CALIFORNIA
Advance Directive
Planning for Important Healthcare Decisions

Caring Connections, 1700 Diagonal Road, Suite 625, Alexandria, VA 22314
www.caringinfo.org, 800/658-8898

Caring Connections, a program of the National Hospice and Palliative Care Organization (NHPCO), is a national consumer engagement initiative to improve care at the end of life, supported by a grant from The Robert Wood Johnson Foundation.

The goal of Caring Connections is for consumers to hear a unified message promoting awareness and action for improved end-of-life care. Through these efforts, NHPCO seeks to support those working across the country to improve end-of-life care and conditions for all Americans.

Caring Connections tracks and monitors all state and federal legislation and significant court cases related to end-of-life care to ensure that our advance directives are always up to date.

CARING CONNECTIONS

HelpLine

You can call our toll-free HelpLine, 800/658-8898, if you have any difficulty understanding your state-specific advance directive, or if you are dealing with a difficult end-of-life situation and need immediate information. We can help provide resources and information on questions like these:

- How do I communicate my end-of-life wishes to my family?
- What type of end-of-life care is available to me?
- What questions should I ask my mother's doctors about her end-of-life care?

It's About How You LIVE

It's About How You LIVE is a national community engagement campaign encouraging individuals to make informed decisions about end-of-life care and services. The campaign encourages people to:

Learn about options for end-of-life services and care
Implement plans to ensure wishes are honored
Voice decisions to family, friends and health care providers
Engage in personal or community efforts to improve end-of-life care

Please call the HelpLine at 800/658-8898 to learn more about the LIVE campaign, obtain free resources, or to join the effort to improve community, state and national end-of-life care.

HOW TO USE THESE MATERIALS

1. Check to be sure that you have the materials for your state. You should complete a form for the state in which you expect to receive health care.

2. These materials include:
   - Instructions for preparing your advance directive.
   - Your state-specific advance directive forms, which are the pages with the gray instruction bar on the left side.

3. Read the instructions in their entirety. They give you specific information about the requirements in your state.

4. You may want to photocopy these forms before you start so you will have a clean copy if you need to start over.

5. When you begin to complete the form, refer to the gray instruction bars - they indicate where you need to mark, insert your personal instructions, or sign the form.

6. Talk with your family, friends, and physicians about your decision to complete an advance directive. Be sure the person you appoint to make decision on your behalf understands your wishes.

If you have questions or need guidance in preparing your advance directive or about what you should do with it after you have completed it, you may call our toll free number 800/ 658-8898 and a staff member will be glad to assist you.

For more information contact:

The National Hospice and Palliative Care Organization
1700 Diagonal Road, Suite 625
Alexandria, VA 22314

Call our HelpLine: 800/658-8898
Visit our Web site: www.caringinfo.org

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INTRODUCTION TO YOUR CALIFORNIA ADVANCE HEALTH CARE DIRECTIVE

This packet contains a legal document, the California Advance Health Care Directive, that protects your right to refuse medical treatment you do not want, or to request treatment you do want, in the event you lose the ability to make decisions yourself.

1. Part 1, **Power of Attorney for Health Care**, lets you name someone to make decisions about your medical care—including decisions about life support—if you can no longer speak for yourself or immediately if you designate this on the document. The Power of Attorney for Health Care is especially useful because it appoints someone to speak for you any time you can not or do not choose to make your own medical decisions, not only at the end of life.

2. Part 2, **Instructions for Health Care**, functions as your state's living will. It lets you state your wishes about medical care in the event that you can no longer speak for yourself and:

a) you have an incurable and irreversible condition that will result in death within a relatively short time, or
b) you become unconscious and, to a reasonable degree of medical certainty, will not regain consciousness, or
c) the likely risks and burdens of treatment would outweigh the expected benefits.

Although you have the option to complete only one part of this document, Caring Connections suggests that you complete Part 1 and Part 2 to best ensure that you receive the medical care you want when you can no longer speak for yourself.

3. Part 3, **Donation of Organs at Death** this is an optional section that allows you to record your wishes regarding organ donation.

4. Part 4, **Primary Physician**, this is an optional section that allows you to designate your primary physician.

Note: This document will be legally binding only if the person completing it is a competent adult who is 18 years of age or older.

INTRODUCTION TO YOUR CALIFORNIA ADVANCE HEALTH CARE DIRECTIVE (CONTINUED)

How do I make my advance health care directive legal?

In order to make your Advance Health Care Directive legally binding you have two options:

1. Sign your document in the presence of two witnesses, who must also sign the document to show that they personally know you (or you provided convincing evidence of identity) and believe you to be of sound mind and under no duress, fraud or undue influence.

Both of your witnesses cannot:

- be the person you appointed as your agent,
- be your health care provider, or an employee of your health care provider.
- be the operator or employee of a community facility,
- be the operator or employee of a residential care facility for the elderly.

In addition, one of your witnesses cannot be:

- related to your by blood or marriage or adoption,
- entitled to any part of your estate either under your last will and testament or by operation of law.

OR

2. Sign your document in the presence of a notary public.

If you are a resident in a skilled nursing facility, one of the witnesses must be a patient advocate or ombudsman designated by the State Department of Aging.

Are there any important facts that I should know?

A copy of your California Advance Health Care Directive has the same effect as the original.

COMPLETING PART 1: POWER OF ATTORNEY FOR HEALTH CARE

Whom should I appoint as my agent?
A health care agent is the person you appoint to make decisions about your medical care if you become unable to make these decisions yourself. Your agent can be a family member or a close friend whom you trust to make serious decisions. The person you name as your agent should clearly understand your wishes and be willing to accept the responsibility of making medical decisions for you. The person you appoint as your agent **cannot be**:

1. the supervising health care provider or employee of the health care institution where you are receiving care; or
2. an operator or employee of a community care facility or residential care facility at which you are receiving care.

Unless:

1. he or she (other than the supervising health care provider) is related to you by blood, marriage, adoption or is your registered domestic partner; or
2. he or she is your co-worker (other than the supervising health care provider) employed by the same health care institution, community care facility, or residential care facility for the elderly where you are a patient.

You can appoint a second and third person as your alternative agents. An alternative agent will step in if the person you name as agent is unable, unwilling or unavailable to act for you.

Should I add personal instructions to my Power of Attorney?
You can use the space provided under paragraph (2) to limit your agent's authority. Unless the form you sign limits the authority of your agent, your agent may make all health care decisions for you including:

a) consenting or refusing consent to any care, treatment, service or procedure to maintain, diagnose or otherwise affect a physical or mental condition;
b) selecting or discharging healthcare providers and institutions;
c) approving or disapproving diagnostic tests, surgical procedures, programs of medications and orders not to resuscitate; and
d) directing the provision, withholding and withdrawal of artificial nutrition and hydration and all other forms of health care.

One of the strongest reasons for naming a health care agent is to have someone who can respond flexibly as your medical condition changes and can deal with situations that you did not foresee.

We urge you to talk with your health care agent about your future medical care and describe what you consider to be an acceptable "quality of life". If you want to record your wishes about specific treatments or conditions, you can use Part 2 of this document, Instructions for Health Care.

What if I change my mind?
If you wish to cancel your Durable Power of Attorney for Health-Care Decisions you may do so by a signed writing or by personally notifying your supervising health care provider, of your intent to revoke.

COMPLETING PART 1: POWER OF ATTORNEY FOR HEALTH CARE (CONTINUED)

Are there any important facts I should know?

Paragraph (4) contains various statements about your agent's authority. Cross out and initial any portion of these statements that do not reflect your wishes. Paragraph (5) gives your agent the authority to make anatomical gifts, authorize an autopsy, and direct the disposition of your remains after your death. Cross out and initial any portion of these statements that do not reflect your wishes. Paragraph (6) nominates your agent or alternate agents to be your court appointed guardian should one become necessary. If this is not your intention, cross out and initial this section.

COMPLETING PART 2: INSTRUCTIONS FOR HEALTH CARE

Can I add personal instructions to my Instructions for Health Care?

Yes. Paragraphs (7) and (8) allow you to include instructions about certain care and treatment. If there are any specific instructions that you would like to include that are not already listed on the document you may list them in paragraph (9). For example, you may want to include a sentence such as, " I especially do not want cardiopulmonary resuscitation, a respirator or antibiotics." If you have appointed an agent, it is a good idea to write a statement such as, "Any questions about how to interpret or when to apply my Instructions for Health Care are to be decided by my agent."

What if I change my mind?

You may cancel your Instructions for Health Care at any time and in any manner that communicates your intent to do so.

It is important to learn about the kinds of life-sustaining treatment you might receive. Consult your doctor or order the Caring Connections booklet, "Advance Directives and End-of-Life Decisions."

AFTER YOU HAVE COMPLETED YOUR DOCUMENT

1. Your California Advance Health Care Directive is an important legal document. Keep the original signed document in a secure but accessible place. Do not put the original document in a safe deposit box or any other security box that would keep others from having access to it.

2. Give photocopies of the signed original to your agent and alternate agent(s), doctor(s), family, close friends, clergy and anyone else who might become involved in your health care. If you enter a nursing home or hospital, have photocopies of your document placed in your medical records.

3. Be sure to talk to your agent and alternate agent(s), doctor(s), clergy, family and friends about your wishes concerning medical treatment. Discuss your wishes with them often, particularly if your medical condition changes.

4. If you want to make changes to your document after it has been signed and witnessed, you should complete a new document.

5. Remember, you can always revoke one or both sections of your California Advance Health Care Directive.

6. Be aware that your California document will not be effective in the event of a medical emergency. Ambulance personnel are required to provide cardiopulmonary resuscitation (CPR) unless they are given a separate order that states otherwise. These orders, commonly called "non-hospital do-not-resuscitate orders," are designed for people whose poor health gives them little chance of benefiting from CPR. These orders must be signed by your physician and instruct ambulance personnel not to attempt CPR if your heart or breathing should stop. Currently not all states have laws authorizing non-hospital do-not-resuscitate orders. Caring Connections does not distribute these forms. We suggest you speak to your physician.

If you would like more information about this topic contact Caring Connections or consult the Caring Connections booklet "Cardiopulmonary Resuscitation, Do-Not-Resuscitate Orders and End-Of-Life Decisions."

Explanation

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 physician. If you use this form, you may complete or modify all or any part of it. You are free to use a different form.

Part 1 of this form is a power of attorney for health care. Part 1 lets you 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 name an alternate agent to act for you if your first choice is not willing, able, or reasonably available to make decisions for you. (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 an employee of the health care institution where you are receiving care, unless your agent is related to you, is your registered domestic partner, or is a co-worker. Your supervising health care provider can never act as your agent.)

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 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 and institutions;
(c) Approve or disapprove diagnostic tests, surgical procedures and programs of medication; and
(d) Direct the provision, withholding, or withdrawal of artificial nutrition and hydration and all other forms of health care, including cardiopulmonary resuscitation;
(e) Make anatomical gifts, authorize an autopsy, and direct the disposition of your 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. Space is 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.

Part 3 of this form lets you express an intention to donate your bodily organs and tissues following your death.

Part 4 of this form lets you designate a physician to have primary responsibility for your health care.
After completing this form, sign and date the form at the end. The form must be signed by two qualified witnesses or acknowledged before a notary public. 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 and is willing to take the responsibility.

You have the right to revoke this advance health care directive or replace this form at any time.

INSTRUCTIONS

PART 1: POWER OF ATTORNEY FOR HEALTH CARE

PRINT THE NAME, HOME ADDRESS AND HOME AND WORK TELEPHONE NUMBERS OF YOUR PRIMARY AGENT

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

_ _
(Name of individual you choose as agent)

_ _
(address) (city) (state) (zip code)

_ _
(home phone) (work phone)

PRINT THE NAME, HOME ADDRESS AND HOME AND WORK TELEPHONE NUMBERS OF YOUR FIRST ALTERNATE AGENT (OPTIONAL)

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 you choose as first alternate agent)

_ _
(address) (city) (state) (zip code)

_ _
(home phone) (work phone)

PRINT THE NAME, HOME ADDRESS AND HOME AND WORK TELEPHONE NUMBERS OF YOUR SECOND ALTERNATE AGENT (OPTIONAL)

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 you choose as second alternate agent)

_ _
(address) (city) (state) (zip code)

_ _
(home phone) (work phone)

INSTRUCTIONS

ADD PERSONAL INSTRUCTIONS ONLY IF YOU WANT TO LIMIT THE POWER OF YOUR AGENT

(2) 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:

_ _

_ _

_ _

_ _

_ _

(Add additional sheets if needed.)

INITIAL THE BOX IF YOU WISH YOUR AGENT'S AUTHORITY TO BECOME EFFECTIVE IMMEDIATELY

(3) 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 mark this box [   ], my agent's authority to make health care decisions for me takes effect immediately.

CROSS OUT AND INITIAL ANY STATEMENTS IN PARAGRAPHS 4, 5, OR 6 THAT DO NOT REFLECT YOUR WISHES

(4) 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.

(5) AGENT'S POSTDEATH AUTHORITY: My agent is authorized to make anatomical gifts, authorize an autopsy, and direct disposition of my remains, except as I state here or in Part 3 of this form:

____

____

____

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

INITIAL THE PARAGRAPH THAT BEST REFLECTS YOUR WISHES REGARDING LIFE-SUPPORT MEASURES

ADDITIONAL INSTRUCTIONS (IF ANY)

PART 2: INSTRUCTIONS FOR HEALTH CARE

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

(7) 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 choice I have marked below: (**Initial only one box**)

[ ] (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, (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, OR

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

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

____

____

____

(9) 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.) I direct that:

_ _

_ _

_ _

_ _

_ _

(Add additional sheets if needed.)

ORGAN DONATION (OPTIONAL)

MARK THE BOX THAT AGREES WITH YOUR WISHES ABOUT ORGAN DONATION

PART 3: DONATION OF ORGANS AT DEATH (OPTIONAL)

(10) Upon my death: (mark applicable box)

[ ] (a) I give any needed organs, tissues, or parts,

OR

[ ] (b) I give the following organs, tissues, or parts only

[ ] (c) My gift is for the following purposes:
(strike any of the following you do not want)

(1) Transplant
(2) Therapy
(3) Research
(4) Education

PART 4: PRIMARY PHYSICIAN (OPTIONAL)

PRINT THE NAME, ADDRESS AND TELEPHONE NUMBER OF YOUR PRIMARY PHYSICIAN (OPTIONAL)

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

_ _
(name of physician)

_ _
(address) (city) (state) (zip code)

_ _
(phone)

PRINT THE NAME, ADDRESS AND TELEPHONE NUMBER OF YOUR ALTERNATE PRIMARY PHYSICIAN (OPTIONAL)

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)

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

SIGN AND DATE THE DOCUMENT AND THEN PRINT YOUR NAME AND ADDRESS

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

_____ _____
(date) (sign your name)

_____ _____
(address) (print your name)

_____
(city) (state)

WITNESSING PROCEDURE

(14) WITNESSES: This advance health care directive will not be valid for making health care decisions unless it is either:

(1) signed by two (2) qualified adult witnesses who are personally known to you and who are present when you sign or acknowledge your signature; or
(2) acknowledged before a notary public.

BOTH OF YOUR WITNESSES MUST AGREE WITH THIS STATEMENT

ALTERNATIVE NO. 1
STATEMENT OF WITNESSES
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 an 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.

HAVE YOUR WITNESSES SIGN AND DATE THE DOCUMENT AND THEN PRINT THEIR NAME AND ADDRESS

First Witness:

_____ _____
(date) (signature of witness)

_____ _____
(address) (printed name of witness)

_____
(city) (state)

Second Witness:

_____ _____
(date) (signature of witness)

_____ _____
(address) (printed name of witness)

_____
(city) (state)

ONE OF YOUR WITNESSES MUST ALSO AGREE WITH THIS STATEMENT

ADDITIONAL WITNESS STATEMENT
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 operation of law.

HAVE ONE OF YOUR WITNESSES ALSO SIGN AND DATE THIS SECTION AND PRINT THEIR NAME AND ADDRESS

_____ _____
(date) (signature of witness)

_____ _____
(address) (printed name of witness)

_____
(city) (state)

OR

A NOTARY PUBLIC SHOULD FILL OUT THIS SECTION OF YOUR DOCUMENT

ALTERNATIVE NO. 2: NOTARY PUBLIC

State of California)
) SS.
County of _____)

On _____ before me,_____
(insert name of notary public)
personally appeared _____,
(insert the name of principal)
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 that he/she executed the same in his/her authorized capacity and that by his/her signature on the instrument the person upon behalf of which the person acted, executed the instrument.

WITNESS my hand and official seal.

NOTARY SEAL _____
(signature of notary)

THIS SECTION IS TO BE COMPLETED ONLY IF YOU ARE A RESIDENT IN A SKILLED NURSING FACILITY

STATEMENT OF PATIENT ADVOCATE OR OMBUDSMAN
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 witness as required by section 4675 of the Probate Code.

_____ _____
(date) (signature)

_____ _____
(address) (printed name)

_ _
(city) (state)

Courtesy of Caring Connections
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