Council on Aging Southern California

ADVANCE HEALTH CARE DIRECTIVE (California Probate Code Section 4670, et. seq.)

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. It also lets you express your wishes regarding donation of organs and the designation of your primary care physician. If you use this form, you may complete or modify all or any part of it. **You should read each and every part of this form carefully and understand it thoroughly before you complete or modify any part of it.**

While you have capacity, you may revoke the designation of any agent named herein *only* by a signed writing *or* by personally informing your supervising health care provider. You may revoke all or any part of this form, *other than the designation of an agent*, at any time and in any manner that communicates the intent to revoke.

You are free to use a different form.

Part 1 of this form is a Durable Power of Attorney for Health Care. Part 1 lets you name another individual as your 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. **It is recommended that you always choose a primary and alternate agent if you decide to complete Part 1 of this form.**

Your agent **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 co-worker.

Unless the form you sign limits the authority of your agent, your agent may make **all** health care decisions for you. **This form has a place for you to limit the authority of your agent.** You need not limit the authority of your agent if you wish to rely on your agent for **all** health care decisions that may have to be made. If you choose **not** to limit the authority of your agent, your agent **will** have the right to:

(a) Consent or refuse to consent to any care, treatment, service, or procedure to maintain, diagnose, or otherwise affect a physical or mental condition;
(b) Select or discharge health care providers or institutions;
(c) Approve or disapprove diagnostic tests, surgical procedures, and programs of medication;
(d) Direct the provision, withholding, or withdrawal of artificial nutrition and hydration and all other forms of health; care, including cardiopulmonary resuscitation; and/or,
(e) Make anatomical gifts; authorize an autopsy, and direct disposition of remains.

Part 2 of this form lets you 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 and the provision of hydration and nutrition. Space is also provided for you to add to the choices you have made or for you to 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. **However, it is recommended that you complete Part 2 of this form in order to give your agent additional information as to your wishes regarding these issues.**

Part 3 of this form lets you express your wishes as to whether or not you want to donate your bodily organs and/or tissues following your death.

Part 4 of this form lets you designate a physician to have the primary responsibility for your health care.

Part 5 of this form deals with the legal requirements necessary to make it valid and enforceable. After completing this form, you will sign and date the form at the end. The form must also be signed by two qualified witnesses or acknowledged before a notary public. **If you reside in a skilled nursing facility (SNF), one of your witnesses must be a Patient Advocate or State Certified Ombudsman. Even if you have this form notarized, if you are in a SNF, a Patient Advocate or State Certified Ombudsman still must witness it.** Give a copy of the signed and completed form to your physician, to any other health care providers you may have, to any health care institution at which you are receiving care, and to any health care agents you have named. **You should talk to the person you have named as agent to make sure that he or she understands your wishes, is willing to abide by those wishes and is willing to take the responsibility of acting as your agent.**

The *Addendum* to this form, on pages 7 and 8, lets you designate an agent to have the responsibility for making your *personal care decisions*, should you wish to do so.

PART 1: DURABLE POWER OF ATTORNEY FOR HEALTH CARE

(1.1a) ☐ I, _____, **wish** to designate a health care agent at this time. **or**
(print full name)

(1.1b) ☐ I, _____, **do not** wish to designate a health care agent at this time.
(print full name)

(1.2a) DESIGNATION OF AGENT: I designate the following individual as my agent to make health care decisions for me:

_____
(name of individual I choose as my agent) (relationship)

_____
(address) (city) (state) (zip code) (home phone)

_____
(work phone) (pager) (cell phone) (FAX) (e-mail)

(1.2b) OPTIONAL: If I revoke my agent's authority or if my agent is not willing, able or reasonably available to make a health care decision for me, I designate as my first alternate agent:

_____
(name of individual I choose as my first alternate agent) (relationship)

_____
(address) (city) (state) (zip code) (home phone)

_____
(work phone) (pager) (cell phone) (FAX) (e-mail)

(1.2c) OPTIONAL: If I revoke the authority of my agent and first alternate agent or if neither is willing, able or reasonably available to make a health care decision for me, I designate as my second alternate agent:

_____
(name of individual I choose as my second alternate agent) (relationship)

_____
(address) (city) (state) (zip code) (home phone)

_____
(work phone) (pager) (cell phone) (FAX) (e-mail)

(1.3) AGENT'S AUTHORITY: My agent is authorized to make all health care decisions for me, including decisions to provide, withhold, or withdraw artificial nutrition and hydration and all other forms of health care to keep me alive, except as I state here:

_____

_____
(Additional sheets, if needed, must be signed and dated the same day the document is executed.)

My agent is authorized to request, receive, examine, copy and consent to the disclosure of medical or other health care information, including, but not limited to, medical records. This authorization *specifically* includes a *waiver* of the HIPAA regulations.

(1.4) WHEN 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 box.

If I initial this box ☐ , my agent's authority to make health care decisions for me takes effect immediately.

(1.5) 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 by 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.

(1.6) AGENT'S POSTDEATH AUTHORITY: My agent is authorized to make anatomical gifts, authorize an autopsy if not otherwise required by law, and direct disposition of my remains, except as I state here or in Part 3 of this form:

_____

_____

(Additional sheets, if needed, must be signed and dated the same day the document is executed.)

(1.7) NOMINATION OF CONSERVATOR:

☐ (a) If a conservator of my person needs to be appointed for me by a court, I nominate the agent designated in Part 1.2a of this form. If that agent is not willing, able, or reasonably available to act as conservator, I nominate the alternate agents whom I have named in Part 1.2b, or 1.2c, in the order designated; **or,**

☐ (b) If a conservator of my person needs to be appointed for me by a court, I nominate the following individual to act in that capacity:

_____
(name of individual I nominate) (relationship)

If that individual is not willing, able, or reasonably available to act as my conservator, I nominate the following individual to act in that capacity:

_____ , **or,**
(name of individual I nominate) (relationship)

☐ (c) If a conservator of my person needs to be appointed for me by a court, I nominate the following individual to act in that capacity:

_____
(name of individual I nominate) (relationship)

If that individual is not willing, able, or reasonably available to act as my conservator, I nominate the agent designated in Part 1.2 of this form. If that agent is not willing, able, or reasonably available to act as conservator, I nominate the alternate agents whom I have named in Part 1.2, in the order designated.

PART 2: INSTRUCTIONS FOR HEALTH CARE

If you fill out this part of the form, you may strike any wording you do not want.

(2.1) END OF LIFE DECISIONS: I direct that my health care providers and others involved in my care provide, withhold, or withdraw treatment in accordance with the choices I have marked:

☐ (a) Choice **Not** To Prolong Life:
I do not want my life to be prolonged if:

(1) I have an incurable and irreversible condition that will result in my death within a relatively short time; or,
(2) I become unconscious and, to a reasonable degree of medical certainty, I will not regain consciousness; or,
(3) The likely risks and burdens of treatment would outweigh the expected benefits.

☐ (b) Choice **To** Prolong Life
I want my life to be prolonged as long as possible within the limits of accepted health care standards.

(2.2) RELIEF FROM PAIN: Except as I state in the following space, I direct that treatment for alleviation of pain or discomfort be provided at all times, even if it hastens my death:

_____

_____

(Additional sheets, if needed, must be signed and dated the same day the document is executed.)

(2.3) HYDRATION AND NUTRITION: If I have made the choice in 2.1(a) of this form not to prolong my life then:

☐ (a) I authorize treatment needed to provide me with food and water but otherwise do not authorize active treatment for my medical conditions as set forth in section 2.1(a); **or,**

☐ (b) I do not authorize the provision of food or water through a tube or an intravenous line and do not authorize active treatment for my medical conditions as set forth in section 2.1(a).

(2.4) OTHER WISHES: If you do not agree with any of the optional choices above and wish to write your own, or if you wish to add to the instructions you have given above, you may do so here:

_____

_____

(Additional sheets, if needed, must be signed and dated the same day the document is executed.)

PART 3: DONATION OF ORGANS AT DEATH

(3.1) Upon my death (mark applicable box(es):

☐ (a) I do **not** wish to donate any organs, tissues or parts; or,
☐ (b) I **give any** needed organs tissues or parts; or,
☐ (c) I **give the following** organs, tissues or parts, only: _____
☐ (d) My gift is for the following **purposes**: ☐ Transplant; ☐ Therapy; ☐ Research; *and/or*; ☐ Education.

(3.2) If you wish to donate any organs, tissues or parts, **you must complete the following section**: I understand that tissue banks work with both nonprofit and for-profit tissue processors and distributors. It is possible that donated skin may be used for cosmetic or reconstructive surgery purposes. It is possible that donated tissue may be used for transplants outside of the United States.

(a) My donated skin may be used for cosmetic surgery purposes. ☐ Yes ☐ No
(b) My donated tissue may be used for applications outside the United States. ☐ Yes ☐ No
(c) My donated tissue may be used by for-profit tissue processors and distributors. ☐ Yes ☐ No

PART 4: PRIMARY PHYSICIAN: *(OPTIONAL)*

(4.1) I designate the following physician as my primary physician:

_____
(name of physician) (address)

_____
(city) (state) (zip code) (phone)

(OPTIONAL) If the physician I have designated above is not willing, able, or reasonably available to act as my primary physician, I designate the following physician as my primary physician:

_____
(name of physician)(address)

_____
(city) (state) (zip code) (phone)

Initials of ☐Principal or ☐Ombudsman: _____ Date _____/____, 20_____Permission to copy is granted if copies are not sold.

PART 5: LEGAL REQUIREMENTS

(5.1) EFFECT OF COPY: A copy of this form has the same effect as the original.

(5.2) SIGNATURE: Sign and date the form here:

Date	Signature
Address	Print Name
City	State, Zip Code

(5.3) STATEMENT OF WITNESSES: I declare under penalty of perjury under the laws of the State of California that: (1) 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) the individual signed or acknowledged this advance directive in my presence; (3) the individual appears to be of sound mind and under no duress, fraud or undue influence; (4) I am not a person appointed as agent by this advance directive; and, (5) 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 a residential care facility for the elderly.

First Witness:	**Second Witness:**
Print Name	Print Name
Signature	Signature
Address	Address
City, State, Zip Code	City, State, Zip Code

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

I further declare under penalty of perjury under the laws of the State 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 operation of law.

Print Name of Witness	Signature of Witness

(5.5) SPECIAL WITNESS REQUIREMENT: The following statement is required only if you are a patient in a skilled nursing facility (SNF) – a health care facility that provided the following basic 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 State Certified Ombudsman **must** sign the following Statement of Patient Advocate or Ombudsman:

STATEMENT OF PATIENT ADVOCATE OR OMBUDSMAN

I declare under penalty of perjury under the laws of the State of California that I am a Patient Advocate or Ombudsman as certified by the State Department of Aging and that I am serving as a witness as required by Section 4670 et.seq. of the California Probate Code.

_____ _____

(print name of Ombudsman) (Ombudsman signature)

Ombudsman Services, 2 Executive Circle, Suite 175 Irvine, CA 92614

(address) (city, state, zip code)

NOTARY ACKNOWLEDGEMENT:
STATE OF CALIFORNIA)
) ss.
COUNTY OF ORANGE)

On _____, 20_____, before me, _____, Notary Public,

personally appeared,_____, who proved to me on the basis of
(print name of principal)

satisfactory evidence to be the person whose name is subscribed to the within instrument and acknowledged to me that he/she executed the same in his/her authorized capacity, and that by his/her signature on the instrument the person, or the entity upon behalf of which the person 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 _____ **Notary Seal**

Council on Aging–Southern California
2 Executive Circle, Suite 175
Irvine, CA 92614
(714) 479-0107 FAX 714-479-0234

Visit our website at www.coasc.org

Initials of ☐Principal or ☐Ombudsman: _____ Date _____/____, 20_____Permission to copy is granted if copies are not sold.

ADDENDUM TO ADVANCE HEALTH CARE DIRECTIVE
DESIGNATION OF AGENT FOR PERSONAL CARE DECISIONS

This Addendum lets you designate an agent to have the responsibility for making your personal care decisions including, but not limited to, determining where you will live, ensuring that meals are provided for you, providing your transportation, handling your mail and arranging your recreation and entertainment.

PART 7: DURABLE POWER OF ATTORNEY FOR PERSONAL CARE DECISIONS

(A.1a) ☐ I, _____, **wish** to designate a personal care agent at this time.
(print full name)

(A.1b) ☐ I, _____, **do not** wish to designate a personal care agent at this time.
(print full name)

(A.2) DESIGNATION OF AGENT:

☐ (a) I designate the agent named in Part 1.2 of this form as my agent to make personal care decisions for me. If that agent is not willing, able, or reasonably available to make a personal care decision for me, I designate the alternate agents whom I have named in Part 1.2, in the order designated; **or,**

☐ (b) I designate the following individual as my agent to make personal care decisions for me:

_____
(name of individual I choose as my agent) (address)

_____
(city (state) (zip code) (home phone)

_____
(cell phone) (pager) (e-mail) (FAX)

My first alternate agent:

_____
(name of individual I choose as my first alternate agent) (address)

_____
(city) (state) (zip code) (home phone)

_____ **or,**
(cell phone) (pager) (e-mail) (FAX)

☐ (c) I designate the following individual as my agent to make personal care decisions for me:

_____
(name of individual I choose as my agent) (address)

_____
(city) (state) (zip code) (home phone)

_____
(cell phone) (pager) (e-mail) (FAX)

If I revoke my agent's authority or if my agent is not willing, able, or reasonably available to make a personal care decision for me, I designate the agent named in Part 1.2 of this form. If that agent is not willing, able, or reasonably available to make a personal care decision for me, I designate the alternate agents whom I have named in Part 1.2, in the order designated.

(A.3) AGENT'S AUTHORITY: My agent is authorized to make all personal care decisions for me including, but not limited to, deciding where I will live; ensuring that I am provided with meals; hiring household employees, if necessary; providing my transportation; handling my mail; and, arranging my recreation and entertainment, except as I state here:

_____

_____

(Additional sheets, if needed, must be signed and dated the same day the document is executed.)

(A.4) WHEN AGENT'S AUTHORITY BECOMES EFFECTIVE: My agent's authority becomes effective when my primary physician determines that I am unable to make my own personal care decisions. **If I initial this box** ☐ **, my agent's authority to make personal care decisions for me takes effect immediately.**

(A.5) AGENT'S OBLIGATION: My agent shall make personal care decisions for me in accordance with my wishes to the extent known to my agent. To the extent my wishes are unknown, my agent shall make personal 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 income, assets, resources and accustomed standard of living.

(A.6) STATEMENT OF WITNESSES: I declare under penalty of perjury under the laws of the State of California that: (1) the individual who signed or acknowledged this *Durable Power of Attorney for Personal Care Decisions* is personally known to me, or that the individual's identity was proven to me by convincing evidence; (2) the individual signed or acknowledged this *advance directive* in my presence; (3) the individual appears to be of sound mind and under no duress, fraud or undue influence; (4) I am not a person appointed as agent by this advance directive; and, (5) 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 a residential care facility for the elderly

(A.7) EFFECT OF COPY: A copy of this form has the same effect as the original.

(A.8) SIGNATURE: Sign and date the form here:

Date	Signature
Address	Print Name
First Witness:	**Second Witness:**
Print Name	Print Name
Signature	Signature
Address	Address
City, State, Zip Code	City, State, Zip Code

NOTARY ACKNOWLEDGEMENT:
STATE OF CALIFORNIA)
) ss.
COUNTY OF ORANGE)

On _____, 20_____, before me, _____, Notary Public, personally appeared,

_____, who proved to me on the basis of satisfactory evidence to be the person whose name is subscribed
(print name of principal)
to the within instrument and acknowledged to me that he/she executed the same in his/her authorized capacity, and that by his/her signature on the instrument the person, or the entity upon behalf of which the person 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_____ **Notary Seal**

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Visit our website at www.coasc.org

Initials of ☐Principal or ☐Ombudsman: _____ Date _____/____, 20_____Permission to copy is granted if copies are not sold.