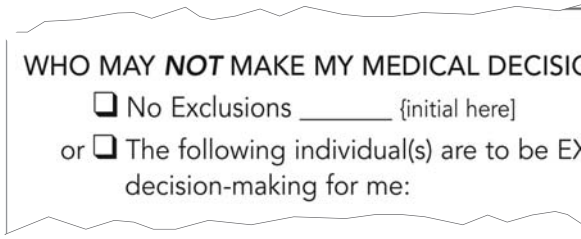
1 D Sign your initials to indicate that you understand that your agent will be able to make all these kinds of decisions.

*If you do **not** want your agent to be able to make these decisions, this is probably not the right advance health care directive form for you.*


WHAT MY AGENT MAY DO
My agent will be allowed to make health ca
make my own. For example, my agent may
including accepting or discontinuing artificia
tube into my stomach or into a vein. (2) Cho
care facility. (3) Receive or review my medica
release of my records for others' review. ___

What if someone else tries to make the decisions?

Is there someone who might argue with your agent and you don't want that person to interfere with your agent's decisions? If there is no such person, check the 1 E "No Exclusions" box and sign your initials.


WHO MAY *NOT* MAKE MY MEDICAL DECISIO
❑ No Exclusions _____ {initial here}
or ❑ The following individual(s) are to be EX
decision-making for me:

If there is such a person, you can **exclude** that person from making health care decisions for you by writing their name in the space and signing your initials.

Examples of Life Support Treatments:

CPR or cardiopulmonary resuscitation when your heart stops

cardio = heart pulmonary = lungs resuscitation = try to restart

This involves all of these actions:

- pressing hard on your chest (this usually breaks ribs) to try pump the blood
- electrical shocks to try to restore heart beat
- a tube into your windpipe attached to a bag to pump air into your lungs
- medicines in your veins

Breathing machine or ventilator when the lungs aren't working well enough on their own

The machine pumps air into your lungs through a tube in your windpipe.

You are not able to talk when you are on the machine.

Dialysis when your kidneys stop working

A dialysis machine cleans your blood. Your blood has to go into the machine and then back onto your body through tubes placed into your neck, arm or groin.

It takes a few hours at a time, three or four days a week.

Feeding tube when you can't swallow

The tube is placed down your throat into your stomach, or it can also be surgically inserted through your abdomen into your stomach.

Each medical treatment might have benefits, but each might have unexpected or unintended results. None of them is certain to make you live longer. Each of these treatments can create new problems, including the need to be restrained. Some of these treatments might be done for a long time, or might be tried for a short time and then stopped.

Talk to your doctor about whether any of these treatments might be needed for your medical illness, and how they might affect your life.

Do you have opinions about wanting or not wanting some of these treatments? You may write them down and/or talk about them with the person who will be your agent.

End of life care

If you might die soon, your health care agent can:

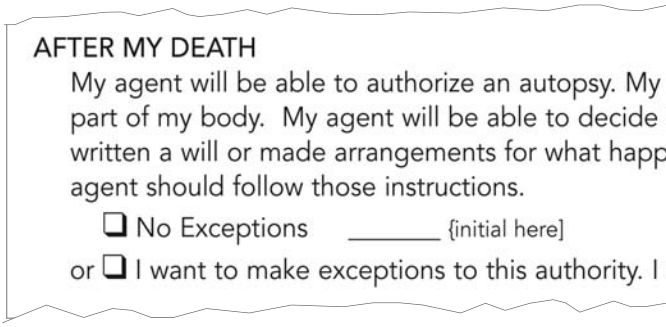
- decide if you are allowed to die a natural death or if you go on life support
- decide if you die at home or in the hospital
- decide if you get treatment aimed at making you as comfortable as possible, or treatments to make you live as long as possible
- decide if you get a visit by a minister, chaplain, priest, rabbi, or other spiritual counselor.

After your death

Your health care agent can:

- decide if any of your organs will be donated. Donated organs can save lives.
- request, consent to, or refuse an autopsy. An autopsy can be done after death to find out why someone died. It is done by surgery. It can take a few days.
- decide what happens to your body, such as burial or cremation.

1 F If you want to leave these decisions to your agent after your death, check the box "No Exceptions" and sign your initials.

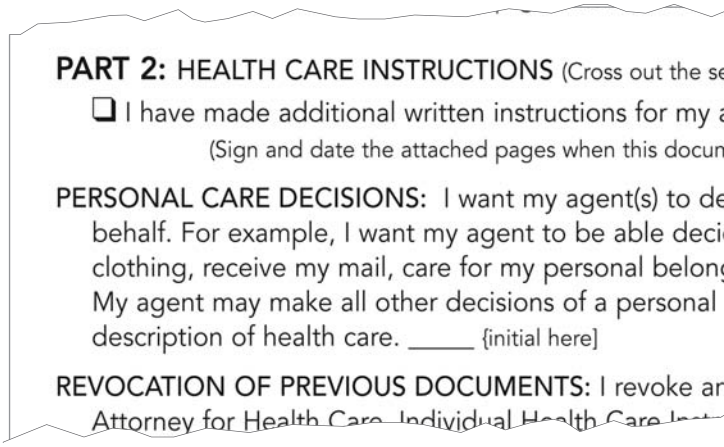

AFTER MY DEATH
My agent will be able to authorize an autopsy. My
part of my body. My agent will be able to decide
written a will or made arrangements for what happ
agent should follow those instructions.
❑ No Exceptions _____ {initial here}
or ❑ I want to make exceptions to this authority. I

If you do not want your agent to make these decisions, you may put in writing your own decisions about what should happen to your body after death.

Part 2: Health care instructions

2 A You may write extra pages in your own words, or use the enclosed "My Health Care Choices" communication form to guide your agent in making difficult decisions.

2 B Some personal care decisions are not automatically given to your health care agent. If you want your health care agent to be able to make personal care decisions, initial this paragraph.



PART 2: HEALTH CARE INSTRUCTIONS (Cross out the se

❑ I have made additional written instructions for my a

(Sign and date the attached pages when this docun

PERSONAL CARE DECISIONS: I want my agent(s) to de behalf. For example, I want my agent to be able deci clothing, receive my mail, care for my personal belon My agent may make all other decisions of a personal description of health care. _____ {initial here]

REVOCATION OF PREVIOUS DOCUMENTS: I revoke ar Attorney for Health Care, Individual Health Care Inst

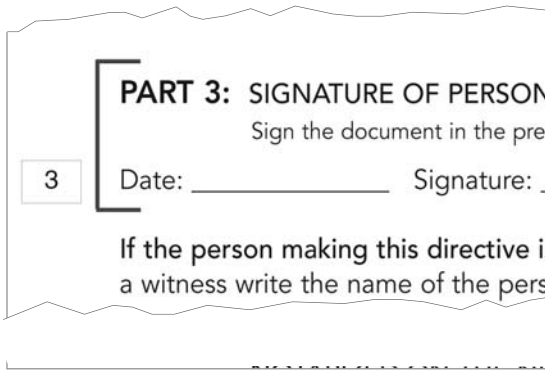
Part 3: Signing the form

Before this form can be used, you must:

- sign this form.
- have two witnesses sign the form.

If you do not have witnesses, you need a notary public. A notary public's job is to make sure it is you who is signing the form.

3 Sign your name and write the date on page 3.



PART 3: SIGNATURE OF PERSON

Sign the document in the pre

3 Date: _____ Signature: _

If the person making this directive i a witness write the name of the pers

Witnesses

Your witnesses must:

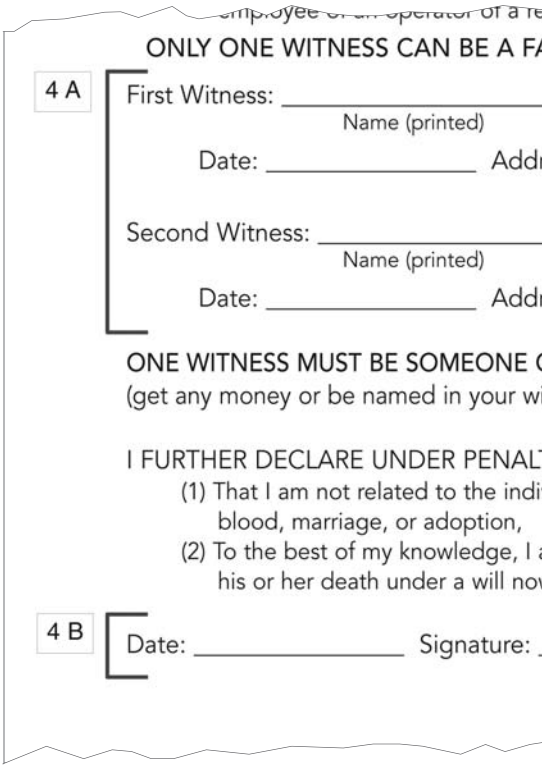
- be over 18 years of age.
- know who you are.
- believe that you are the one who signed the form.

Your witnesses cannot:

- be your health care agent, doctor, nurse, or social worker.
- work at the place that you live.

4 A

If you have witnesses, have them sign on page 3.


ONLY ONE WITNESS CAN BE A FA

4 A

First Witness: _____
Name (printed)

Date: _____ Addr

Second Witness: _____
Name (printed)

Date: _____ Addr

ONE WITNESS MUST BE SOMEONE
(get any money or be named in your wi

I FURTHER DECLARE UNDER PENAL
(1) That I am not related to the indi
blood, marriage, or adoption,
(2) To the best of my knowledge, I
his or her death under a will no

4 B

Date: _____ Signature:

Only one witness can be a family member.

4 B

The second witness must be someone other than family and must not benefit financially (get any money or be named in your will) after you die.

Notary as Witness

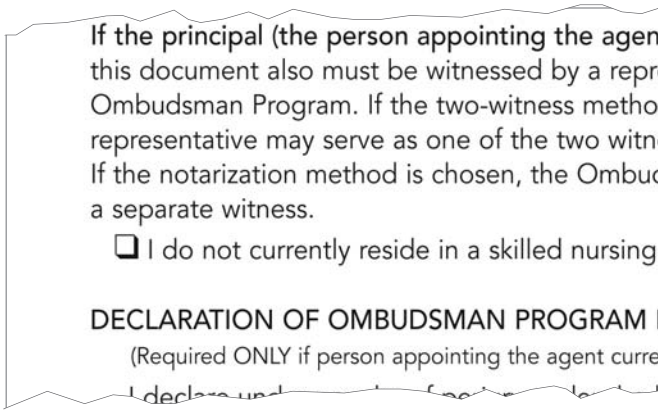
Take this form to a notary public **only** if two witnesses have not signed this form.

Bring photo I.D. (driver's license, passport, etc.)

Go to page 4 of the form.

If you do not live in a nursing home,

4 C check the box next to "I do not currently reside in a skilled nursing facility" and sign your initials.


If the principal (the person appointing the agen
this document also must be witnessed by a repr
Ombudsman Program. If the two-witness metho
representative may serve as one of the two witn
If the notarization method is chosen, the Ombu
a separate witness.

❑ I do not currently reside in a skilled nursing

DECLARATION OF OMBUDSMAN PROGRAM

(Required ONLY if person appointing the agent curre

If you do live in a nursing home:

- Give this form to your nursing home director or social worker if you live in a nursing home. You will need an additional witness.
- California law requires nursing home residents to have the nursing home ombudsman as a witness of advance directives.
- In addition to the ombudsman, you will need either a notary or one other witness who will meet the qualifications listed above.

What do I do with the form after I fill it out?

Keep the original for yourself. Make copies of the form to share with those who care for you. Keep a list of who has copies.

- family
- friends
- doctors
- nurses
- social workers

Remember to talk to all of these people about your choices.

What if I change my mind?

- Complete a new form.
- Collect all the old forms from your agent(s) and loved ones.
- Give out copies of the new form to all the same people.

What if I have questions about the form?

Take it to your family, friends or to your doctor, nurse, or social worker to answer your questions.

What if I want to make health care choices that are not on this form?

- Write your choices on a piece of paper or on the enclosed "My Health Care Choices" communication form.
- Sign the paper or supplement the same day you sign the form.
- Keep the paper with this form and copies of the paper with copies of your form.
- Talk about your choices with those who care about you.

Talk with your agent about what your medical treatment should accomplish.

You may want to consider the following questions when discussing your health care choices with your agent:

- When would you want them to keep on trying?
- When is it time to allow a natural death?

The **"Roles and Responsibilities of the Health Care Agent"**—the last 3 pages of this booklet—are designed to help you and your agent understand their potential duties in carrying out your health care wishes. Please share that document with your agent.

CALIFORNIA ADVANCE HEALTH CARE DIRECTIVE

Including Power of Attorney for Health Care

IMPRINT / MRN

PART 1: APPOINTING AN AGENT TO MAKE HEALTH CARE DECISIONS

Note: You should discuss your wishes in detail with your designated agent(s).

1 A

My name is: _____ Date of birth: _____

My address is: _____

In this document I appoint an agent. I want this person to help make my medical decisions.

Your agent or alternate agent **cannot** be:

- Your primary physician
- Someone who works where you receive care (unless you are related to that person or you are co-workers).

1 B

• PRIMARY AGENT:

Agent's Name: _____

Address: _____

Phone: _____

(Indicate home, work, pager, and cellular phone.)

• 1st ALTERNATE AGENT (If agent is not willing, able, or reasonably available to serve.)

Name of first alternate agent: _____

Address: _____

Phone: _____

(Indicate home, work, pager, and cellular phone)

• 2nd ALTERNATE AGENT (If agent and 1st alternate are unavailable or unwilling to serve.)

Name of second alternate agent: _____

Address: _____

Phone: _____

(Indicate home, work, pager, and cellular phone)

WHEN WILL MY AGENT MAKE DECISIONS?:

(Put an X next to the sentence you agree with.)

1 C

❑ My health care agent can make health care decisions for me while I still have mental capacity to make decisions. _____ {initial here]

❑ My health care agent will make health care decisions for me ONLY when I do not have the mental capacity to make my own health care decisions. _____ {initial here]

WHAT MY AGENT MAY DO

My agent will be allowed to make health care decisions for me just as I can presently make my own. For example, my agent may (1) accept or refuse treatment for me, including accepting or discontinuing artificial nutrition and fluid that is given through a tube into my stomach or into a vein. (2) Choose for me a particular physician or health care facility. (3) Receive or review my medical information and records, or permit release of my records for others' review. _____ {initial here} 1 D

WHO MAY ***NOT*** MAKE MY MEDICAL DECISIONS

1 E

❑ No Exclusions _____ {initial here}

or ❑ The following individual(s) are to be EXCLUDED from any part of health care decision-making for me:

_____ _____ {initial here}

AFTER MY DEATH

My agent will be able to authorize an autopsy. My agent will be able to donate all or part of my body. My agent will be able to decide what to do with my body. If I have written a will or made arrangements for what happens to my body after my death, my agent should follow those instructions.

❑ No Exceptions _____ {initial here} 1 F

or ❑ I want to make exceptions to this authority. I write them here:

_____

_____ {initial here}

or ❑ I want to make exceptions to this authority. See the attachment to this form.

(Sign and date the attached pages when this document is witnessed.)

PART 2: HEALTH CARE INSTRUCTIONS (Cross out the sections that do not apply)

❑ I have made additional written instructions for my agent and attached them. 2 A

(Sign and date the attached pages when this document is witnessed.)

PERSONAL CARE DECISIONS: I want my agent(s) to decide about personal care on my behalf. For example, I want my agent to be able to decide where I will live, choose my clothing, receive my mail, care for my personal belongings and care for my pet(s) if any. My agent may make all other decisions of a personal nature not included in the description of health care. _____ {initial here} 2 B

REVOCATION OF PREVIOUS DOCUMENTS: I revoke any previously-executed Power of Attorney for Health Care, Individual Health Care Instruction, or Natural Death Act Declaration. I have the right to revoke this directive later by creating a new one. _____ {initial here}

PART 3: SIGNATURE OF PERSON WHO IS MAKING THIS DIRECTIVE

Sign the document in the presence of the witnesses or the Notary.

3 Date: _____ Signature: _____

If the person making this directive is unable to write, have the person make a mark. Have a witness write the name of the person making this directive and sign the next page.

PART 4: THIS DOCUMENT MUST EITHER BE SIGNED BY TWO WITNESSES OR NOTARIZED ON THE NEXT PAGE.

WITNESSES: Certain individuals cannot serve as witnesses. Those rules are set forth in the following witness statements:

I DECLARE UNDER PENALTY OF PERJURY UNDER THE LAWS OF CALIFORNIA

(1) That the individual who signed or acknowledged this Advance Health Care Directive is personally known to me, or that the individual's identity was proven to me by convincing evidence,

(2) That the individual signed or acknowledged this Advance Directive in my presence,

(3) That the individual appears to be of sound mind and under no duress, fraud, or undue influence,

(4) That I am not a person appointed as agent by this Advance Directive, and

(5) That I am not the individual's health care provider, an employee of the individual's health care provider, the operator of a community care facility, an employee of an operator of a community care facility, the operator of a residential care facility for the elderly, nor an employee of an operator of a residential care facility for the elderly.

ONLY ONE WITNESS CAN BE A FAMILY MEMBER.

4 A First Witness: _____ _____
Name (printed) Signature

Date: _____ Address: _____

Second Witness: _____ _____
Name (printed) Signature

Date: _____ Address: _____

ONE WITNESS MUST BE SOMEONE OTHER THAN FAMILY and must not benefit financially (get any money or be named in your will) after you die. Have that person sign again below:

I FURTHER DECLARE UNDER PENALTY OF PERJURY UNDER THE LAWS OF CALIFORNIA

(1) That I am not related to the individual executing this Advance Health Care Directive by blood, marriage, or adoption,

(2) To the best of my knowledge, I am not entitled to any part of the individual's estate upon his or her death under a will now existing or by operation of law.

4 B Date: _____ Signature: _____

ONLY if the person making this directive is unable to write, witnesses complete this section:

_____, being unable to write, made his/her mark in our presence and requested the first of the undersigned to write his/her name, which he/she did, and we now subscribe our names as witnesses thereto.

_____ _____

Signature of Witness #1 Signature of Witness #2

CERTIFICATE OF ACKNOWLEDGEMENT OF NOTARY PUBLIC

(Not required if two-witness method is followed)

State of California, County of _____

On this ____ day of _____, _____, before me, the undersigned, a Notary Public in and for said State, personally appeared _____, personally known to me or proved to me on the basis of satisfactory evidence to be the person whose name is subscribed to the within instrument, and acknowledged to me that he/she executed it.

WITNESS my hand and official seal.

Signature _____

(seal)

If the principal (the person appointing the agent) currently resides in a nursing facility, this document also must be witnessed by a representative of California's Long-Term Care Ombudsman Program. If the two-witness method is chosen, the Ombudsman Program representative may serve as one of the two witnesses, or may serve as a third witness. If the notarization method is chosen, the Ombudsman Program representative serves as a separate witness.

❑ I do not currently reside in a skilled nursing facility. _____ {initial here]

4 C

DECLARATION OF OMBUDSMAN PROGRAM REPRESENTATIVE

(Required ONLY if person appointing the agent currently resides in a nursing facility.)

I declare under penalty of perjury under the laws of California that I am an ombudsman designated by the California Department of Aging and that I am serving as a witness as required by Section 4675 of the California Probate Code.

_____ _____ _____

Name (printed) Signature Date