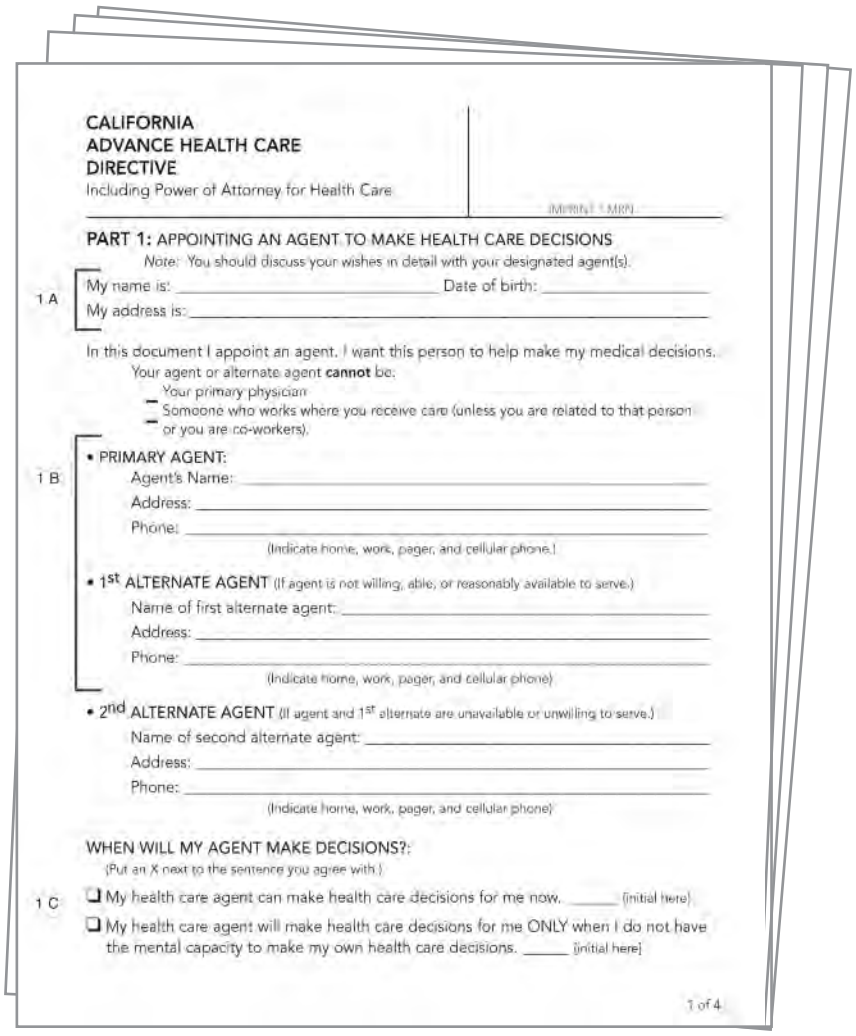
# COMMUNICATE **YOUR HEALTH CARE** WISHES.

## California Advance Health Care Directive Kit

KAISER PERMANENTE®

# CALIFORNIA ADVANCE HEALTH CARE DIRECTIVE



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

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 now. _____ (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)

1 of 4

## Your Packet Includes:

# INTRODUCTION

## What is an Advance Health Care Directive (AHCD)?

If you are able, it is up to you to make all of your health care decisions. However, if you are unable or unwilling to make decisions, the law allows you to choose someone else to make health care decisions on your behalf.

An Advance Health Care Directive or AHCD is a legal document. It allows you to tell others what kind of health care you want to receive when you are too sick and unable to make decisions about your care.

The AHCD form also lets you identify the person(s) you choose who will work with your doctors and others to help ensure that your wishes about your health care are carried out. This person is called the **health care agent**.

You can also write down your wishes about organ donation and identify your personal care physician.

Unlike the earlier Durable Power of Attorney for Health Care (DPAHC), the Advance Health Care Directive does not expire. It will stay in effect until you revoke or change it. (Please note: If you have a signed DPAHC that was valid **before** July 1, 2000, it remains valid.)

Anyone age 18 years or older who is able to make his or her own health care decisions can establish an Advance Health Care Directive.

## Why is it so important to have a signed Advance Health Care Directive?

Completing an AHCD can help your loved ones and your doctors understand your wishes concerning your health care. It will help lessen confusion and disagreement over your personal wishes and choices concerning your care at a time when you are too sick to make those choices yourself. So it's important to talk about your wishes with your doctor, family, and close friends ***now,* before you are too sick to talk or write** about issues such as your quality of life, your choices about treatment, and how you would want to spend your final days.

## If this is a legal document, will I need to see a lawyer to complete it?

No, you do not need a lawyer to complete an AHCD.

## Why do I need to choose an agent?

If a situation arises in which you are no longer able to make health care decisions for yourself, family and other loved ones may become involved in making those decisions. Even when you write down and share your wishes with others close to you, occasionally people will disagree about what may be the best care for you. This is why you need to select one person to help ensure your wishes about your care are honored and to make any additional heath care decisions for you. It is best to choose a close relative or personal friend whom you trust, who understands your values, and who will agree to honor your wishes. You can also name another person(s) to act on your behalf in case the first person you select is no longer available or is unable to make health care decisions for you. These people are called the **alternate agent(s)**. You can also indicate if there is a specific person(s) you do **not** want to be involved in making decisions for you.

If you are concerned and want to spare loved ones from the burden of decision-making, you may want to consider choosing a ***close friend*** who understands your wishes and who can act as your agent.

Try to select an agent who is most likely to be comfortable carrying out your wishes about your care.  Make your wishes known to him or her, as well as to everyone else who is likely to be close to you in such circumstances. This is especially important if you think people may not agree or there could be conflict about your care.

## What if I don't choose a health care agent?

If you became unable to make your own decisions, your doctors will ask your closest family members to act on your behalf. If family members cannot agree and decisions cannot be reached in a timely fashion, emotional stress and conflicts among family members can result. Also, if there is no one willing or available to make health care decisions on your behalf, a court appointed representative who doesn't necessarily know your values and wishes may have to make critical care decisions for you.

## What types of decisions can my health care agent make?

Your agent becomes your representative. He or she participates in medical decisions by representing your interests. This includes decisions like:

- Changing your doctor, nurse, or social worker.
- Where you receive medical care (at home, or in a hospital).
- Your medications, tests, and medical treatment.
- What happens to your body and organs after you die.

**Becoming your agent *does not* mean that he/she assumes financial responsibility for you.**

Your health care agent acts for you and makes all health care decisions on your behalf, **unless** you limit his or her authority.

## Who cannot be my health care agent?

*Your health care agent cannot be:*

- The doctor who is managing your care.
- An operator or employee of a community care facility or a residential care facility where you are receiving care.
- An employee of the health care institution where you are receiving care, unless that person is related to you by blood, marriage, or adoption.

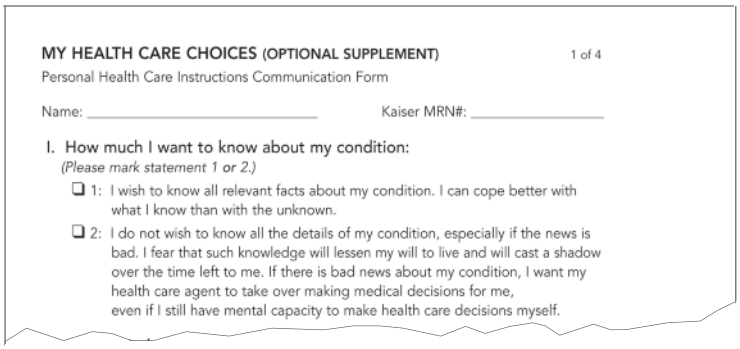
## When does my health care agent make decisions for me?

Your health care agent will usually make decisions only if you are unable to make them yourself, such as if you have lost the ability to understand things.

You can appoint your health care agent to act on your behalf at any time, even when you are still capable of making your own decisions, but you no longer want to make decisions about your care.

If you do not have an Advance Directive and suddenly become ill, you can appoint a temporary health care agent to let the doctor know who you want to make decisions for you. Your oral instruction is just as valid as a written one.

## What if I want to provide specific health care instructions that are not on the AHCD form?



**MY HEALTH CARE CHOICES** (OPTIONAL SUPPLEMENT) 1 of 4

Personal Health Care Instructions Communication Form

Name: _____ Kaiser MRN#: _____

I. How much I want to know about my condition:

*(Please mark statement 1 or 2.)*

❑ 1: I wish to know all relevant facts about my condition. I can cope better with what I know than with the unknown.

❑ 2: I do not wish to know all the details of my condition, especially if the news is bad. I fear that such knowledge will lessen my will to live and will cast a shadow over the time left to me. If there is bad news about my condition, I want my health care agent to take over making medical decisions for me, even if I still have mental capacity to make health care decisions myself.

You can write more detailed health care instructions on additional sheets of paper, or you can use the communication form, ***"My Health Care Choices,"*** which was designed to help you clarify your wishes for your doctor and loved ones. (See pages 11–14.)

Attach your instruction sheet(s) to the Advance Health Care Directive and write the number of pages you are attaching.

Sign and date the attachments and have them witnessed or notarized at the same time you have your form witnessed or notarized.

Provide your health care agent(s) and doctor(s) with a copy of your specific health care instruction sheet(s) to ensure they understand your wishes.



## Who needs to sign this form?

You must sign the 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 you are the person who is signing the form.

Your witnesses must be over the age of 18, they must know you, and must either be present when you sign the form or, believe you are the person who signed the form.

***Your witnesses cannot be:***

- Your health care provider or an employee of your health care provider.
- Your agent or alternate agent(s).
- An operator or employee of an operator of a community care or residential care facility.

At least one of the witnesses cannot be related to you by blood, marriage or adoption, be named in your will, or be someone who would benefit from your estate.

## What should I do after I have my AHCD signed and witnessed?

- Make several copies of the form. Keep the original in a place where you can find it easily, and tell others where you put the forms. **Do not** keep your AHCD in a safe deposit box because other people may need to find it quickly in an emergency.
- Return the original signed and witnessed form to your doctor at your next visit. Your doctor will include it in your medical records.
- Give photocopies to your agent and alternate agent (s). Be sure that everyone who might be involved with your health care, such as your family, clergy, or friends has a copy. Photocopies are just as valid as the original.
- Make a list of all the people and facilities who receive copies of your AHCD.
- Keep a copy for yourself in a visible, easy-to-find location and **not** locked up in a drawer.
- Take a copy of the form with you if you are going to be admitted to a hospital, nursing home, or other health care facility.

## What if I change my mind after completing my AHCD?

You can change or cancel your AHCD at any time. Remember to **get back all the old forms** and replace them with your new AHCD forms.

## Where can I find more information about Advance Health Care Directives?

- Contact your local Kaiser Permanente Health Education Center or Department.
- Connect to our Web site at **kp.org** and enter "writing an advance directive" in the search box.
- You can also visit your doctor's home page at **kp.org/mydoctor** if you are a Kaiser Foundation Health Plan member in Northern California. Go to the "Health Information and Resources" section on the left navigation bar, then click "advance care planning."

# DECIDE WHAT IS IMPORTANT TO YOU

The following information can help you decide on the type of care that is right for you in case you become seriously ill or come to the end of your life. Use the attached ***Personal Health Care Instructions Communication Form*** to share your wishes with your health care agent, other loved ones, and your health care providers.

**Your Quality of Life, Values, and Decisions** – An important step in helping your agent understand your wishes is to communicate what gives value to your life. There are many things to consider. Be sure to tell your agent your beliefs about serious illnesses and death. If you were found to have a serious illness, to what extent do you want to be treated? Do you want to be on life support?

**Treatment choices** – It is important to think about different situations where you would need treatment. Think about what types of treatment you would want for sudden illness, for example, a heart attack, or for an illness that could end your life, such as cancer.

For each illness, think about what type of treatment you would want. Be sure to communicate this to your agent.

Examples of Life Support Treatments:

**CPR or cardiopulmonary resuscitation** – when your heart stops

cardio = heart  pulmonary = lungs  resuscitation = try to restart

This kind of treatment involves all of these actions:

- Pressing hard on your chest to try to pump the blood, sometimes so forcefully that it breaks ribs.
- Using electrical shocks to try to restore heart beat.
- Placing a tube into your windpipe attached to a bag to pump air into your lungs.
- Injecting medicines into 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 hooked up to the machine.

**Dialysis** – when your kidneys stop working

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

The Personal Health Care Instructions Communication form on the following page is an optional supplement designed to help you clarify your wishes. It contains some of the kinds of questions you will have to answer in your Advance Directive. By filling in the answers on the attached form now, it will help you fill out the Advance Directive that begins on page 21. You can also have this optional supplement witnessed along with your Advance Directive in order to help guide your health care agent(s).

## MY HEALTH CARE CHOICES (OPTIONAL SUPPLEMENT)



Personal Health Care Instructions Communication Form

Name: _____ Kaiser MRN#: _____

### I. How much I want to know about my condition:

*(Please mark statement 1 **or** 2.)*

- ❑ 1: I wish to know all relevant facts about my condition. I can cope better with what I know than with the unknown.
- ❑ 2: I do not wish to know all the details of my condition, especially if the news is bad. I fear that such knowledge will lessen my will to live and will cast a shadow over the time left to me. If there is bad news about my condition, I want my health care agent to take over making medical decisions for me, even if I still have mental capacity to make health care decisions myself.

### II. How strictly I want my agent to follow my instructions:

- ❑ A. ___ I am writing how I want health care decisions made. **I want my agent to strictly follow this document.** If other decisions come up that I have not made here, I want my agent to rely on other information he or she has about my wishes and my values.
- ❑ B. ___ I am trying to guide my agent in how I want health care decisions made, but I realize that I cannot think of everything that might happen. **I want my agent to have ultimate authority to make decisions concerning my health care for me if I cannot do so for myself.** I trust my agent to draw on all sources of knowledge about my wishes and values.

Additional comments to guide your agent in making decisions on your behalf (add additional sheets if you need them):

### III. If I am dying, it is important for me to be:

- ❑ at home.
- ❑ in the hospital.

Additional Instructions:

Initials: _____

## IV. Near the end of life, when would you want your doctors to allow your death to take its natural course? For example, which of these sentences do you most agree with: 1 or 2?

❑ 1: My life is only worth living if I can:
*(Check all that apply; add more if you want.)*

- ❑ talk to family or friends
- ❑ communicate in some way with my loved ones
- ❑ recover enough to feed, bathe, or take care of myself
- ❑ be free from pain
- ❑ live without being hooked up to machines
- ❑ not be a burden to my family or others
- ❑ make decisions for myself
- ❑ be faithful to my beliefs
- ❑ I am not sure

❑ 2: My life is always worth living no matter how sick I am, even if I am unable to communicate at all and even if I won't get better.

## V. If I have a serious chronic illness or I am so sick that I may die soon:

*(Choose the option you agree with most.)*

❑ Any treatments can be tried to see if they will help. Even if treatments **do not work** and there is little hope of getting better, **I want to stay** on life support machines until I die.

❑ Any treatments can be tried to see if they will help. If the treatments **do not work** and there is little hope of getting better, **I do not want to stay** on life support machines.

Initials: _____

V. cont'd. Check all that apply:

❑ I have already decided that I do **not** want to have the following treatments, even if it means that I might die by not having them:

- ❑ I want **no** attempts at CPR.
- ❑ I want **no** breathing machine.
- ❑ I want **no** dialysis.
- ❑ I want **no** blood transfusion.
- ❑ I want **no** artificial feeding and hydration.
- ❑ I want **no** medicines of any kind.
- ❑ _____
- ❑ **I do not want *any* life support** treatments at all, even if it means that I might die by not having them.
- ❑ **I do not want to stay life support** machines longer than_____ and would want to _____.
  (fill in time span)

## VI. Religion or spirituality is

❑ important to me

❑ unimportant to me

What my doctors should know about my religion or spirituality:

## VII. After my death

❑ I **want** to donate my organs. *Which organs do you want to donate?*

- ❑ any organs
- ❑ only the following organs _____

❑ I **do not** want to donate my organs.

❑ I want my **health care agent** to decide.

## VIII. What my agent and doctors should know about how I want my body to be treated after I die:

❑ I **do not** want an autopsy.

❑ I **want** an autopsy if there are questions about my death.

❑ I want my **health care agent** to decide about authorizing an autopsy.

❑ My preferences about funeral/burial/cremation are_____

_____

_____.

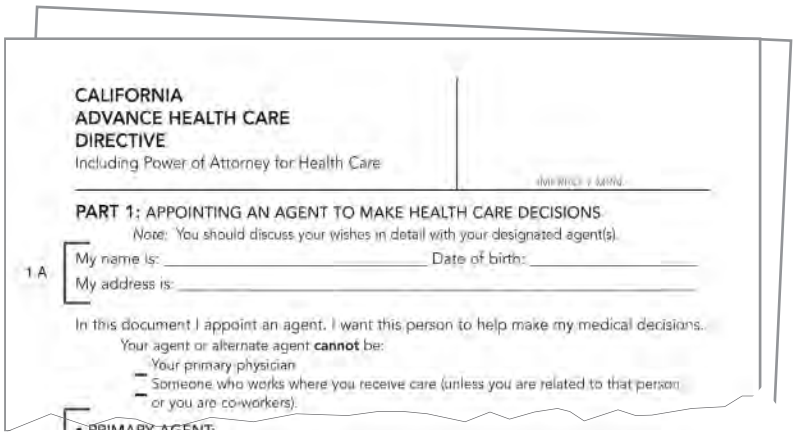
❑ I want my **health care agent** to decide about burial or cremation.

Additional instructions:

Signature: _____ Date: _____

If you are completing this form at the same time as your Advance Health Care Directive, please remember to attach it to the AHCD so your signature can also be witnessed or verified by a notary public.

# STEP BY STEP INSTRUCTIONS FOR COMPLETING THE CALIFORNIA ADVANCE HEALTH CARE DIRECTIVE



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

**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).

**Start:** Take out the Advance Directive forms, pages 21–24.

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 unable to tell them yourself.

Part 3: **Sign the form**.

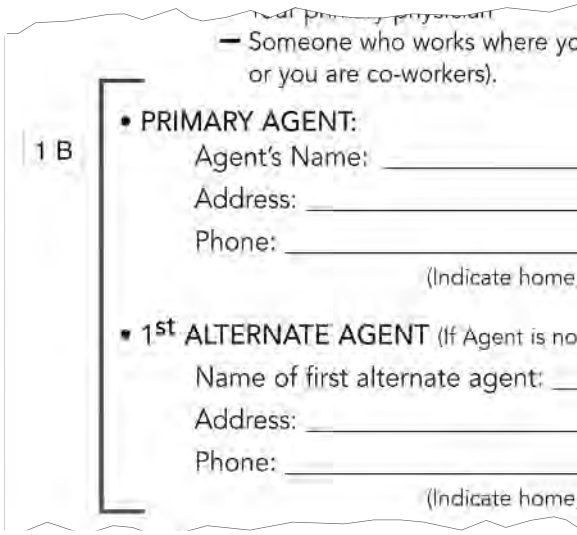
It must be signed before it can be used.

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

## Go to **PART 1**, page 1:


CALIFORNIA ADVANCE HEALTH CA
Including Power of Attorney for Health Ca
PART 1: APPOINTING AN AGENT TO MA
*Note:* You should discuss your wishes i
1 A
My name is: _____
My address is: _____

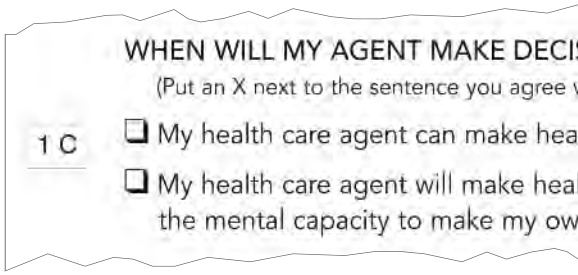
**1 A** Print your first name, last name, date of birth, address, city, state, and ZIP code so it is clear who is making this directive.


— Someone who works where yo
or you are co-workers).
1 B
• PRIMARY AGENT:
Agent's Name: _____
Address: _____
Phone: _____
(Indicate home
• 1st ALTERNATE AGENT (If Agent is no
Name of first alternate agent: _____
Address: _____
Phone: _____
(Indicate home

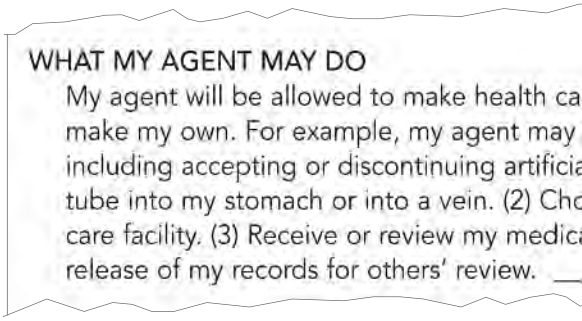
**1 B** Write in the name of your agent. Your agent is the person who you want to make medical decisions for you if you are too sick to make them yourself.

In case the first person cannot do act as your health care agent, write in the name of a second person that you authorize to make medical decisions on your behalf.

See pages 5 – 7 for information about health care agents.


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

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


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 medic
release of my records for others' review. ___

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

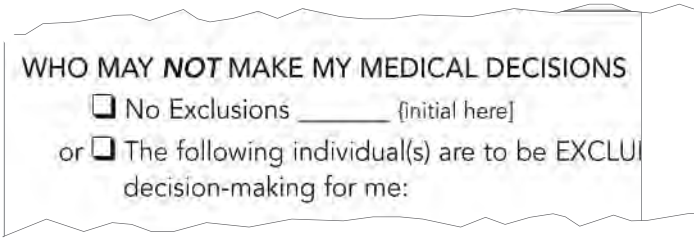
*If you do **not** want your agent to be able to make these decisions, this is probably not the right advance health care directive form for you.*

### What if someone else tries to make the care decisions?

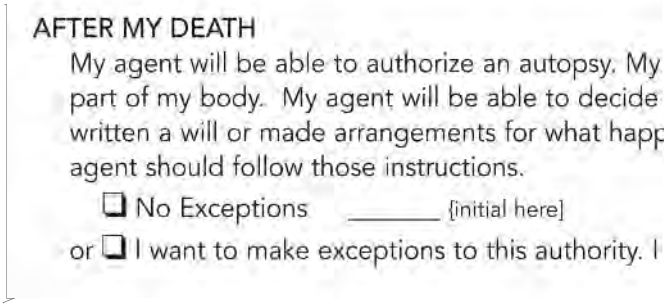
Is there someone who might argue with your agent and interfere with your agent's decisions?

1 E If there is such a person, you can **exclude** (stop) that person from making health care decisions for you by writing his or her name in the space and signing your initials.

If there is no such person, check the "No Exclusions" box and sign your initials.


WHO MAY *NOT* MAKE MY MEDICAL DECISIONS
❑ No Exclusions _____ [initial here]
or ❑ The following individual(s) are to be EXCLU
decision-making for me:

## After your death


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.

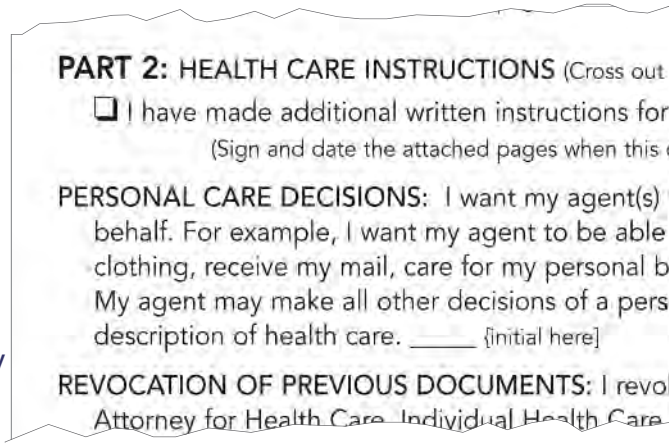
1 F If you want to leave these decisions to your agent after your death, check the box "No Exceptions" and sign your initials.

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. See the tear-out pages prior to these step-by-step instructions.

2 B Some 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

❑ I have made additional written instructions for

(Sign and date the attached pages when this

PERSONAL CARE DECISIONS: I want my agent(s)

behalf. For example, I want my agent to be able

clothing, receive my mail, care for my personal b

My agent may make all other decisions of a pers

description of health care. _____ [initial here]

REVOCATION OF PREVIOUS DOCUMENTS: I revo

Attorney for Health Care, Individual Health Care

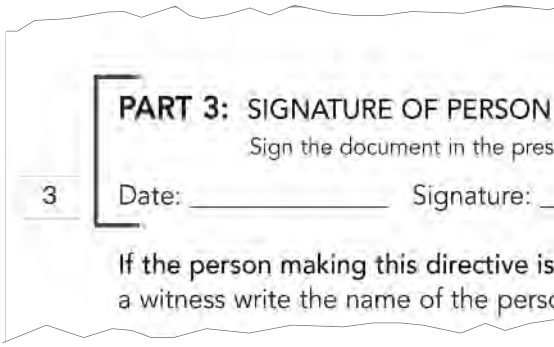
## **Part 3:** Signing the form

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 pres

3 Date: _____ Signature: _

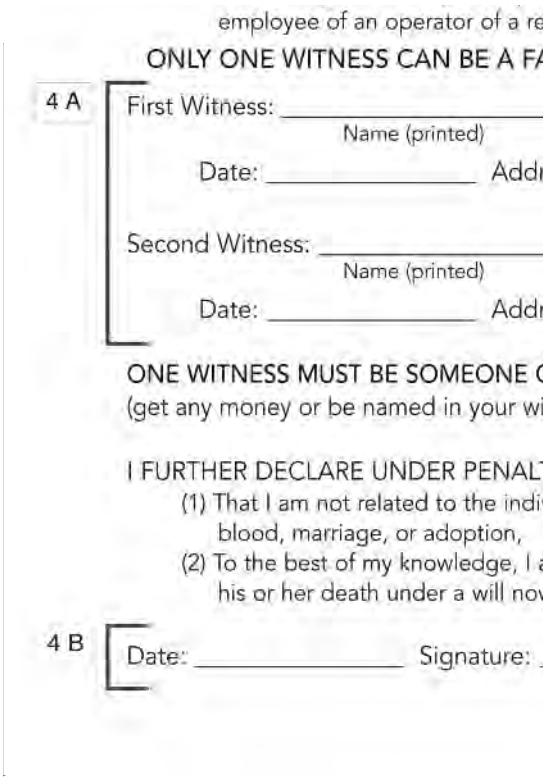
If the person making this directive is

a witness write the name of the perso

# Witnesses

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

See page 8 for details on witnesses.


employee of an operator of a re
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:

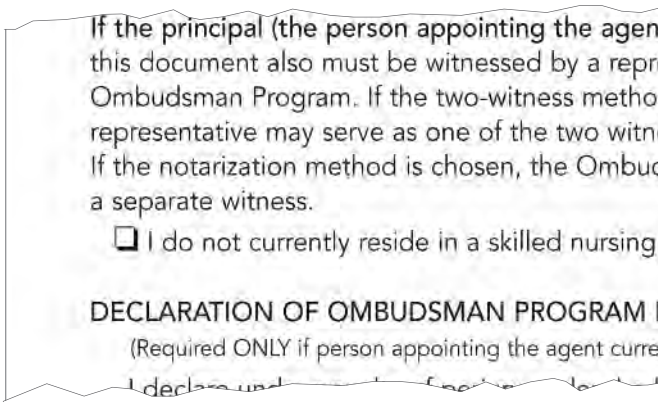
## Notary as Witness

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.)

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.


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

## 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 you do live in a nursing home:

- Give this form to your nursing home director or social worker. You will need an additional witness.
- California law requires nursing home residents to have the nursing home ombudsman be a witness of their 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 after I have my AHCD signed and witnessed?

- Make several copies of the form. Keep the original in a place where you can find it easily, and tell others where you put the forms. **Do not** keep your AHCD in a safe deposit box because other people may need to find it quickly in an emergency.
- Return the original signed and witnessed form to your doctor at your next visit. Your doctor will include it in your medical records.
- Give photocopies to your agent and alternate agent(s). Be sure that everyone who might be involved with your health care, such as your family, clergy, or friends has a copy. Photocopies are just as valid as the original.
- Make a list of all the people and facilities who receive copies of your AHCD.
- Keep a copy for yourself in a visible, easy-to-find location and **not** locked up in a drawer.
- Take a copy of the form with you if you are going to be admitted to a hospital, nursing home, or other health care facility.

## What if I change my mind?

You can change or cancel your AHCD at any time. Remember to **get back all the old forms** and replace them with your new AHCD forms.

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

The "Roles and Responsibilities of the Health Care Agent," the information on the last 3 pages of this booklet, are designed to help your agent understand his or her role in carrying out your health care wishes. Please share that information 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]

Name: _____ MRN#:_____

## 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}

Name: _____ MRN#:_____

## 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: _____

Name: _____ MRN#:_____

**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

## CALIFORNIA ALL-PURPOSE ACKNOWLEDGEMENT OF NOTARY PUBLIC

(Not required if two-witness method is followed)

State of California, County of _____

On _____ before me, _____

Date Name and Title of Officer

Personally appeared _____

Names(s) of Signer(s)

who provided to me on the basis of satisfactory evidence to be the person(s) whose name(s) is/are subscribed to the within instrument and acknowledged to me that he/she/they executed the same in his/her/their authorized capacity(ies), and that by his/her/their authorized signature(s) on the instrument the person(s) acted, executed the instrument. I certify under PENALTY OF PERJURY under the laws of the State of California that the foregoing paragraph is true and correct.

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

# Roles and responsibilities of the health care agent

*Please share this information with all those that you may be considering to serve as your health care agent so that they understand their roles and responsibilities.*

Being a health care agent may be one of the most important roles anyone can carry out. It is a way to fulfill a request made by a loved one or close friend to be sure that his or her wishes about receiving care are carried out when he or she can no longer make decisions about his or her care for him or herself.

## How do I become a health care agent?

Health care agents are typically chosen when a person completes an **Advance Health Care Directive**. The Advance Health Care Directive (AHCD) is a legal document. It allows people to write down in advance the type of care they would or would not want, as well as identify someone 18 years or older who is close to them who has agreed to carry out their wishes at a time when they can no longer able to make decisions about their care for themselves. This person is called the "**health care agent**." The terms "surrogate" or "proxy" are sometimes used in the place of "agent" but they mean the same thing.

The person completing the Advance Health Care Directive knows the health care agent well and trusts the agent to carry out that person's wishes and advocate on his or her behalf. The agent, therefore, should have a good understanding of their loved one's values and treatment preferences beforehand so they are prepared to carry out the role of agent when that time comes. Becoming an agent does **not** mean that you assume financial responsibility for your loved one.

## As the health care agent, when would I start making health care decisions for my loved one?

Sometimes the agent may be asked to make health care decisions for a loved one even when that person is still capable of making his or her own health care decisions. Most often, however, it is when your loved one ***is no longer able*** to make his or her own health care decisions. Your role as the health care agent will be ***activated*** (begin) when care providers decide your loved one is too ill to participate in discussions about treatment options. When this happens, the care providers will begin to rely on you to help decide about the continued course of treatment for your loved one. However, when or if your loved one regains the ability to make decisions, your role as the agent may no longer be needed (or ***deactivated***), and the health care team will again work with your loved one to make these decisions.

## How would I make care decisions for my loved one?

Your role as the health care agent will be to make decisions on behalf of your loved one. You will be able to talk with your loved one's care providers about various treatment choices. Your decisions will be based on what you know about your loved one's wishes or how you feel your loved one would make certain choices. This is a very important responsibility. The decisions you make will depend on the following:

- Your loved one's written statements about treatment options in their Advance Directive, as well as conversations he or she had held with health care providers that are documented (written down) in his or her medical records.
- Conversations your loved one has had with you or others about the types of health care treatment he or she may or may not want, his or her values, and spiritual preferences.
- Working with the health care team to make decisions about issues that may not be clearly covered by your loved one's Advance Directive, or by documented conversations with health care providers, or by prior conversations with you and other family members or close friends.

## What types of decisions will I be asked to make?

Your loved one's health care providers will help you understand what is involved in any proposed treatment or procedure. They will talk with you about the risks, benefits, and other options. Your task as agent will be to make choices based on what your loved one would probably choose if he or she were well enough to participate, *even if it is not what you would choose for yourself*. These decisions may include:

- Use of a breathing machine or ventilator. A ventilator pumps air into the lungs and breathes for someone when they can no longer breathe normally.
- Surgical operations or procedures.
- Starting, changing, or stopping certain medications.
- Use of artificial nutrition and hydration (food and water) when your loved one can no longer swallow food.
- Whether to give blood transfusions.
- Use of CPR (Cardio-Pulmonary Resuscitation) to restart the heart.
- Use of a dialysis machine that cleans the blood when the kidneys are no longer working.
- Choosing or changing health care providers, or arranging transfers to other health care facilities such as another hospital or nursing home.
- Contacting your loved one's minister, clergy or other spiritual advisor for spiritual support.
- Deciding where your loved one spends his or her final days (at home, in the hospital, or elsewhere).
- Donating organs or tissues, authorizing an autopsy, or making decisions about what will be done with the body upon death.

## Making the tough health care decisions – end of life care

There may come a time when your loved one's condition worsens and it is clear he or she will not get better. When that time comes, you may be asked to make decisions about starting or stopping life-support treatments. These are the toughest decisions you may have to make. It can be emotionally difficult knowing that the decisions that are required might result in your loved one's death.

More than ever you will need to draw upon your loved one's stated or expressed wishes, his or her outlook on life, values, and spirituality to decide how he or she would want to spend the final days of his or her life.

## We are here to help you.

When the time comes, you will not have to face these decisions alone. Our doctors, nurses, social workers, bioethics committees, and other staff are here to help answer your questions and discuss treatment options. We can help to provide the emotional support you may need to carry out your loved one's wishes.

# Keeping Track of My Advance Health Care Directive

Date of my Advance Health Care Directive (AHCD): _____.

Where I have put extra, easy-to-find copies of my AHCD:

_____

All the people and facilities to whom I have given copies of my AHCD:

name: _____
address: _____
_____
phone: _____
(home, work, cell, and pager)

name: _____
address: _____
_____
phone: _____
(home, work, cell, and pager)

name: _____
address: _____
_____
phone: _____
(home, work, cell, and pager)

name: _____
address: _____
_____
phone: _____
(home, work, cell, and pager)

name: _____
address: _____
_____
phone: _____
(home, work, cell, and pager)

name: _____
address: _____
_____
phone: _____
(home, work, cell, and pager)

name: _____
address: _____
_____
phone: _____
(home, work, cell, and pager)

name: _____
address: _____
_____
phone: _____
(home, work, cell, and pager)

Cut out and place in your wallet with your medical card.

**Important notice to medical personnel:**
I have a California Advance Health Care Directive.

_____
Signature

In an emergency, please consult my health care agent(s):

_____
primary agent name

_____
address city / state / zip

_____
phone (cell, home)

**see other side**

Fold

_____
alternate agent name

_____
address city / state / zip

_____
phone (cell, home)

My Advance Health Care Directive is located at:

_____
_____
_____


This information is not intended to diagnose health problems or to take the place of medical advice or care you receive from your physician or other health care professional. If you have persistent health problems, or if you have additional questions, please consult with your doctor.


98168 (Revised 4-09)