

CALIFORNIA POWER OF ATTORNEY FOR HEALTH CARE AND HEALTH CARE DIRECTIVE

NOTE: COMPLETION OF THIS FORM IS ONLY THE FIRST STEP.

YOU SHOULD DISCUSS YOUR WISHES IN DETAIL WITH YOUR DESIGNATED AGENT(S).

• **WITH THIS FORM YOU MAY DO ANY OR ALL OF THE FOLLOWING:**

1. **NAME AN AGENT TO MAKE HEALTH CARE DECISIONS FOR YOU IF YOU CANNOT.**
 2. **INSTRUCT DOCTORS AND OTHER HEALTH CARE PROFESSIONALS HOW YOU WOULD LIKE TO BE TREATED IF YOU ARE HURT OR SERIOUSLY ILL AND UNABLE TO TELL THEM YOUR WISHES.**
- **READ THE FORM CAREFULLY. CROSS OUT ANY PROVISION YOU DO NOT WANT.**
 - **THIS FORM REVOKES ANY PRIOR DIRECTIVES YOU HAVE MADE.**
 - **AFTER YOU COMPLETE THIS FORM SIGN AND DATE IT. TWO WITNESSES OR A NOTARY MUST ALSO SIGN AND DATE IT.**

My name is: _____

also known as/formerly known as: _____

In this document I appoint an agent. That agent will make health care decisions for me in the future, if and when I no longer have the capacity to make my own health care decisions. My primary care physician will determine when I am unable to make my own health care decisions.

OPTIONAL: I want my agent's authority to make health care decisions for me to take effect immediately.

Initial here if this statement reflects your desires:

Part 1 - NAMING YOUR AGENT (If you do not have an agent, please proceed to Part 2 on page 3.)

Do not select any of the following persons as your agent or alternate agent:

- *Your primary physician.*
- *An employee or operator of the health care institution, community care facility, or residential care facility where you receive care (unless you are related to that person).*

AGENT

Name: _____

Address: _____
City State Zip

Phone: () _____ Alt. Phone: () _____ Email: _____

1ST ALTERNATE AGENT (If Agent is not reasonably available to make a health care decision for me.)

Name: _____

Address: _____
City State Zip

Phone: () _____ Alt. Phone: () _____ Email: _____

2ND ALTERNATE AGENT (If Agent and 1ST Alternate Agent is not reasonably available to make a health care decision for me.)

Name: _____

Address: _____
City State Zip

Phone: (____) _____ Alt. Phone: (____) _____ Email: _____

AGENT'S AUTHORITY

Except as limited by this document, my agent will have authority to make all health care decisions for me. This authority includes, but is not limited to, the authority 1) to accept or refuse treatment, nutrition and hydration, 2) to choose a particular physician or health care facility, and 3) to receive, or consent to the release of, medical information and records.

Agent's Post Death Authority: My agent is authorized to donate all or part of my body, to authorize an autopsy and/or determine the disposition of my remains. The agent's actions must be consistent with my will or trust, and with any arrangements which I have made. (Cross this out if you do not wish your agent to have this authority.)

Agent's Authority Under HIPAA & CMIA: My agent shall be my personal representative under HIPAA and legal representative under CMIA and shall have the same rights to inspect, obtain and disclose my protected health information as I have.

AGENT'S OBLIGATIONS

1. My agent shall make decisions for me in accordance with this power of attorney, other instructions I make in this form and my personal wishes, to the extent my agent knows them. If my wishes on a subject are not known, my agent shall make health care decisions for me consistent 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 by my agent.
2. My agent shall provide a copy of this advance health care directive to any health care provider or facility that takes on responsibility for my care.

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 here if this statement reflects your desires:

Part 2 - HEALTH CARE INSTRUCTIONS I make the following health care instructions to my agent, or to my health care provider if my agent is not reasonably available or I do not have an agent:

I do not want efforts made to prolong my life and I do not want life-sustaining treatment to be provided or continued:

- (1) If I am in an irreversible coma or persistent vegetative state; or
- (2) if I am terminally ill and the use of life sustaining procedures would serve only to artificially delay the moment of my death; or
- (3) under any other circumstances where the burdens of treatment outweigh the expected benefits.

In making decisions about life sustaining treatment under (3) above, I want my agent or health care provider to consider the relief of suffering and the quality of my life as well as the extent of the possible prolongation of my life.

Initial here if this statement reflects your desires:

I authorize all treatments to prolong my life for as long as possible.

Initial here if this statement reflects your desires:

Other instructions/authorizations:

REVOCATION OF PREVIOUS DOCUMENTS: I revoke any previously-executed Power of Attorney for Health Care, Individual Health Care Instruction, or Natural Death Act Declaration.

SIGNATURE OF PRINCIPAL (Sign and date form here in front of witnesses or a notary.)

Date: _____ Signature: _____

(If principal is not physically able to sign, he or she can instruct another person to sign the principal's name, if signature is done in the principal's presence.)

STATEMENT OF WITNESSES

This document must either be notarized, or signed by two witnesses. 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. 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
- (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.

First Witness: _____
Name (printed) *Signature*

Date: _____ Address: _____
City *State* *Zip*

Second Witness: _____
Name (printed) *Signature*

Date: _____ Address: _____
City *State* *Zip*

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 operation of law.

Date: _____ Signature: _____

DECLARATION OF OMBUDSMAN PROGRAM REPRESENTATIVE

(Required 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.

Date: _____ Signature: _____

CERTIFICATE OF ACKNOWLEDGMENT OF NOTARY PUBLIC (Not required if two-witness method is followed.)

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

State of California, County of _____

On _____ before me, (name and title of officer) _____,

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(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 _____

**NOTE: USE OF THIS FORM IS NOT APPROPRIATE FOR EVERY PERSON OR EVERY SITUATION.
 FOR MORE INFORMATION ABOUT POWERS OF ATTORNEY FOR HEALTH CARE, CONSULT WITH AN ATTORNEY.**