CALIFORNIA
Advance Directive
Planning for Important Healthcare Decisions

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

Caring Connections, 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.

Caring Connections tracks and monitors all state and federal legislation and significant court cases related to end-of-life care to ensure that our advance directives are up to date.

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 healthcare providers
Engage in personal or community efforts to improve end-of-life care

Using these Materials

BEFORE YOU BEGIN

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

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

3. You may want to photocopy these forms before you start so you will have a clean copy if you need to start over.

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

5. 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.

6. 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, healthcare providers and/or faith leaders so that the form is available in the event of an emergency.

CALIFORNIA ADVANCE HEALTHCARE DIRECTIVE - PAGE 1 OF 8

Explanation

You have the right to give instructions about your own healthcare. 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; and
(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 the disposition of your 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 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 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 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)

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

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 individual you choose as first alternate agent)

_____
(address)

_____
(city) (state) (zip code)

_____
(home phone) (work phone)

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

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:

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

_____
(address)

_____
(city) (state) (zip code)

_____
(home phone) (work phone)

ADD PERSONAL INSTRUCTIONS 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 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.

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

ADDITIONAL INSTRUCTIONS (IF ANY)

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**)

[ ] (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:

____

____

____

(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.)

ORGAN DONATION (OPTIONAL)

MARK THE BOX THAT AGREES WITH YOUR WISHES ABOUT ORGAN DONATION

PART 3: DONATION OF ORGANS AT DEATH
(OPTIONAL)

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

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

OR

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

[ ] (c) 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.

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

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

_____ _____

(date) (sign your name)

_____

(print your name)

_____

(address)

_____

(city) (state) (zip code)

WITNESSING PROCEDURE

(14) WITNESSES: This advance health care directive will not be valid for making health care decisions unless it is either:

(1) signed by two (2) qualified adult witnesses who are personally known to you and who are present when you sign or acknowledge your signature; or
(2) acknowledged before a notary public.

BOTH OF YOUR WITNESSES MUST AGREE WITH THIS STATEMENT

ALTERNATIVE NO. 1
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.

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

First Witness:

_____ _____

(date) (signature of witness)

_____

(printed name of witness)

_____

(address)

_____

(city) (state) (zip code)

Second Witness:

_____ _____
(date) (signature of witness)

_____
(printed name of witness)

_____
(address)

_____
(city) (state) (zip code)

ONE OF YOUR WITNESSES MUST ALSO AGREE WITH 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.

HAVE ONE OF YOUR WITNESSES ALSO SIGN AND DATE THIS SECTION AND PRINT THEIR NAME AND ADDRESS

_____ _____
(date) (signature of witness)

_____
(printed name of witness)

_____
(address)

_____
(city) (state) (zip code)

OR

ALTERNATIVE NO. 2: NOTARY PUBLIC

A NOTARY PUBLIC SHOULD FILL OUT THIS SECTION OF YOUR DOCUMENT

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 IS TO BE COMPLETED ONLY 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 Connections
1731 King St., Suite 100, Alexandria, VA 22314
www.caringinfo.org, 800/658-8898

You Have Filled Out Your Advance Directive, Now What?

1. Your California Advance Healthcare 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(s), doctor(s), family, close friends, clergy and anyone else who might become involved in your healthcare. 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 and alternate 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. If you want to make changes to your document after it has been signed and witnessed, you should complete a new document.

5. Remember, you can always revoke one or both sections of your California Advance Healthcare Directive.

6. Be aware that your California document will not be effective in the event of a medical emergency. Ambulance personnel are required to provide cardiopulmonary resuscitation (CPR) unless they are given a separate order that states otherwise. These orders, commonly called “non-hospital do-not – resuscitate orders, “ are designed for people whose poor health gives them little chance of benefiting from CPR. These orders must be signed by your physician and instruct ambulance personnel not to attempt CPR if your heart or breathing should stop.

Currently not all states have laws authorizing non-hospital do-not-resuscitate orders. We suggest you speak to your physician for more information. **Caring Connections does not distribute these forms.**