

# Instructions for completing the California Advance Health Care Directive form

## An Advance Health Care Directive has 3 parts:

### Part 1: The 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: Health care choices.

You can have a say about how you are treated.

### Part 3: Signatures and Witnesses.

It must be signed and witnessed to be legally binding.

## Getting Started

### Go to Page 1, Part 1

1A: Print your first name, last name, date of birth, address, city, state, and ZIP code so it is clear who is making this directive.

The image shows a thumbnail of the California Advance Health Care Directive form. The title is "CALIFORNIA ADVANCE HEALTH CARE DIRECTIVE" with the subtitle "Including Power of Attorney for Health Care". The page number "1" is in the top right corner. The section is titled "PART 1: APPOINTING AN AGENT TO MAKE HEALTH CARE DECISIONS". A note states: "NOTE: You should discuss your wishes in detail with your designated agent(s)". There are two lines for "My name is:" and "Date of Birth:" and one line for "My address is:". Below this is the text: "In this document I appoint an agent. I want this person to help make my health care decisions."

## Whom should I choose as my health care agent?

Choose a family member or friend who:

- is at least 18 years old
- knows you well
- can be there for you when you need them
- you trust to do what is best for you
- can tell your doctors about the decisions you would want made

Your agent cannot be your doctor or someone who works at your hospital or clinic where you get health care, unless they are a family member or your co-worker.

## Go to 1B

1B: Write in the name of your agent. Your agent is the person who you want to make medical decisions for you

In case the first person cannot do it, write in who should help make your medical decisions.

**1 B**

**PRIMARY AGENT:**  
Agent's Name: \_\_\_\_\_  
Address: \_\_\_\_\_  
Phone: \_\_\_\_\_  
(Indicate home, work, pager, and cellular phone)

**1<sup>st</sup> 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)

**Your health care agent can start helping with your medical decisions right away; or you can ask that they get involved only if you cannot make your own decisions.**

## Go to 1C

1C: If you want your agent to start right away place an "X" in the first box and sign your initials in the space.

or, if you want your agent to start only when you cannot make your own decisions, place an "X" in the second box and sign your initials in the space.

**1 C**

**WHEN WILL MY AGENT MAKE DECISIONS:**  
(Put an X next to the sentence you agree with.)

My health care agent can make health care decisions for me now. \_\_\_\_\_

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. \_\_\_\_\_ (initials)

## What kind of decisions can my health care agent make?

Your agent can agree to, say "no" to, change, stop or choose:

- doctors, nurses, social workers
- hospitals or clinics
- medical treatment (including artificial feeding), medications or tests
- what happens to your body and organs after you die

If you do not want your agent to be able to make all these kinds of decisions, this is probably not the right advance health care directive form for you.

**Becoming your agent does *not* mean that he/she assumes financial responsibility for you.**

**Go to Page 2, 1D**

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

**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)

**Is there someone you DON'T want to make the decisions?**

Is there someone who might argue with your agent and you don't want that person to interfere with your agent's decisions?

**Go to Page 2, 1E**

1E: If there is no such person, check the "No Exclusions" box and sign your initials.

If there is such a person, you can exclude that person from making health care decisions for you by writing their name in the space and signing your initials.

**WHO MAY NOT MAKE MY MEDICAL DECISIONS**

No Exclusions \_\_\_\_\_ (initial here)  
or  The following individual(s) are to be EXCLUDED from any part of health care decision-making for me:  
\_\_\_\_\_ (initial here)

**After Your Death**

Your health care agent can:

- decide if any of your organs will be donated. Donated organs can save lives.
- request, consent to, or refuse an autopsy. An autopsy can be done after death to find out why someone died. It is done by surgery. It can take a few days.
- decide what happens to your body, such as burial or cremation.

**Go to Page 2, 1F**

1F: If you want to leave these decisions to your agent after your death, check the box "No Exceptions" and sign your initials.

If you do not want your agent to make these decisions, you should put in writing your own decisions about what should happen to your body after death.

**AFTER MY DEATH**

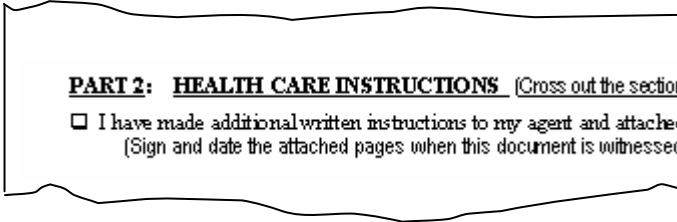
My agent will be able to authorize an autopsy. My agent will be able to donate all of my body. My agent will be able to determine the disposition of my remains. If written a will or made arrangements for what happens to my body after my death, agent should follow those instructions.

No Exceptions \_\_\_\_\_ (initial here)  
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.)

What if I want to provide specific health care instructions that are not on the AHCD form?

Go to Page 2, Part 2  
HEALTH CARE INSTRUCTIONS

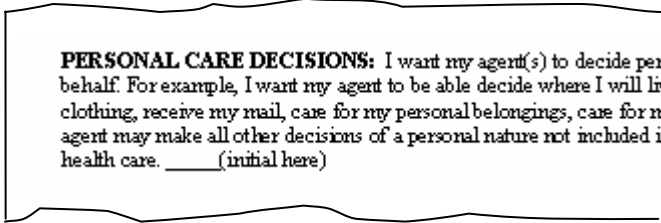
2A: You may write extra pages in your own words, or use a values history form to guide your agent in making difficult decisions



Attach the extra pages to the Advance Health Care Directive. Sign and date the attachments and have them witnessed or notarized at the same time you have your form witnessed or notarized.

Talk to your agent(s) and doctor(s) about your specific health care instructions to be sure they understand your wishes.

2B: Some personal 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.

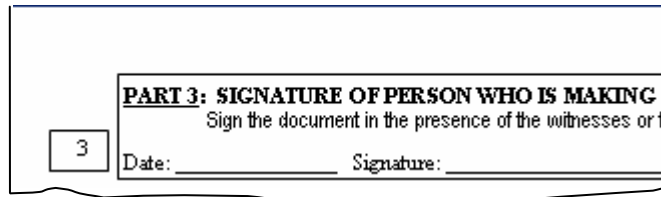


Part 3: SIGNING THE FORM

You must sign the form, and you will need witnesses or a notary public to sign too.

Go to Page 3, Part 3

3: Sign and date the document in the presence of the witnesses or the notary



Your witnesses must:

- be over 18 years of age.
- know who you are.
- believe that you are the one who signed the form.

Your witnesses cannot:

- be your doctor, nurse, or social worker.
- work at the place that you live, if you live in a care facility.

The person you chose as your agent or alternate agent CANNOT be a witness

Only one of the witnesses can be related to you by blood, marriage or adoption, be named in your will, or be someone who would benefit from your estate.

### Go to Page 3, 4A Witnesses Signatures

4A: Have the witnesses read the witness statements before they sign.

4B: One witness must be someone other than family and must not benefit financially (get any money or be named in your will) after you die. Have that person sign again at 4B

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

**ONE OF THE PRECEDING WITNESSES ALSO MUST SIGN THE FOLLOWING DECLARATION:**  
I further declare under penalty of perjury under the laws of California that the individual executing this advance health care directive by blood and, to the best of my knowledge, I am not entitled to any part of the estate of the individual by reason of a will now existing or by operations of law.

4 B	Date: _____ Signature: _____
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### If you live in a nursing home:

- You will need an additional witness. California law requires nursing home residents to have the nursing home ombudsman as a witness of advance directives.
- In addition to the ombudsman, you will need either a notary or one other witness who will meet the qualifications listed above.

### Go to Page 4, 4C

4C: If you do **not** live in a nursing home, check the box next to "I do not reside in a skilled nursing facility" and sign your initials.

<input type="checkbox"/> I do not currently reside in a skilled nursing facility.	_____ (initials)
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## What do I do with the form once it is all filled out?

Keep the original yourself. Make copies of the form to share with those who care for you. Keep a list of who has copies.

- family
- friends
- doctors
- nurses
- social workers

## What if I change my mind?

- Complete a new form. Give out copies of the new form to all the same people.