ADVANCE DIRECTIVE for Health Care

per California Probate Code Sections 4670-4678

You have the right to give instructions about your own health care. You also have the right to name someone else to make health care decisions for you. This form lets you do either or both of these things. If you use this form, you may complete or modify all or any part of it. You are free to add pages to this form (such as a letter in your own words) or to use a different form. **Your right to make your own decisions and give verbal directives is not affected by your use of this form.** This form has 3 sections:

PART 1 – Durable POWER OF ATTORNEY for Health Care

You can name another individual as agent to make health care decisions for you if you become incapable of making your own decisions, or if you want someone else to make those decisions for you now even though you are still capable. You may also name an alternate agent to act for you if your first choice is not willing, able, or reasonably available to make decisions for you. (Note: Your agent must be 18 years or older, and may not be an operator or employee of a community care facility or a residential care facility where you are receiving care, or your supervising health care provider or employee of the health care institution where you are receiving care, unless your agent is related to you or is a coworker.)

Unless the form you sign limits the authority of your agent, your agent may make all health care decisions for you. You can if you wish limit the authority of your agent. Unless you limit the authority of your agent, your agent will have the power to:

1. Consent or refuse consent to any care, treatment, or procedure to maintain, diagnose, or otherwise affect a physical or mental condition. Direct the provision, withholding, or withdrawal of all forms of health care, including diagnostic tests, surgical procedures, programs of medication and, and including cardiopulmonary resuscitation artificial nutrition and hydration.
2. Select or discharge / change health care providers and institutions.
3. Make anatomical gifts, authorize an autopsy, and direct disposition of remains.

PART 2 - INSTRUCTIONS FOR YOUR HEALTH CARE [OPTIONAL]

You can give specific instructions about any aspect of your health care, whether or not you appoint an agent. Choices are provided for you to express your wishes regarding the provision, withholding, or withdrawal of treatment to keep you alive, as well as the provision of pain relief. You can cross out or add to the text of these choices or write out any additional wishes. If you are satisfied to allow your agent to determine what is best for you in making end-of-life decisions, you need not fill out Part 2 of this form. In any case you should talk to the person(s) you have named as agent or alternate(s) to make sure that he or she understands your wishes and is willing to take this responsibility. It is also good to talk with your physician(s) both to clarify your preferences in light of any specific medical situations relevant to you, and also to ensure he/she understands your wishes and is willing in good conscience to follow your directives and preferences.

PART 3 – YOUR SIGNATURE, AND WITNESSES' SIGNATURES

After completing this form, sign and date it. Either ask two witnesses OR a Notary Public to witness your signature. If you are a patient in a nursing home you must also ask an Ombudsman to sign.

A copy of this form has the same effect as the original. **Give copies of the signed and completed form** 1) to the health care agent(s) you name in the form, and to your family, 2) to your physician(s) and other health care providers you may have, and 3) to any health care institution in which you receive care.

You have the right to revoke this Advance Health Care Directive, or replace this form, at any time.

PART 1 – Durable POWER OF ATTORNEY for Health Care

(1.1) ***DESIGNATION OF AGENT:*** **I,** *[print your name:]* _____**, designate as my Agent to make health care decisions for me:**

Name of individual you choose as your **Primary Agent**: _____

Address: _____

Telephone(s) [Home/Work/Cell]: _____

OPTIONAL: If I revoke my agent's authority or if my agent is not reasonably available, able, or willing to make a health care decision for me, I designate as **my first and second alternate agents**:

Name of individual you choose as **First Alternate Agent**: _____

Address: _____

Telephone(s) [Home/Work/Cell]: _____

Name of individual you choose as **Second Alternate Agent**: _____

Address: _____

Telephone(s) [Home/Work/Cell]: _____

(1.2) MY AGENT'S OBLIGATION: My agent shall make health care decisions for me in accordance with this power of attorney for health care, any instructions I give in PART 2 of this form, and my other wishes to the extent known to my agent. To the extent my wishes are unknown, my agent shall make health care decisions for me in accordance with what my agent determines to be in my best interest. In determining my best interest, my agent shall consider my personal values to the extent known to my agent.

(1.3) MY AGENT'S AUTHORITY My agent, except as I state here, and consistent with my known wishes and any "Instructions for Health Care" in PART 2, is authorized to make all health care decisions for me, including decisions to provide, withhold, or withdraw any treatments, including resuscitation, {artificial nutrition and hydration} and any other forms of health care to keep me alive. My agent will be the final interpreter of my wishes and preferences. My agent is authorized to make anatomical gifts, authorize an autopsy, and direct disposition of my remains. [**OPTIONAL:** *You may cross out or add text / exceptions*]*:*

_____

(*Add additional sheets if needed; pages added?* ☐.)

NOTE: I understand that the possible treatments in a particular situation are a matter of medical judgment, and will not include treatments known to be ineffective in the circumstances. In all circumstances my hygiene, comfort and dignity are to be supported.

(1.4) WHEN MY AGENT'S AUTHORITY BECOMES EFFECTIVE: My agent's authority becomes effective when my primary physician determines that I am unable to make my own health care decisions, unless I mark the following **OPTIONAL** box. ☐. If I mark this box, my agent's authority to make health care decisions for me takes effect immediately, including while I am still able to make health care decisions.

(1.5) NOMINATION OF CONSERVATOR: If a conservator of my person needs to be appointed for me by a court, I nominate my agent (or an alternate agent, in the order designated).

PART 2 - INSTRUCTIONS FOR MY HEALTH CARE [OPTIONAL]

If you use this part, you may strike out or modify any wording — note especially text in {brackets}.

(2.1) END-OF-LIFE DECISIONS: I direct that my Agent and my health care providers and others involved in my care provide, withhold, or withdraw treatment in accordance with the choices I have indicated below [choose (1) if it expresses your intentions and/or write your own statement in (2) below]:

(1) Choice Not To Prolong Life when the 'burdens' of treatment outweigh the 'benefits'

[you may cross out any text, such as in {brackets}, that does not fit your preferences]

☐ When my agent concludes that the burdens of treatments may outweigh the expected benefits I do not want any such treatments {including use of artificial nutrition and hydration}. My agent will determine, guided by any statements I have made verbally or in writing, what are the relevant "burdens" and "benefits" of treatments. I want my agent to consider the quality of my life {during the course of, as well as} at the outcome of treatment in making all healthcare decisions. When the duration of my life is likely short, I want my agent to consider hospice and primarily seek relief of suffering in treatment choices.

(2) In addition to, or instead of, CHOICE (1) above, *you may write about personal preferences or guidelines* *related to your current medical situation or to possible illnesses, injuries or treatments, your ethical values or faith/spiritual perspectives, personal abilities or qualities of living that are important to you. You may also add / attach additional pages or personal letter.*

(*Add additional sheets if needed; pages added?* ☐.)

(2.2) RELIEF FROM PAIN: [You may cross out text that does not fit your preferences] I direct that treatment for alleviation of pain or discomfort be provided as needed, even if it hastens my death (e.g., by slowing respirations)

PART 3 - SIGNATURES

(3.1) ☐ I have added [#] _____ pages to this pre-printed 4-page document.

YOUR SIGNATURE:

(3.2) **SIGN here**: _____ (PRINT Name) _____

Address: _____

Date: _____(for Medical Record ID:) Social Security #: _____Date of Birth:_____

SIGNATURES OF WITNESSES:

(3.3) ***STATEMENT OF WITNESSES****: [If you prefer to have a Notary Public witness your signature, skip to that section below. In a hospital a Notary Public is often convenient.]*

I declare under penalty of perjury under the laws of California

(1) that the individual who signed or acknowledged this Advance Directive for health care 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.

FIRST WITNESS

Print Name: _____

Address: _____

Signature of Witness: _____ Date: _____

SECOND WITNESS

Print Name: _____

Address: _____

Signature of Witness: _____ Date: _____

(3.4) ***ADDITIONAL STATEMENT OF WITNESS(ES)****:*
At least one of the above witnesses must also sign the following declaration:

I further declare under penalty of perjury under the laws of California that I am not related to the individual executing this Advance Directive by blood, marriage, or adoption, and, 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.

Signature(s) of Witness(es): _____ _____

STATEMENT OF NOTARY PUBLIC *[If you prefer to have two witnesses to your signature instead, just skip this section. In a hospital a Notary Public is often convenient.]*

(3.5) *Certificate of Acknowledgment before a Notary Public:*

State of California, County of _____ On *(date)*_____,

before me, *(name and title of officer)* _____

personally appeared *(name of signer)* _____

☐ personally known to me, OR ☐ proved to me on the basis of satisfactory evidence to be the person whose name is subscribed to the instrument and acknowledged to me that he/she executed the same by his/her signature .

WITNESS my hand and OFFICIAL SEAL. (Civil Code Section 1189.)

Signature of Notary: _____

STATEMENT OF OMBUDSMAN OR PATIENT ADVOCATE *[required only in nursing homes]*

(3.6) The following statement is required only if you are a patient in a skilled nursing facility -a health care facility that provides the following services: skilled nursing care and supportive care to patients whose primary need is for availability of skilled nursing care on an extended basis. The Patient Advocate or Ombudsman must sign the following statement:

I declare under penalty of perjury under the laws of California that I am a patient advocate or 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.

Name:

*(SIGN)*_____ *(PRINT)*_____

Date: _____ Address: _____