

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:

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.

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.

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.

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

CALIFORNIA ADVANCE HEALTH CARE

Including Power of Attorney for Health Care

PART 1: APPOINTING AN AGENT TO MAKE HEALTH CARE DECISIONS

Note: You should discuss your wishes in advance with your doctor.

1 A

My name is: _____

My address is: _____

1 B

• PRIMARY AGENT:

Agent's Name: _____

Address: _____

Phone: _____

(Indicate home or work phone.)

• 1st ALTERNATE AGENT (If Agent is not available):

Name of first alternate agent: _____

Address: _____

Phone: _____

(Indicate home or work phone.)

WHEN WILL MY AGENT MAKE DECISIONS?

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

1 C

My health care agent can make health care decisions *right away*.

My health care agent will make health care decisions *only when I cannot make my own decisions* because I do not have the mental capacity to make my own decisions.

WHAT MY AGENT MAY DO

My agent will be allowed to make health care decisions for me that I cannot make myself. For example, my agent may: (1) Accept or refuse medical treatment, including accepting or discontinuing artificial nutrition and hydration, such as a feeding tube into my stomach or into a vein. (2) Choose or refuse to be admitted to, or to remain in, a health care facility. (3) Receive or review my medical records, or authorize the release of my records for others' review. _____

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 is done.)

PERSONAL CARE DECISIONS: I want my agent(s) _____ to make decisions on my behalf. For example, I want my agent to be able to decide whether I should wear clothing, receive my mail, care for my personal belongings, etc.
My agent may make all other decisions of a personal nature not described in this description of health care. _____ {initial here}

REVOCAION OF PREVIOUS DOCUMENTS: I revoke all previous Health Care Directives, 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 presence of two witnesses.

3 Date: _____ Signature: _____

If the person making this directive is not the person signing, and the person signing is a witness write the name of the person making the directive.

Witnesses

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

See page 8 for details on witnesses.

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.

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.

employee or operator of a re

ONLY ONE WITNESS CAN BE A FA

4 A First Witness: _____
Name (printed)
Date: _____ Address: _____

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

ONE WITNESS MUST BE SOMEONE C
(get any money or be named in your will)

I FURTHER DECLARE UNDER PENALTY OF PERJURY:
(1) That I am not related to the individual by blood, marriage, or adoption,
(2) To the best of my knowledge, I am not named in his or her death under a will now in effect.

4 B Date: _____ Signature: _____

If the principal (the person appointing the agent) is a resident of a skilled nursing facility, this document also must be witnessed by a representative of the Ombudsman Program. If the two-witness method is chosen, the representative of the Ombudsman Program may serve as one of the two witnesses. If the notarization method is chosen, the Ombudsman Program representative must be a separate witness.

I do not currently reside in a skilled nursing facility.

DECLARATION OF OMBUDSMAN PROGRAM REPRESENTATIVE
(Required ONLY if person appointing the agent currently resides in a skilled nursing facility.)

I declare under penalty of perjury that I am a representative of the Ombudsman Program and I am not related to the individual by blood, marriage, or adoption, and I am not named in his or her death under a will now in effect.

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
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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

No Exclusions _____ {initial here}

1 E

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.

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

2 A

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

REVOCAION 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#: _____

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