CALIFORNIA ADVANCE HEALTH CARE DIRECTIVE
Including Power of Attorney for Health Care

Imprint / MRN

PART 1: APPOINTING AN AGENT TO MAKE HEALTH CARE DECISIONS

NOTE: You should discuss your wishes in detail with your designated agent(s)

1 A

My name is:_____ Date of Birth:_____

My address is:_____

In this document I appoint an agent. I want this person to help make my medical decisions.

Your agent or alternate agent **cannot** be:

- Your primary physician
- Someone who works where you receive care (unless you are related to that person or you are co-workers).

1 B

PRIMARY AGENT:

Agent's Name: _____

Address:_____

Phone: _____

(Indicate home, work, pager, and cellular phone)

1st 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)

2nd ALTERNATE AGENT (If Agent and 1st Alternate are unavailable or unwilling to serve.)

Name of second alternate agent: _____

Address:_____

Phone: _____

(Indicate home, work, pager, and cellular phone)

WHEN WILL MY AGENT MAKE DECISIONS:

(Put an X next to the sentence you agree with.)

1 C

❑ My health care agent can make health care decisions for me now. _____(initial here)

❑ 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. _____(initial here)

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)

1 D

WHO MAY NOT MAKE MY MEDICAL DECISIONS

❑ No Exclusions _____(initial here)

1 E

or ❑ The following individual(s) are to be EXCLUDED from any part of health care decision-making for me:

_____ _____(initial here)

AFTER MY DEATH

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

❑ No Exceptions _____(initial here)

1 F

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.)

PART 2: HEALTH CARE INSTRUCTIONS (Cross out the sections that do not apply)

❑ I have made additional written instructions to my agent and attached them.
(Sign and date the attached pages when this document is witnessed.)

2 A

PERSONAL CARE DECISIONS: I want my agent(s) to decide personal care on my behalf. For example, I want my agent to be able decide where I will live, choose my clothing, receive my mail, care for my personal belongings, care for my pet(s) if any. My agent may make all other decisions of a personal nature not included in the description of health care. _____(initial here)

2 B

REVOCATION OF PREVIOUS DOCUMENTS: I revoke any previously-executed Power of Attorney for Health Care, Individual Health Care Instruction, or Natural Death Act Declaration. I have the right to revoke this directive later by creating a new one.

PART 3: SIGNATURE OF PERSON WHO IS MAKING THIS DIRECTIVE

Sign the document in the presence of the witnesses or the Notary.

3

Date: _____ Signature: _____

If the person making this directive is unable to write, have the person make a mark. Have a witness write the name of the person making this directive and sign the next page.

PART 4: THIS DOCUMENT MUST EITHER BE SIGNED BY TWO WITNESSES OR NOTARIZED ON THE NEXT PAGE.

WITNESSES: Certain individuals cannot serve as witnesses. Those rules are set forth in the following witness statements:

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 agent by this Advance Directive, and

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

ONLY ONE WITNESS CAN BE A FAMILY MEMBER

4 A

First Witness: _____ _____

Name (printed) Signature

Date: _____ Address: _____

Second Witness: _____ _____

Name (printed) Signature

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 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 operations of law.

4 B

Date: _____ Signature: _____

Only if the person making this directive is unable to write, witnesses complete this section:

_____, being unable to write, made his/her mark in our presence and requested the first of the undersigned to write his/her name, which he/she did, and we now subscribe our names as witnesses thereto.

_____ _____

Signature of Witness #1 Signature of Witness #2

A notary public or other officer completing this certificate verifies only the identity of the individual who signed the document, to which this certificate is attached, and not the truthfulness, accuracy, or validity of that document.

NOTARY ACKNOWLEDGEMENT
(Not required if two-witness method is followed)

STATE OF CALIFORNIA, COUNTY OF _____

On _____, before me, _____, the

undersigned notary public, personally appeared _____, proved to me on the basis of satisfactory evidence to be the person(s) whose name(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.

Signature _____ (Seal)

If the principal (the person appointing the agent) currently resides in a nursing facility, this document also must be witnessed by a representative of California's Long-Term Care Ombudsman Program. If the two-witness method is chosen, the Ombudsman Program representative may serve as one of the two witnesses, or may serve as a third witness. If the notarization method is chosen, the Ombudsman Program representative serves as a separate witness.

❑ I do not currently reside in a skilled nursing facility. _____ (initial here) 4 C

DECLARATION OF OMBUDSMAN PROGRAM REPRESENTATIVE
(Required ONLY if person appointing the agent currently resides in a nursing facility.)
I declare under penalty of perjury under the laws of California that I am an ombudsman designated by the California Department of Aging and that I am serving as a witness as required by Section 4675 of the California Probate Code.

_____ _____ _____

Name (printed) Signature Date