Advance Health Care Directive



CANHR

Long Term Care Justice and Advocacy

Advance Health Care Directive Form

California law recognizes that every adult has the fundamental right to control the decisions relating to his or her own health care, including the decision to have life-sustaining treatment withheld or withdrawn.

The purpose of this form is to do either or both of the following things:

1. Name someone to make health care decisions for you. This person is called your health care agent. You may give your agent the ability to make decisions on your behalf immediately or not unless you become incapacitated. Your agent may make all health care decisions for you unless you impose limits on the agent's authority. You may name alternate agents to act on your behalf if your first choice is not able to make a decision for you.

2. Give instructions and express preferences about your health care to direct your agent or health care providers if there is ever a time when you cannot state your preferences. Because it is very difficult to anticipate your future health care scenarios, it is most important to give your agent or health care providers an idea of what is most important to you when choosing medical treatment.

This form does NOT give your agent any ability to manage your financial affairs. It is limited to health care decisions only.

Notwithstanding this form, you have the right to make health care decisions for yourself so long as you can give informed consent to that particular decision. In addition, no treatment may be given to you over your objection, and health care necessary to keep you alive may not be stopped or withheld if you object at any time, unless a court of law has determined otherwise.

This form will not be valid unless it is either signed by two qualified witnesses or notarized.

This form should be easily accessible in case of a health care emergency. Each agent and alternate agent should have a copy of this executed document, as well as your health care providers. Keep the original in a secure location.

You have the right to revoke or replace this form at any time.

This form is meant to be completed with the help of an attorney or a representative of a legal services organization who is supervised by an attorney.

Part 1 – Power Of Attorney For Health Care

(1.1) DESIGNATION OF AGENT: I designate the following individual as my agent to make health care decisions for me (your agent may not be an operator or employee of a community care, residential care, or skilled nursing 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):

(Name of the individual you choose as your agent)

Address | City | State | ZIP code

Phone | Alt. Phone | Email Address

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 the individual you choose as your agent)

Address | City | State | ZIP code

Phone | Alt. Phone | Email Address

OPTIONAL: If I revoke the authority of my agent and first alternative 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 the individual you choose as your agent)

Address	City	State	ZIP code

Phone	Alt. Phone	Email Address

(1.15) AGENT AS REPRESENTATIVE: My agent(s) shall be treated as my authorized "personal representative" under HIPAA (42 USC §1320d) and its implementing regulations, especially 45 C.F.R. § 164.502(g), and as my "legal representative" under CMIA (California Civil Code § 56.11(c)(2)).

(1.2) 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.

(1.25) AGENT'S LIMITATIONS: My agent may **not**:

a. enter into binding pre-dispute arbitration agreements on my behalf or otherwise waive my rights to pursue legal remedies, including actions in a court of law, in advance of a dispute;

b. authorize placement in a locked door facility or any other placement where my ingress / egress is substantially impeded;

c. authorize psychotropic drugs for the treatment of dementia;

d. authorize the use of physical restraints.

My agent **may** waive my right to privacy in the case of video surveillance my agent deems necessary or helpful for my safety.

If this statement reflects your desires, initial here: _____

My agent may not make any decisions over my objections unless a court of law has found that I lack capacity to make decisions. (Probate Code 4689)

(1.3) 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. If my primary physician cannot be reached, my agent's authority will become effective when two (2) physicians determine that I am unable to make my own health care decisions. My agent's authority becomes effective immediately if I sign the following statement:

OPTIONAL: I want my agent's authority to make health care decisions for me to begin immediately, even though I currently have the mental capacity to make my own health care decisions. My decision to choose this option is proven by my signature here:

(consider carefully before signing): _____

(1.35) ACCESS TO HEALTH INFORMATION: I currently have the mental capacity to make my own health care decisions and will retain my own decision making authority until I lose capacity pursuant to Section 1.3 above, or unless I sign the optional section above. Regardless, my agent's authority is effective immediately for the limited purpose of obtaining my otherwise protected health and medical information as defined in HIPAA and CMIA, with respect to information relevant to a determination of capacity. I acknowledge that information disclosed by a healthcare provider or other covered entity may be redisclosed and may no longer be subject to the privacy rules provided by law (including 45 C.F.R. § 160 through § 164).

(1.4) AGENT'S OBLIGATION: My agent shall make health care decisions for me in accordance with any instructions I give in 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. My agent may not override or change any end-of-life decision I have made.

(1.5) 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:

- ☐ I wish to be buried
- ☐ I wish to be cremated
- ☐ I am not sure.

(1.6) NOMINATION OF A 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 I named, in the order designated.

Part 2 – Instruction For Health Care

(2.05) VALUES: To assist your agent in making end-of-life decisions, it is important to provide some guidance for assessing the quality of your life. If the space for any answer provided is insufficient, add additional pages. Initial and date these pages.

What are the most important things in your life and what gives your life meaning??

(2.1) END-OF-LIFE PREFERENCES: I direct my health care providers and others involved in my care provide, withhold, or withdraw treatment in accordance with the preferences I initial below: [Please select one]

- ☐ Life is always worth living no matter what type of illness, disability, or pain I may be experiencing.
- ☐ There may be some health situations that would make my life not worth living.
- ☐ I am not sure.

In the event of serious illness or a severe medical condition: [Please select one]

- ☐ I want medical treatments to live as long as possible and do not want to stop treatment even if I were in pain
- ☐ I want to try treatments to prolong life for a period of time, but I don't want to suffer. If the treatments are not helping or I am suffering, I want to stop. Please treat medical conditions but avoid overly burdensome measures.
- ☐ I want to focus on my quality of life and being comfortable, even if it means having a shorter life. Relief of pain and suffering is my priority.
- ☐ I am not sure.

(2.15) In the event I am placed in a hospital, board and care, skilled nursing facility, or any other place outside my home, my health care agent is instructed that it is my intention to return to my home to complete my life. I instruct said agent to return me to my home before death if possible, so that I can end my days in my own home.

If this statement reflects your desires, initial here: _____

(2.2) RELIEF FROM PAIN: Except as I state in the following space, I direct that treatment for alleviating pain or discomfort be provided at all times even if it dulls consciousness and indirectly shortens my life.

_____

_____

If this statement reflects your desires, initial here: _____

(2.25) DEMENTIA GUIDANCE: If I am diagnosed with dementia or any other chronic neuro-cognitive disorder, I instruct my agent to demand non-pharmacologic comfort-focused care. Psychotropic drugs are ineffective for treating dementia and have side effects, including possible death, that I wish to avoid. I have determined that non-pharmacologic treatment that considers behavior as communication and focuses on making me feel secure, comfortable, valued, and happy, is best for my quality of life.

Music & Memory: Listening to music, using headphones if needed, is important to me and will likely enhance my health and well-being. For people with dementia, music can produce responsiveness that other modes of communication do not. I direct that I be given ample opportunities to listen to music that I like. The following is a list of genres or artists that I enjoy:

(2.3) OTHER WISHES: If you wish to write your own end-of-life preferences, or add other personal wishes to the instructions given above, you may do so here:

Part 3 – Donation Of Organs At Death

Upon my death, I agree to give any needed organs, tissues, or parts as anatomical gifts.

If you disagree and do NOT want to make anatomical gifts, initial here: _____

If you want to limit your anatomical gifts in some way, please state your restrictions on the following lines:

Part 4 – Primary Physician (Optional)

I designate the following physician as my primary care physician:

Name of Physician: _____

Address: _____

Telephone: _____

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: _____

Telephone: _____

Part 5 – Signature

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

(5.2) REVOCATION OF PRIOR DIRECTIVES: I hereby revoke any and all prior living wills, Powers of Attorney for Health Care, and Advanced Health Care Directives made by me.

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

Date: _____

Name: _____ _____

(sign) (print)

Address: _____

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 has been proven to me by convincing evidence (A valid state driver's license, identification card, passport, or other official legal identification), (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 (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 a residential care facility for the elderly.

FIRST WITNESS		SECOND WITNESS	
Signature	_____	Signature	_____
Name	_____	Name	_____
Address	_____	Address	_____
Date	_____	Date	_____

ADDITIONAL STATEMENT OF WITNESSES: At least one of the above witnesses must also sign the following declaration:

I further declare under penalty of perjury under the laws of California that I am not related to the individual exercising 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 the operation of law.

Signature of Witness: _____

Signature of Witness: _____

Part 6 – 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 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 California that I am a patient advocate ombudsman as designated by the State Department of Aging and that I am serving as a witness for the advance directive of

_____, as required by Section
(printed name of principal)

4675 of the Probate Code.

Date: _____

Name: _____ _____
(sign) (print)

Address of Patient Advocate or Ombudsman: _____

_____

Part 7 - Certificate Of Acknowledgment Of Notary Public

Acknowledgment before a notary public is not required if you have two qualified witnesses. If you are a patient in a skilled nursing facility and you choose to use the notarization option, you must have a patient advocate or ombudsman sign the STATEMENT OF PATIENT ADVOCATE OR OMBUDSMAN in Part 6 above.

A notary public or other office 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.

State of California _____)

County of _____)

On _____

personally appeared _____ (notary),

personally appeared _____, who 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 acted, executed the instrument.

I certify under PENALTY OF PERJURY under the State of California that the foregoing paragraph is true and correct.

WITNESS my hand and official seal

Signature _____ (seal)

Notary Public