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

Imprint / MRN

NOTE: The document meets legal requirements for most Californians, but might not be appropriate in special circumstances. If you might have special needs, consult an attorney.

PART 1: APPOINTING AN AGENT TO MAKE HEALTH CARE DECISIONS

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

My name is:_____ Date of Birth:_____

My address is:_____

In this document I appoint an agent. That agent will make health care decisions for me in the future, if and when I no longer have the mental capacity to make my own health care decisions.

Optional: I want my agent to make my health care decisions **now**, even though I currently have the mental capacity to make my own health care decisions. _____ (Do not initial here if you want to continue making your own health decisions for as long as you are able.)

The following persons cannot be selected as your agent or alternate agent:

- Your primary physician
- An employee of the health care institution or residential care facility where you receive care (unless you are related to that person or you are co-workers).

PRIMARY AGENT:
Agent's Name: _____
Address:_____
_____
(Phone numbers – 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 numbers – 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 numbers – indicate home, work, pager, and cellular phone)

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, I give my agent my trust to make decisions (1) to accept or refuse treatment for me, including accepting or discontinuing food and fluid that is given through a tube into my stomach or into a vein; (2) to choose for me a particular physician or health care facility; and (3) to receive or review my medical information and records, or to permit release of my records for others' review. _____(initial here)

WHAT MY AGENT MUST DO

My agent shall make health care decisions for me by considering what I have written here, and by considering my other wishes. My agent will try to find out as much as he/she can about my wishes. If my agent does not know my wishes, he/she shall consider my personal values as much as possible and make decisions that he/she thinks are in my best interest. I ask that when my agent is trying to consider my values and prior wishes, that he/she talk to other loved ones who know me and care about me. _____(initial here)

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

❑ No Exclusions _____ _____(initial here)

AFTER MY DEATH

My agent will be able to authorize an autopsy, donate all or part of my body, and/or determine the disposition of my remains. If I have written a will or made funeral arrangements, my agent should follow those instructions on what happens to my body after my death or other arrangements I have made. **If I want to make exceptions to this authority, I write them here** or in an attachment to this form:

❑ No Exceptions _____ _____(initial here)

(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 to my agent and attached them. _____(initial here)

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

TRUST IN AGENT: The instructions I give to my agent are guidelines to assist him/her in making the best medical decisions for me. The subject of unacceptable treatments is a complex one. Whether I would or would not want a particular medical intervention might depend on context. At some point there might be a conflict between treatment instructions I have given and what my agent thinks best in circumstances that I could not have predicted. I trust that my agent will honor my goals and values. _____(initial here)

PERSONAL CARE DECISIONS: By my initials here I direct that my agent(s) named above authorize personal care on my behalf including, but not limited to, choice of residence, clothing, receipt of my mail, care for my personal belongings, care for my pet(s) if any, and all other decisions of a personal nature not included in the description of health care. _____(initial here)

DNR ORDER: I have completed a Prehospital Do Not Resuscitate Form. _____(initial here)

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 at a future date by creating a new one.

PART 3: SIGNATURE OF PERSON WHO IS MAKING THIS DIRECTIVE

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

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 next page.

PART 4: THIS DOCUMENT MUST EITHER BE NOTARIZED OR SIGNED BY TWO WITNESSES 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.

First Witness: _____ _____
Name (printed) Signature
Date: _____ Address: _____

Second Witness: _____ _____
Name (printed) Signature
Date: _____ Address: _____

ONE OF THE PRECEDING WITNESSES ALSO MUST 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 health care 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 operations of law.

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

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.

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

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.

(seal) Signature _____