CALIFORNIA
Advance Directive
Planning for Important Health Care Decisions

Caring Info
1731 King St., Suite 100, Alexandria, VA 22314

800/658-XXXX

Caring Info, 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.

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

Note: The following is not a substitute for legal advice. While Caring Info updates the following information and form to keep them up-to-date, changes in the underlying law can affect how the form will operate in the event you lose the ability to make decisions for yourself. If you have any questions about how the form will help ensure your wishes are carried out, or if your wishes do not seem to fit with the form, you may wish to talk to your health care provider or an attorney with experience in drafting advance directives. **If you have other questions regarding these documents, we recommend contacting your state attorney general's office.**

Using these Materials

BEFORE YOU BEGIN

1. Check to be sure that you have the materials for each state in which you may receive health care.

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

ACTION STEPS

1. You may want to photocopy or print a second set of these forms before you start so you will have a clean copy if you need to start over.

2. When you begin to fill out the forms, refer to the gray instruction bars — they will guide you through the process.

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

4. Once the form is completed and signed, photocopy the form and give it to the person you have appointed to make decisions on your behalf, your family, friends, health care providers and/or faith leaders so that the form is available in the event of an emergency.

5. California maintains an Advance Directive Registry. By filing your advance directive with the registry, your health care provider and loved ones may be able to find a copy of your directive in the event you are unable to provide one. You can read more about the registry, including instructions on how to file your advance directive, at http://www.sos.ca.gov/registries/advance-health-care-directive-registry/

6. You may also want to save a copy of your form in an online personal health records application, program, or service that allows you to share your medical documents with your physicians, family, and others who you want to take an active role in your advance care planning.

INTRODUCTION TO YOUR CALIFORNIA ADVANCE HEALTH CARE DIRECTIVE

This packet contains a legal document, a **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. You may complete any or all of the first four parts, depending on your advance planning needs. You must complete part 5.

Part 1 is a **Power of Attorney for Health Care**. This part lets you name someone (an agent) to make decisions about your health care. Unless otherwise written in your advance directive, your power of attorney for health care becomes effective when your primary doctor determines that you lack the ability to understand the nature and consequences of your health care decisions or the ability to make and communicate your health care decisions. If you want your agent to make health care decisions for you now, even though you are still capable of making health care decisions, you can include this instruction in your power of attorney for health care designation.

Part 2 includes your **Individual Instructions**. This is your state's living will. It lets you state your wishes about health care in the event that you can no longer speak for yourself and you may limit the individual instructions to take effect only if a specified condition arises.

Part 3 allows you to express your wishes regarding organ donation.

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

Part 5 contains the signature and witnessing provisions so that your document will be effective.

This form does not expressly address mental illness. If you would like to make advance care plans regarding mental illness, you should talk to your physician and an attorney about an advance directive tailored to your needs.

Note: These documents will be legally binding only if the person completing them is a competent adult, who is 18 years of age or older, or an emancipated minor.

INSTRUCTIONS FOR YOUR CALIFORNIA ADVANCE HEALTH CARE DIRECTIVE

How do I make my advance health care directive legal?

You must sign and date your advance directive or direct an adult to do so for you if you are unable to sign it yourself.

You r signature must be witnessed by or you must acknowledge your signature before a notary public or two adult witnesses. Your two adult witnesses may not be

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

In addition, one of your witnesses must be unrelated to you by blood, marriage, or adoption and not entitled to any portion of your estate.

If you are a patient in a skilled nursing facility when you execute your advance directive, one of your witnesses must be a patient advocate or ombudsman.

Whom should I appoint as my agent?

Your agent is the person you appoint to make decisions about your health care if you become unable to make those decisions yourself. Your agent may 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 health care decisions for you.

Your agent cannot be

- your supervising health care provider,
- the operator of a community care facility or residential care facility where you are receiving care, or
- the employee of a health care institution where you are receiving care or employee of a community care facility or residential care facility where you are receiving care, <u>unless:</u>
    - the employee is related to you by blood, marriage, or adoption,
    - the employee is your registered domestic partner, or
    - the employee is your coworker at the facility or institution.

If you have a conservator appointed for you as part of involuntary commitment proceedings under the Lanterman-Petris-Short Act, that conservator cannot be appointed as your agent unless you are represented by a lawyer who signs a certificate stating that you have been advised of your rights. If this applies to you, you should talk with your lawyer about your rights, the applicable law, and the potential consequences involved.

On the other hand, you may include in your advance directive a nomination for the individual appointed as your conservator, if necessary. The court will consider your nomination in any protective proceeding.

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

Should I add personal instructions to my advance directive?

One of the strongest reasons for naming an agent is to have someone who can respond flexibly as your medical situation changes and deal with situations that you did not foresee. If you add instructions to this document it may help your agent carry out your wishes, but be careful that you do not unintentionally restrict your agent's power to act in your best interest. In any event, be sure to talk with your agent about your future health care and describe what you consider to be an acceptable "quality of life."

What if I change my mind?

Except for the appointment of your agent, you may revoke any portion or this entire advance directive at any time and in any way that communicates your intent to revoke. This could be by telling your agent or physician that you revoke, by signing a revocation, or simply by tearing up your advance directive.

In order to revoke your agent's appointment, you must either tell your supervising health care provider of your intent to revoke or revoke your agent's appointment in a signed writing.

If you execute a new advance directive, it will revoke the old advance directive to the extent of any conflict between the two documents.

Unless you specify otherwise in Part 2, if you designate your spouse as your agent, that designation will automatically be revoked by divorce or annulment of your marriage.

What other important facts should I know?

Your agent, if you appoint one, does not have authority to authorize convulsive treatment, psychosurgery, sterilization, or abortion, or to have you committed or placed in a mental health treatment facility.

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;
(d) Direct the provision, withholding, or withdrawal of artificial nutrition and hydration and all other forms of health care, including cardiopulmonary resuscitation; and
(e) Make anatomical gifts, authorize an autopsy, and direct the disposition of your remains.

Explanation Continued

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 in **Part 5**. 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 and alternate agent(s) 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

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

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

_____
(Name of individual you choose as agent)

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

_____
(home phone) (work phone)

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:

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

_____
(Name of individual you choose as first alternate agent)

_____
(address)

_____
(city) (state) (zip code)

_____
(home phone) (work phone)

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:

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

_____
(Name of individual you choose as second alternate agent)

_____
(address)

_____
(city) (state) (zip code)

_____
(home phone) (work phone)

ADD INSTRUCTIONS HERE 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, in paragraph (2) above, 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.

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**)

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

[ ] (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:

ADD INSTRUCTIONS HERE ONLY IF YOU WANT TO LIMIT PAIN RELIEF OR COMFORT CARE

_____

_____

_____

_____

_____

_____

_____

_____

ADD OTHER INSTRUCTIONS, IF ANY, REGARDING YOUR ADVANCE CARE PLANS

THESE INSTRUCTIONS CAN FURTHER ADDRESS YOUR HEALTH CARE PLANS, SUCH AS YOUR WISHES REGARDING HOSPICE TREATMENT, BUT CAN ALSO ADDRESS OTHER ADVANCE PLANNING ISSUES, SUCH AS YOUR BURIAL WISHES

ATTACH ADDITIONAL PAGES IF NEEDED

(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.)

PART 3: DONATION OF ORGANS AT DEATH
(OPTIONAL)

ORGAN DONATION (OPTIONAL)

INITIAL THE BOX THAT AGREES WITH YOUR WISHES ABOUT ORGAN DONATION

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

[ ] (a) I do not give any of my organs, tissues, or parts and do not want my agent, conservator, or family to make a donation on my behalf,

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

OR

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

_____

_____

_____

STRIKE THROUGH ANY USES YOU DO NOT AGREE TO

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.

PART 5: EXECUTION

This Health Care Directive will not be valid unless it is EITHER:

(A) Signed by two (2) qualified adult witnesses who are personally known to you or to whom you have proven your identity by convincing evidence and who are present when you sign or acknowledge your signature. Your witnesses may not be

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

In addition, one of your witnesses must be unrelated to you by blood, marriage, or adoption and not entitled to any portion of your estate. (Use Alternative 1, below, if you decide to have your signature witnessed.)

OR

(B) Witnessed by a notary. (Use Alternative 2, below (page 12), if you decide to have your signature notarized.)

IF YOU CHOOSE TO SIGN WITH WITNESSES, USE ALTERNATIVE 1, BELOW

IF YOU CHOOSE TO HAVE YOUR SIGNATURE NOTARIZED, USE ALTERNATIVE 2, BELOW (PAGE 12)

THERE ARE SPECIAL WITNESSING REQUIREMENTS IF YOU LIVE IN A SKILLED NURSING FACILITY

If you are a patient in a skilled nursing facility when you execute your advance directive, one of your witnesses must be a patient advocate or ombudsman. This witness must sign the statement on page 13, even if you have had your advance directive notarized.

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

OPTION 1: Sign before a Witness

_____ _____
(date) (sign your name)

_____
(print your name)

_____
(address)

_____
(city) (state) (zip code)

WITNESSING PROCEDURE

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.

BOTH OF YOUR WITNESSES MUST AGREE WITH THIS STATEMENT

First Witness:

_____ _____
(date) (signature of witness)

_____
(printed name of witness)

_____
(address)

_____
(city) (state) (zip code)

ONE WITNESS MUST ALSO SIGN THE STATEMENT ON PAGE 11

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

Second Witness:

_____ _____
(date) (signature of witness)

_____
(printed name of witness)

_____
(address)

_____
(city) (state) (zip code)

ONE OF YOUR WITNESSES MUST ALSO SIGN 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.

_____ _____

(date) (signature of witness)

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

A NOTARY PUBLIC MUST FILL OUT THIS PORTION OF THE FORM

ALTERNATIVE NO. 2: NOTARY PUBLIC

_____ _____
(date) (sign your name)

_____
(print your name)

_____
(address)

_____
(city) (state) (zip code)

State of California)
) SS.
County of _____)

On _____ before me,_____
(insert name of notary public)
personally appeared _____,
(insert the name of principal)

Who proved to me on the basis of satisfactory evidence to be the person(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 signature(s) on the instrument the person(s), or the entity upon behalf of which 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.

NOTARY SEAL

_____
(signature of notary)

THIS SECTION MUST BE COMPLETED BY A PATIENT ADVOCATE OR OMBUDSMAN 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)

_____

(printed name)

_____

(address)

_____

(city) (state) (zip code)

Courtesy of Caring Info
1731 King St., Suite 100, Alexandria, VA 22314
www.caringinfo.org, 800/658-8898

You Have Filled Out Your Health Care Directive, Now What?

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, 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(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. California maintains an Advance Directive Registry. By filing your advance directive with the registry, your health care provider and loved ones may be able to find a copy of your directive in the event you are unable to provide one. You can read more about the registry, including instructions on how to file your advance directive, at http://www.sos.ca.gov/registries/advance-health-care-directive-registry/

5. You may also want to save a copy of your form in an online personal health records application, program, or service that allows you to share your medical documents with your physicians, family, and others who you want to take an active role in your advance care planning.

6. If you want to make changes to your documents after they have been signed and witnessed, you must complete a new document.

7. Remember, you can always revoke your California document.

8. Be aware that your California document will not be effective in the event of a medical emergency. Ambulance and hospital emergency department personnel are required to provide cardiopulmonary resuscitation (CPR) unless they are given a separate directive that states otherwise. These directives called "prehospital medical care directives" or "do not resuscitate orders" are designed for people whose poor health gives them little chance of benefiting from CPR. These directives instruct ambulance and hospital emergency personnel not to attempt CPR if your heart or breathing should stop.

   Currently not all states have laws authorizing these orders. We suggest you speak to your physician if you are interested in obtaining one. **Caring Info does not distribute these forms.**

Congratulations!

You've downloaded **your free, state specific advance directive.**

You are taking important steps to make sure your wishes are known. Help us keep this free.

Your generous support of the National Hospice Foundation and Caring Info allows us to continue to provide these FREE resources, tools, and information to educate and empower individuals to access advance care planning, caregiving, hospice and grief services, and information.

I hope you will show your support for our mission and make a tax-deductible gift today.

Since 1992, the National Hospice Foundation has been dedicated to creating FREE resources for individuals and families facing a life-limiting illness, raising awareness for the need for hospice care, and providing ongoing professional education and skills development to hospice professionals across the nation.

Your gift strengthens the Foundation's ability to provide FREE caregiver and family resources.

Support your National Hospice Foundation by returning a **generous tax-deductible gift of $23, $47, $64,** or the most generous amount you can send.

You can help us provide resources like this advance directive FREE by sending in your gift to help others.

Please help to make this possible with your contribution! Cut along the dotted line and use the coupon below to return a check contribution of the most generous amount you can send. Thank you.

YES! I want to support the important work of the National Hospice Foundation.

$23	helps us provide free advance directives
$47	helps us maintain our free HelpLine
$64	helps us provide webinars to hospice professionals

Return to:
National Hospice Foundation
PO Box 824401
Philadelphia, PA 19182-4401

AD_2018

OR donate online today: www.caringinfo.org/donate