

# **INTRODUCTION TO ADVANCE HEALTH CARE DIRECTIVES**

## **What is an Advance Health Care Directive?**

An Advance Health Care Directive (Advance Directive) is a document in which you give instructions about your health care if, in the future, you cannot speak for yourself. You can give someone you name (your “agent”) the power to make health care decisions for you. You also can give instructions about the kind of health care you do or do not want.

In a traditional Living Will, you state your wishes about life-sustaining medical treatments if you are terminally ill. In a Health Care Power of Attorney, you appoint someone else to make medical treatment decisions for you if you cannot make them for yourself.

The Advance Directive combines and expands the traditional living Will and Health Care Power of Attorney into a single comprehensive document.

## **Which of these documents is recognized in California?**

The Advance Directive replaced both the Living Will and the Health Care Power of Attorney as the legally recognized document in California. It is the legally recognized format for the living will replacing the Natural Death Act Declaration. It also replaced the Durable Power of Attorney for Health Care as the legally recognized document for appointing an agent.

## **What is the Advantage of having an Advance Directive?**

Unlike most Living Wills, an Advance Directive is not limited to cases of terminal illness. If you cannot make or communicate decisions because of a temporary or permanent illness or injury, an Advance Directive helps you keep control over health care decisions that are important to you. In your Advance Directive, you state your wishes about any aspect of your health care, including decisions about life-sustaining treatment, and choose a person to make and communicate these decisions for you.

Appointing an agent is particularly important. At the time a decision needs to be made, your agent can participate in discussions and weigh the pros and cons of treatment decisions based on your wishes. Your agent can decide for you wherever you cannot decide for yourself, even if your decision-making ability is only temporarily affected.

Unless you formally appoint someone to decide for you, many health care providers and institutions will make critical decisions for you that might not be based on your wishes. In some situations, a court may have to appoint a conservator unless you have an advance directive.

An advance directive can relieve family stress. By expressing your wishes in advance, you help family or friends who might otherwise struggle to decide on their own what you would want done.

## **How Do I Appoint My Health Care Agent?**

Part I of this form is a Power of Attorney for Health Care. This is where you appoint an agent who will make health care decisions for you if you cannot decide for yourself. You can define how much or how little authority you want to give. You can name persons to act as alternate agents if your primary agent cannot act. You can also state when your agent's authority becomes effective.

## **Who May I Appoint As My Health Care Agent?**

You can appoint any adult over the age of 18 years to be your agent. You can choose an adult relative or any other person you trust to speak for you with exceptions. The law prohibits you from choosing certain people as your agent.

You **may not choose** your doctor, or a person who operates a community care facility or a residential care facility in which you receive care. The law also prohibits you from appointing a person who works for the health facility in which you are being treated or the community care or residential care facility in which you receive care, unless that person is related to you blood, marriage, adoption, or is a co-worker.

## **How Do I State What My Wishes Are?**

You can provide specific instructions about your health care treatment in Part II of the Advance Directive. Your instructions provide evidence of your wishes to your agent, or anyone providing you with medical care.

## **What if I Change My Mind, Can I Cancel or Change a Advance Directive?**

An Advance Directive is valid forever, unless you revoke it or state a specific date on which you want it to expire. If you decide to cancel or change it, tell your agent or health care provider in writing of your decision to do so. Destroy all copies of the old one and create a new one. Make sure you give a copy of the new one to your agent, your physician, and anyone else who received the old one.

## **What Do I Need to Consider Before Making a Advance Directive?**

**First** - What Are Your Goals for Medical Treatment: While it is impossible to anticipate all of the different medical decisions that may come up, you can make your preferences clear by stating your goals for medical treatment. Once you have stated your goals of treatment, your family and physicians can make medical decisions for you on the basis of your goals. For example, if treatment would help achieve one of your goals, the treatment would be provided. If treatment would not help achieve one of your goals, the treatment would not be provided.

**Second** - Who Should Be Your Agent? Choosing your agent is the most important part of this process. Your agent will have great power over your health and personal care. Choose one person to serve as your agent to avoid disagreements. If possible, appoint at least one alternate agent in case your primary agent is not available. Speak to your agent beforehand to explain your goals. Confirm their willingness to act for you and their understanding of your wishes. If you do not appoint an agent, make sure that you provide instructions that will guide your doctor or court-appointed decision maker.

**Third** - How Specific Should You Be? If you have specific wishes or preferences it is important that you spell them out in the document. It is impossible to predict all the circumstances you may face. Write instructions carefully so they do not restrict the authority of your agent in ways you did not intend. **For example** a simple statement like “ I never want to be placed on a ventilator” may not reflect your true wishes. You might want ventilator assistance if it were temporary and you then could resume your normal activities.

## **What Happens If I Do Not Have An Advance Directive?**

If you do not have an advance directive and you cannot make health care decisions, some state laws give decision-making power to default decision-makers or “surrogates.” These surrogates, who are usually family members in order of kinship, can make some or all health care decisions. Some states authorize a “close friend” to make decisions, but usually only when family members are unavailable.

Even without such statutes, most doctors and health facilities routinely consult family, as long as there are close family members available and there is no disagreement. However, problems can arise because family members may not know what the patient would want in a given situation. They also may disagree about the best course of action. Disagreement can easily undermine family consent. A hospital physician or specialist who does not know you well may become your decision-maker, or a court proceeding may be necessary to resolve a disagreement.

In these situations, decisions about your health care may not reflect your wishes or may be made by persons you would not chose. Family members and persons close to you may go through needless agony in making life and death decisions without your guidance. It is far better to make your wishes known and appoint an agent ahead of time through a Health Fare Advance Directive.

## **Who Can Help Me Create a Advance Directive?**

You do not need a lawyer to make a Advance Directive. However, a lawyer can be helpful if your family situation is uncertain or complex, or you expect problems to arise. Your doctor is also an important participant in creating your Advance Directive. Discuss the kinds of medical problems you may face, based on your current health and health history. Your doctor can help you understand the treatment choices your agent may face. Share your ideas for instructions with your doctor to make sure medical care providers can understand them.

## **Once I Fill out the Form, What Should I Do with It?**

Keep in the original in a safe place and tell someone (family, friend, agent) where it is kept. Give copies of the completed form to the people you have appointed as your agent, alternate agents, doctor, health plan, family members, or anyone else who is likely to be called if there is a medical emergency. *Tell them to present a copy of the form at the request of your health care providers or emergency medical personnel.*

Take a copy of the form when admitted to the hospital, nursing home, or other health care facility. **Copies can be relied upon by your agent and doctors as though they were the original.**

Fill out a contact list, include the name, address, telephone, fax, and cell number for each person or facility that you gave a copy of your Advance Directive form.

## **ADVANCE HEALTH CARE DIRECTIVE**

**(California Probate Code Section 4701)**

### **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.**

**Part 1** of this form is a *Power of Attorney for Health Care*. This 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.*

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:***

- (1) Consent or refuse consent to any care, treatment, service, or procedure to maintain, diagnose, or otherwise affect a physical or mental condition.
- (2) Select or discharge health care providers and institutions.
- (3) Approve or disapprove diagnostic tests, surgical procedures, and programs of medication.
- (4) Direct the provision, withholding, or withdrawal of artificial nutrition and hydration and all other forms of health care, including cardiopulmonary resuscitation.
- (5) Make anatomical gifts, authorize an autopsy, and direct disposition of remains.

**Part 2** of this form is your *Instructions for Health Care*. 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 decide 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. This is optional.

**Part 4** of this form lets you designate a physician to have primary responsibility for your health care. This is optional.

**Part 5** of this form has several statements. The first revokes prior Advance Directives that you may have executed. The second discusses the validity of copies of this document. Finally, the third allows you to insert the number of additional pages that you may have added to this document.

**Part 6** is where you execute the document with your signature.

**Part 7** is where your witnesses sign and at least one makes a declaration regarding their qualification to witness this document.

**Part 8** is required when you are a patient in a skilled nursing facility. A patient advocate or ombudsman is required to make a declaration.

**Part 9** is the acknowledgment by a notary if you do not have two witnesses.

**The form must be signed by two qualified witnesses or acknowledged before a notary public.**

**REMEMBER TO:**

*(1) 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.*

*(2) 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.*

*(3) Attach additional sheets of specific instructions to this document. Sign and date on the day that you sign this directive and indicate how many pages you have added.*

**\*\*\*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**

**(1.1) DESIGNATION OF AGENT:** I designate the following individual as my agent to make health care decisions for me:

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*(name of individual you choose as agent)*

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*(address)                      (city)                      (state)                      (zip code)*

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*(home phone)                      (work phone)                      (cell Phone)*

**OPTIONAL: FIRST ALTERNATE AGENT:** 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:

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*(name of individual you choose as first alternate agent)*

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*address)                      (city)                      (state)                      (zip code)*

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*(home phone)                      (work phone)                      (cell phone)*

**OPTIONAL, SECOND ALTERNATE AGENT::** 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:

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*(name of individual you choose as second alternate agent)*

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*(address)                      (city)                      (state)                      (zip code)*

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*(home phone)                      (work phone)                      (cell phone)*

**(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 healthcare to keep me alive, **except as I state here:**

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(If you add additional sheets please date, sign and secure to this document)

**(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 *unless I have signed the following statement.*

**OPTIONAL, AGENTS AUTHORITY BECOMES EFFECTIVE IMMEDIATELY: I want my agent's authority to make healthcare decisions for me to start now, even though I am able to make them for myself. I understand and authorize this statement as proved by my signature.** \_\_\_\_\_

*(signature)*

**(1.4) 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.

**(1.5) AGENT'S POST DEATH 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:

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(If you add additional sheets please date, sign and secure to this document)

**(1.6) 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.

**PART 2**  
**HEALTH CARE INSTRUCTIONS**

**If you fill out this part of the form, you may strike any wording you do not want.**

**(2.1) 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 (*check only one and initial*):

\_\_\_\_\_ **(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. \_\_\_\_\_ (*Initial here if this is your choice*)

\_\_\_\_\_ **(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. (*Initial here if this is your choice*)

**(2.2) RELIEF FROM PAIN:** Except as I state in the following space, I direct that treatment for alleviation of pain or discomfort be provided at all times, even if it hastens my death:

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(If you add additional sheets please date, sign and secure to this document)

**(2.3) 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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(If you add additional sheets please date, sign and secure to this document)

**PART 3  
DONATION OF ORGANS AT DEATH (OPTIONAL)**

**Initial one choice:**

\_\_\_\_ I do not wish to be an organ donor

\_\_\_\_ I wish to be an organ donor. See my driver=s license or the following specific instructions.  
If I have initialed any of the following I direct my agent upon my death to:

**Initial one choice:**

\_\_\_\_ 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 (Indicate by initialing your choice

\_\_\_\_ 1) Transplant                      \_\_\_\_ (2) Therapy                      \_\_\_\_ (3) Research  
\_\_\_\_ (4) Education                      \_\_\_\_ (5) Any purpose (Agent=s discretion)

**PART 4  
PRIMARY PHYSICIAN (OPTIONAL)**

**(4.1) I designate the following physician as my primary physician:**

\_\_\_\_\_  
*(name of physician)*

\_\_\_\_\_  
*(address)    (city)    (state)    (zip code)*

\_\_\_\_\_  
*(phone)*

**(4.2) ALTERNATE PRIMARY PHYSICIAN:** (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)*

**PART 5**  
**REVOCAION OF PRIOR DIRECTIVES, EFFECT OF COPIES & ADDITIONAL PAGES**

**(5.1) PRIOR DESIGNATIONS REVOKED.** I revoke any prior durable power of attorney for health care.

**(5.2) EFFECT OF COPY:** My agent and others may use copies of this document as though they were originals. A copy of this form has the same effect as the original.

**(5.3) STATEMENT REGARDING ADDITIONAL PAGES:** I have added \_\_\_\_\_ pages(s) of specific health care instructions to this directive, each of which is signed and dated on the same day I signed this directive.

**PART 6**  
**DATE AND SIGNATURE OF PRINCIPAL**

I sign my name to and acknowledge this Advance Health Care Directive:

\_\_\_\_\_ on \_\_\_\_\_  
(signature) (date)

at \_\_\_\_\_  
(address) (city) (state) (zip code)

**PART 7**  
**STATEMENT OF WITNESS**

**(7.1) EVIDENCE OF IDENTITY:** (READ CAREFULLY BEFORE SIGNING). You can sign as a witness only if you personally know the principal or the identity of the principal is proved to you by convincing evidence. To have convincing evidence of the identity of the principal, you must be presented with and reasonably rely on any one or more of the following:

1. An identification card or driver's license issued by the California Department of Motor Vehicles that is current or has been issued within five years.
2. A passport issued by the Department of State of the United States that is current or has been issued within five years.
3. Any of the following documents if the document is current or has been issued within five years and contains a photograph and description of the person named on it, is signed by the person, and bears a serial or other identifying number:
  - a. A passport issued by a foreign government that has been stamped by the United States Immigration and Naturalization Service.
  - b. A driver's license issued by a state other than California or by a Canadian or Mexican public agency authorized to issue drivers' licenses.
  - c. An identification card issued by a state other than California.
  - d. An identification card issued by any branch of the armed forces of the United States.

4. If the principal is a patient in a skilled nursing facility, a witness who is a patient advocate or ombudsman may rely upon the representations of the administrator or staff of the skilled nursing facility, or of family members, as convincing evidence of the identity of the principal if the patient advocate or ombudsman believes that the representations provide a reasonable basis for determining the identity of the principal.

**Other kinds of proof of identity are not allowed.**

**(7.2) 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 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 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.

First witness	Second witness
(print name)	(print name)
(signature of witness)	(signature of witness)
(address)	(address)
(city)                      (state)	(city)                      (state)
(date)	(date)

**(7.3) 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 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.***

(print name)	(signature of witness)
(print name)	(signature of witness)

