Advance Health Care Directive Witnessing/Intake Form

Resident's Name:		Reference Number:
LTC Ombudsman's Name:		LTC Ombudsman Certification #:
Intake Date:	Action Date:	Witness Date:
Facility Name:		Intake Staff:
Facility No:	Physician's Name (Optional):	
Time Spent (Min):	Travel Time (Min):	

Preliminary Information

1. Individual requesting LTC Ombudsman to witness AHCD, if other than resident:

Name:	Relationship:	
Address:		Phone:
City:	State:	Zip Code:

2. Primary Agent's Name

Name:	Relationship:	
Address:		Phone:
City:	State:	Zip Code:

Meeting with the Resident

In witnessing an AHCD, a LTC Ombudsman must interview the resident. If there are any questions regarding the resident's ability to understand what he or she is signing, the LTC Ombudsman should obtain the resident's or legal representative's consent to briefly examine the resident's medical record to see if there is a notation regarding the resident's capacity. If consent to review the medical record is refused, and you have doubts about the resident's capacity to execute the AHCD, do not proceed with witnessing of the AHCD.

Chart Reviewed/Date: _____ By: _____
State Certified Ombudsman

I, _____am authorizing the ombudsman to review my medical chart for the purpose of gaining any clarification as to the ability to witness my Advanced Health Care Directive, or to review my POLST. Date: _____

Questions to Ask the Resident (Witnessing/Intake Interview)

1. What is your name? (Verify on wristband and one other means of identification.)
2. Have you read, or has someone read to you, this AHCD or the AHCD within this document?
3. Do you have any concerns about this document?
4. Are you naming _____ (name of primary agent) to make your health care decisions for you. Are you certain that this is the person you want to name to make your health care decisions for you? ☐ Yes ☐ No
5. Has any employee of this facility, a family member, or any other person tried to influence you against your own choice to name _____ as your primary agent to make health care decisions for you? ☐ Yes ☐ No (if you receive a "yes" response, do not witness the AHCD.)
6. Have you discussed the Advance Health Care Directive with the person you are naming as your primary agent to

make health care decisions for you? ☐ Yes ☐ No (If the resident has not yet discussed with the person they are naming as their agent, suggest that they do this as soon as it is possible.)
7. Do you have a Physician Order for Life Sustaining Treatment or POLST? ☐ Yes ☐ No ☐ I don't know (If "yes" or "I don't know," ask whether the resident would like to review his or her medical chart with you.)

Ombudsman Witness Statement

1. I believe this resident is capable of signing the AHCD voluntarily, and with knowledge and understanding of what he/she is doing/signing. (Check the appropriate box below.)

☐ Yes
☐ Yes, but resident is unable to sign due to physical limitations. (Explain below.)
☐ No (Explain below.)

2. If the AHCD was not witnessed, please list below all of the dates and times of interview attempts and the reason(s) witnessing was not done.

DATE:	TIME:	REASON

3. This resident has signed the AHCD document or acknowledged the signature on the document as his/her in my presence. ☐Yes ☐ No
4. I signed the AHCD document and indicated that I was serving as a LTC Ombudsman witness. ☐ Yes ☐ No
5. Name of second witness _____ and their relationship to this resident:

6. Does the resident have a POLST? ☐ Yes ☐ No
7. Is the POLST in agreement with the provisions of the AHCD? ☐ Yes ☐ No (Explain below)

Complete if an AHCD Contains Other Powers of Attorney

8. I signed the *Long-Term Care Ombudsman Witness Addendum to an Advance Health Care Directive* (OSLTCO S102) and indicated that I was serving as an Ombudsman witness and that I only witnessed the portion of this document that relates to the AHCD. ☐ Yes ☐ No
9. This resident has initialed the AHCD addendum in my presence. ☐ Yes ☐No

_____ _____
LTC Ombudsman Signature Date

_____
Printed Name of LTC Ombudsman Witnessing AHCD

LONG-TERM CARE OMBUDSMAN WITNESS ADDENDUM TO AN ADVANCE HEALTH CARE DIRECTIVE

The following statement is required if an attorney for a resident of a skilled nursing facility has prepared a non-standard Advance Health Care Directive (AHCD) containing financial powers or other powers of attorney. As described in Probate Code Section 4701(6.1), the patient advocate or Long-Term Care (LTC) Ombudsman must sign the following statement:

STATEMENT OF PATIENT ADVOCATE OR LONG-TERM CARE OMBUDSMAN

I declare under penalty of perjury under the laws of California that I am a patient advocate or LTC Ombudsman as designated by the State Department of Aging and that I am serving as a witness as required by Section 4675 of the Probate Code.

I am only witnessing the portion of this document which relates to the Advance Health Care Directive.

_____
Date

_____
LTC Ombudsman Name

Solano LTC Ombudsman
400 Contra Costa Street
Address

_____
LTC Ombudsman Signature

Vallejo, CA 94590
City State Zip Code

_____
Resident's Initials