

## ***ADVANCE HEALTH CARE DIRECTIVE***

### *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 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. (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 coworker. Additionally, you should consult an attorney before designating your conservator 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 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 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.
- (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. 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.

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 provider 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.

***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:

**Agent:**

Name: \_\_\_\_\_

Address: \_\_\_\_\_

Phone: Home: \_\_\_\_\_, \_\_\_\_\_ Work: \_\_\_\_\_

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:

**First Alternate:**

Name: \_\_\_\_\_

Address: \_\_\_\_\_

Phone: Home: \_\_\_\_\_, \_\_\_\_\_ Work: \_\_\_\_\_

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.

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.

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. **NOMINATION OF GUARDIAN OR CONSERVATOR.** If a guardian or conservator of my person or estate or both, 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 guardian or conservator, I nominate the alternate agents whom I have named, in the order designated.

## ***PART 2***

### ***INSTRUCTIONS FOR HEALTH CARE***

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 this part of the form.

6. **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 initialed below:

\_\_\_\_\_ **CHOICE NOT TO PROLONG LIFE.** I do not want my life to be prolonged if:

7. **ARTIFICIAL NUTRITION AND HYDRATION.** Artificial nutrition and hydration must be provided, withheld or withdrawn in accordance with the choice I have made in paragraph 6.

8. **RELIEF FROM PAIN.** I direct that treatment for alleviation of pain or discomfort 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:

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## ***PART 3***

### ***DONATION OF ORGANS AT DEATH***

10. Upon my death, I give any needed organs, tissues or parts.

My gift is for the following purposes: education, research, therapy, and transplantation

## ***PART 4***

**PRIMARY PHYSICIAN**

11. I designate the following physician as my primary physician:

**Physician:**

Name: \_\_\_\_\_

Address: \_\_\_\_\_

\_\_\_\_\_, \_\_\_\_\_

Phone: \_\_\_\_\_

**PART 5**

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

13. SIGNATURE.

**Declarant Signature:** \_\_\_\_\_

Name: \_\_\_\_\_

Address: \_\_\_\_\_

\_\_\_\_\_, \_\_\_\_\_

Date: \_\_\_\_\_

NOTICE: SPECIAL RULES APPLY IF YOU ARE A RESIDENT OF A SKILLED NURSING FACILITY. IF YOU RESIDE IN SUCH A FACILITY, THIS DOCUMENT MUST BE SIGNED BY A PATIENT ADVOCATE OR OMBUDSMAN. IF YOUR DOCUMENT IS BEING WITNESSED BY TWO WITNESSES, ONE OF THOSE WITNESSES MUST BE THE ADVOCATE OR OMBUDSMAN WHO SIGNS ALL WITNESS STATEMENTS. IF YOUR DOCUMENT IS BEING NOTARIZED, THE ADVOCATE OR OMBUDSMAN MUST SIGN THE SPECIAL WITNESS REQUIREMENT SECTION.

14. STATEMENT OF WITNESSES: [If you are a resident in a skilled nursing facility, a patient advocate or ombudsman must sign this statement as one of your two witnesses.]

I declare under penalty of perjury under the laws of \_\_\_\_\_(State):

(1) that the individual who signed or acknowledged this advance health care directive is personally known to me, or that the individual's identity was proven to me by convincing evidence,

(2) that the individual signed or acknowledged this advance directive in my presence,

(3) that the individual appears to be of sound mind and under no duress, fraud, or undue influence,

(4) that I am not a person appointed as agent by this advance directive,

(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,  
and  
(6) that I am an adult.

**Witness Signature:** \_\_\_\_\_

Name: \_\_\_\_\_

Address: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Date: \_\_\_\_\_

**Witness Signature:** \_\_\_\_\_

Name: \_\_\_\_\_

Address: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Date: \_\_\_\_\_

15. ADDITIONAL STATEMENT OF ONE OF THE ABOVE WITNESSES. [If you are a resident in a skilled nursing facility, the patient advocate or ombudsman must sign this statement.]

I further declare under penalty of perjury under the laws of \_\_\_\_\_ (State) 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.

**Witness Signature:** \_\_\_\_\_

Name: \_\_\_\_\_

Address: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Date: \_\_\_\_\_

16. SPECIAL WITNESS REQUIREMENT.

The following statement is required only if you are a patient in a skilled nursing facility - a health care facility that provides 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 ombudsman must sign the following statement:

STATEMENT OF PATIENT ADVOCATE OR OMBUDSMAN: I declare under penalty of perjury under the laws of \_\_\_\_\_ that I am a patient advocate or ombudsman as designated by the State Department of Aging and that I am serving as a witness as required by Section \_\_\_\_\_ of the Probate Code.

**Witness Signature:** \_\_\_\_\_

Name: \_\_\_\_\_

Address: \_\_\_\_\_

City, State, Zip: \_\_\_\_\_

## Final Checklist for Advance Health Care Directive

For: \_\_\_\_\_  
DATE: \_\_\_\_\_

### **Make It Legal**

- \_\_\_\_\_ You must be an adult (18 in most states) and mentally competent to execute a valid document. The document must be signed and dated in order to be effective.
- \_\_\_\_\_ You should sign this document in the presence of two witnesses who then sign the document in your presence and in each other's presence or in the presence of a notary.
- \_\_\_\_\_ The state requires that special provisions within the document be separately initialed or signed. \_\_\_\_\_ (State) also has special witnessing requirement if you are a patient in a skilled nursing facility.
- \_\_\_\_\_ The specific requirements for who can be a witness, whether the document must be notarized, and other execution formalities are printed on the document itself. **THESE ARE SPECIFIC TO YOUR STATE AND MUST BE READ CAREFULLY AND COMPLIED WITH TO HELP ENSURE YOU HAVE A VALID DOCUMENT.**
- \_\_\_\_\_ You should initial on the bottom margin of each page of the document. This prevents the subsequent substitution of pages. To print out an initials line at the bottom of each page of your document, go to the "View" menu at the top of the screen and choose "Preferences." Select the "Print" tab and choose the appropriate checkbox.
- \_\_\_\_\_ An indication should be made on the document itself regarding who has received a copy, in case there is a need for later retrieval, modification, or revocation.

### **Copies**

- \* Give a signed copy of the document to:
  - \_\_\_\_\_ Your health care provider(s), including your physician and any hospital where you are treated
  - \_\_\_\_\_ Appropriate family members, a close friend, or clergy
  - \_\_\_\_\_ \_\_\_\_\_ (your Agent)

- \* You should retain the original or a copy of the document for your own records.

### **When to Consult a Lawyer**

- \* The document may not be valid in your state of residence unless that state was selected in the program. A lawyer should be consulted if there is any uncertainty regarding which state's document to use.
- \* Before signing the document, you should be completely comfortable that you understand the nature and range of decisions that may be made on your behalf. You should discuss the range of medical decisions with a physician, another health care provider, social worker, pastor, or a lawyer -- someone who is knowledgeable about these issues and can answer questions.

### **Other Information**

- \* While each state has its own restrictions on who may be a witness, in general, persons should not be used as a witness if they have been appointed as your Agent in the directive; are your relative by blood, marriage, or adoption; are or may become directly involved in providing health care to you; are an employee of your health care provider; or are less than 18 years of age.
- \* You should discuss the document and your wishes with any person you want to designate as an Agent before doing so to assure they agree to act on your behalf.
- \* If you learn that you have a terminal condition after signing a health care directive, execute a new Directive. This will provide an opportunity to restate or change your wishes in light of your new health status.

### **Reasons to Update**

- \* Change or set limits on the medical care that is provided.
- \* Respond to changing medical technology.
- \* Respond to a change in health care laws.
- \* Respond to a change in health, including pregnancy.
- \* Designate a different person to make health care decisions for you.