Chapter Nine

Planning For (And Dealing With) Incapacity

This chapter was originally prepared in part by Janet Morris of Bet Tzedek Legal Services. Much of the material is drawn from the "Residents' Health Care Decision Making" chapter of the ***Nursing Home Companion*** *published by Bet Tzedek Legal Services which can be ordered from Bet Tzedek by calling (323) 549-5897.*

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Health Care Decisions

Benefits of Advance Planning

An individual has the ability and the right to make her own health care decisions as long as she is of sound mind. If, however, she lacks capacity (due to a stroke, coma, disease, or accident), she legally can receive health care only if the care is authorized by her legal representative, or she previously had executed adequate written instructions. Capacity is the ability to understand the nature and consequences of the proposed health care, and the ability to communicate decisions.

Documents for Advance Planning

California law authorizes three types of documents for advance planning of health care.

- ***Advance Health Care Directive:*** This is the official new name for advance directives executed after July 1, 2000. It has two parts: (1) the "Power of Attorney for Health Care" allows a person to appoint an agent; and (2) the "Instruction for Health Care," which describes a person's wishes regarding end-of-life care. This form replaces all older forms. Other optional terms may also be included, if decided (e.g., designation of primary care physician, personal care powers and requests, giving the right to visit, etc).

- ***Durable Power of Attorney for Health Care:*** Until June 2000, California law specifically authorized a Durable Power of Attorney for Health Care, and all such documents executed prior to that date are still valid (as well as pre-printed forms from prior to July 2000). These documents allowed one to appoint an agent (and alternates) to make health care decisions in the event one became incapacitated. Optional provisions also allowed one to state one's wishes regarding terminal illness, autopsy, donation of organs, and other specific instructions.

- ***Request Regarding Resuscitative Measures:*** As the name suggests, these documents are used to specify a person's wishes regarding CPR and other resuscitative measures. They are signed both by the person (or the person's authorized agent) and the person's physician. There are two types of these documents: 1) the POLST form (Physician Order for Life-Sustaining Treatment) and 2) the Pre-Hospital Do Not Resuscitate (DNR) form. The POLST form is useful broadly in hospitals and other health care settings. The Pre-Hospital DNR form is useful primarily with paramedics for persons who are living at home, or in assisted living facilities or other community care settings.

In addition to the three documents listed above, a "living will" often is mentioned. This is a general, non-California term used for instructions that set forth wishes regarding life support. In California, an Advance Health Care Directive format should now be used, where possible.

NOTE*: The Bet Tzedek form appears at page 9-20 et seq. Although it is titled "California Power of Attorney for Health Care," this form is an up-to-date Advance Health Care Directive as discussed in this chapter.*

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Why Appoint a Representative?

An individual of any age may become incapacitated or be in a life-threatening accident in the future. Consequently, an individual should prepare now to assure that she receives appropriate health care if she ever becomes incapacitated and unable to communicate about health care decisions.

If an individual has no legal representative when the individual becomes incapacitated and unable to communicate, she may not be able to receive needed medical treatment. Likewise, an individual without a legal representative may not be able to refuse medical treatment, which will only prolong the individual's treatment, even if she has no real prospect of recovery.

On the other hand, if a legal representative has been appointed to make health care decisions for a mentally incapacitated individual, those decisions can be made in a way most consistent with the individual's expressed desires.

TIP: *Every mentally competent adult, regardless of age or health, should select a health care agent and complete an Advance Health Care Directive.*

How to Appoint Another Person to Make Health Care Decisions

In California, an adult of sound mind can create an advance health care directive, which is a legally binding document that allows the person appointed (the "agent") to make health care decisions for the individual if the individual becomes unable to make such decisions. The Advance Health Care Directive thus allows a physician, hospital, or nursing home to receive clear instructions, even if the individual no longer can make health care decisions.

Whom to Select as Agent

An individual probably should select an agent who knows the individual well, can follow the individual's wishes, and can discuss life and death issues with the individual. The agent can be a family member, friend, or other person. The agent cannot be a health care provider to the individual.

The individual should always select one or two alternate agents in case the primary agent is unable or unwilling to act. It is not a good idea to appoint co-agents; appointing a primary agent and alternates is preferred. The doctor will go down the list to find the first available agent.

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Instructions to Agent

Common forms for an Advance Health Care Directive provide an optional section in which an individual can declare her desire to receive or not receive life-sustaining treatment under certain conditions. These optional sections also often provide space for an individual to list any instructions relating to health care decisions that she wishes to express.

In addition to written instructions, an individual should discuss her desires with the agent. Discussing health care decisions now, while the individual is able to explain her desires, can give the agent a greater sense of comfort about difficult decisions that may have to be made in the future. Your Way, a helpful guide to discussing and choosing future health care, is available from the Healthcare and Elder Law Programs Corporation (H.E.L.P.) of Torrance, California, (310) 533-1996.

NOTE: *An individual should discuss personal desires and beliefs with her health care agent.*

Decisions That Can Be Made By Agent

An Advance Health Care Directive allows an agent to make any and all health care and treatment decisions for an incapacitated individual, or one who is unable to communicate, subject to the individual's instructions listed in the Advance Health Care Directive. The agent can consent to diagnostic procedures and surgery, and (as discussed later in this chapter) decide whether to withhold or withdraw life-sustaining procedures and make other personal health-related decisions subject to the principal's instructions.

Instructions Without Appointing an Agent

An Advance Health Care Directive enables an individual to state her desires about future health care even without an agent. These instructions must be honored by future health care providers, if at that time the individual no longer is capable of making her own health care decisions.

To give adequate direction to those health care providers, the individual should list her instructions as specifically as possible.

EXAMPLE

Q. What are some optional provisions that can be included in an Advance Health Care Directive?

A. California allows the statement of additional medical treatment desires and specific health care instructions to be added to the Advance Health Care Directive. Some optional provisions include:

- *Naming primary physician*
- *Giving the power to make personal care decisions (e.g., arranging where to live and how meals will be provided; and arranging household help, transportation, mail, recreation and entertainment)*
- *Giving non-immediate family members the right to visit in the hospital (e.g., "I wish for Mrs. Jones to have the same visitation rights as my immediate family.")*
- *Adding a No-Contest Clause if the choice of agent is likely to be controversial (e.g., "If anyone contests my choice of agent, that individual shall be disqualified from acting as my agent.")*
- *Nominating a conservator (and alternatives) of the person and/or estate should one become necessary*

If there is insufficient space in the form to add desired provisions, make an attachment on a new page and reference it (e.g., "See Attachment A for my additional instructions.").

Witnessing Requirements

An Advance Health Care Directive must be witnessed by two qualified adult witnesses or notarized. If the document is being signed by an individual who is a nursing home resident, the document also must be witnessed by a representative of the Ombudsman Program, either as one of the two adult witnesses or in addition to the notarization. (The telephone numbers for the Ombudsman Program are listed as an appendix to Bet Tzedek Legal Service's Nursing Home Companion, and are available online at *http://www.aging.ca.gov/programs/LTCOP/Contacts/*).

A witness cannot be the appointed agent or the individual's physician. At least one of the two witnesses must be someone who is neither related to the individual, nor entitled to any of the individual's property after the individual's death.

Do-It-Yourself Forms

Although attorneys prepare Advance Health Care Directives, they also can be completed with a relatively inexpensive fill-in-the-blanks form. If an individual's desires are relatively straightforward, a form document generally is adequate. A mentally competent individual can complete a form simply by following the directions on the form. Some hospitals and health plans provide them at no cost.

A form can be obtained from Bet Tzedek Legal Services, (323) 939-0506 or (818) 769-0136, the California Medical Association (forms in English or Spanish), (800) 882-1262, or from the Healthcare and Elder Law Programs Corporation (H.E.L.P.), *www.help4srs.org.*

California residents should be sure to use forms that comply with California law as each state has its own laws governing advance directives.

What is HIPAA?

The Health Insurance Portability and Accountability Act of 1996, requires health care providers to follow strict rules regarding patients' medical information. California law provides that an agent appointed under an AHCD (or a Power of Attorney for Health Care) can access patient records. Many of the newer AHCDs include a specific HIPAA provision.

How Long Are Documents Effective?

Once completed, an Advance Health Care Directive remains effective indefinitely. While the individual is of sound mind, she may revoke the document at any time. It is best to revoke an Advance Health Care Directive in writing, and to provide an updated document to all persons and institutions who had the old documents, so there can be no confusion.

TIP: *Make multiple copies of health care documents and distribute them to family, friends, physicians, hospitals, HMOs, and other health care personnel and facilities.*

Letting Others Know

An individual should give copies of an Advance Health Care Directive to family members and to her physician and hospital. Under California law, a copy is just as authoritative as an original. It is a good idea to keep a list of all persons and institutions who receive a copy.

An individual also can register the document with the California Secretary of State ((916) 653-3984) for a cost of $10. See*: http://ahcdr.cdn.sos.ca.gov/forms/sfl-461.pdf*. If an individual has appointed an agent through an Advance Health Care Directive, the individual should prepare a card that lists the telephone number(s) of the individual's agent(s), and keep the card in her wallet or purse.

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Who Decides When an Individual Has Lost Capacity?

Unless otherwise specified in an Advance Health Care Directive, an individual's primary physician determines the individual's ability to make health care decisions.

Where can I get health care decision making forms?

- *Bet Tzedek Legal Services (323) 939-0506 or (818) 769-0136*
- *H.E.L.P. (310) 533-1996; www.help4srs.org*
- *California Medical Association (800) 882-1262*
- *Hospitals and other health care providers*

Must Physicians Comply With Agent's Decisions?

A physician or other health care provider must comply with the decisions of a legally appointed agent or with a written instruction, with three rare exceptions. A health care provider is not required to obey a request for health care if that health care is (1) medically ineffective; (2) contrary to generally accepted health care standards; or (3) contrary to a conscience-based policy of the provider. A provider must give a patient clear advance notice of any conscience-based policies that may affect the provision of care. A provider who refuses the request of a patient or agent must also arrange for transfer of the patient to another provider or facility who will provide the care requested.

If a health care provider refuses to obey an appropriate decision or instruction, and none of the three above-described exceptions apply, the provider is liable for $2,500 or actual damages, whichever is greater, and must pay the other party's attorney's fees.

Q. What happens at the time of death of the individual?

A. An Advance Health Care Directive may allow the agent to make certain provisions after the death of the individual, if specifically provided for in the document.

This includes the following:

- *making a disposition under the Uniform Anatomical Gift Act;*
- *authorizing an autopsy; and/or*
- *directing the disposition of remains.*

Family's Rights If No Agent Was Appointed

According to California case law, the nearest relative of an individual who is unable to communicate can make the health care decisions for that individual if no one else has been appointed to make those decisions. This case law, however, does not give a relative any formal documentation of her authority over the incapacitated individual's health care decisions. As a result, a health care provider often is hesitant to accept the health care decision of the nearest relative of an incapacitated individual, unless the proper decision is obvious or unless the entire family of the incapacitated individual agrees with the decision of the nearest relative.

This law applies to domestic partners as well as spouses.

Conservatorships

When a difficult health care decision must be made for an incapacitated individual, or when the family members and friends of an incapacitated individual disagree on the proper medical treatment, a family member or friend should seek formal, documented authority to make health care decisions on behalf of the individual. The family member or friend can petition the court: (1) to be appointed conservator over the individual; or (2) to be given authority to make a particular health care decision for the individual.

If there is no family, a private professional conservator or the Public Guardian can be appointed by the court. Their fees are paid by the incapacitated individual's estate.

In a conservatorship, a court appoints someone to act indefinitely on behalf of an incapacitated adult. The person appointed (the "conservator") can be given the power to determine the medical treatment, residence, and/or finances of the incapacitated adult (the "conservatee").

If an incapacitated individual does not need an ongoing conservator, a family member, friend, or other interested person can petition a court for authority over a particular health care decision of the individual. Unlike a conservatorship, this procedure cannot give a family member or friend authority over the individual's residence or finances, and expires at the conclusion of the particular medical treatment.

A family member or friend desiring a conservatorship or a particularized authorization should consult an attorney.

TIP: *To have health care wishes carried out, it is best to put them in writing.*

End Of Life Decision-Making

Refusing Treatment

In California, any competent adult has the right to refuse medical treatment just as they have the right to accept any given medical treatment. Case law defines medical treatment to include "furnishing food and water," even if such refusal causes death. The agent under a Power of Attorney for Health Care has the same rights as the principal to accept or refuse treatment subject to the known wishes or instructions of the principal.

A person (or the person's authorized agent) can specify the person's wishes through a POLST form (Physician Order for Life-Sustaining Treatment) and/or a Pre-Hospital Do Not Resuscitate (DNR) form. Each form must also be signed by the person's physician. These forms should be used when someone is terminally ill to supplement, but not to replace, an Advance Health Care Directive.

The POLST form is used chiefly in hospitals and other health care settings. The advantage is that the POLST form is an order and can be used and followed by health care personnel.

The Pre-Hospital DNR form is used with paramedics. Again, the advantage of the form is that it can be used and followed by health care personnel – in this case, the paramedics. The California Emergency Medical Services Authority has developed a form that is recognized by paramedics across the state. In addition to signing such a DNR form, a person can wear a DNR medallion that will be recognized and honored by paramedics. These medallions are available from Medic Alert.

NOTE: *POLST forms and DNR forms are not advance planning documents for healthy persons. The POLST and DNR forms are generally used near the end of life, and are not substitutes for Advance Health Care Directives.*

Many times an Advance Health Care Directive has instructions to forego life-sustaining treatment if the principal is terminally ill or will not benefit from such treatment. In the hospital setting, the agent can authorize palliative (comfort) care, a Do Not Resuscitate Order, and even withdraw life-sustaining treatments such as a feeding or breathing tube. It is sometimes necessary to convene a conference with the hospital's ethics committee or request the assistance of an attorney or patient advocate to enforce the principal's rights to stop active medical treatment. Some hospitals have their own Palliative Care departments, which should be called on for consultation with terminally ill patients.

If the patient is in an assisted living facility or at home, hospice care is a benefit which transitions the patient and family in the dying process and provides the assistance to the patient and family with bathing, nursing, pain control and spiritual support. Hospice care is usually delivered through a licensed hospice agency and is covered by Medicare, Medi-Cal, or private insurance. It requires a doctor's prescription to get started.

When a person chooses to live at home throughout their illness, it is a good idea to have a Pre-Hospital Do Not Resuscitate form signed, so that the patient is not unnecessarily resuscitated by emergency personnel. Most hospice agencies will coordinate and assist with this document.

Whether the decision is made by the patient, the patient's agent, conservator or family member, the patient's desires and choices should be of primary importance to create a peaceful end of life.

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End of Life Option Act

The End of Life Option Act was passed in California on October 5, 2015. California became the fifth state to allow physicians to prescribe medications to end the life of terminally ill patients.

The law (AB X2-14), goes into effect June 9, 2016 and ends on January 1, 2026 unless it is re-authorized.

In order to access the prescription from an attending physician, the patient must:

- Be diagnosed with a terminal illness
- Have medical decision-making capacity
- Be a California resident
- Comply with the request requirements (two oral and one written)
- Have the physical and mental ability to self-administer the aid-in-dying drug

Patient protections include specific requirements of the attending physician to ensure that the patient is making an informed decision. Under no circumstances can a surrogate (spouse, parent, conservator or power of attorney agent) make the request on behalf of the patient. A patient may withdraw or rescind his/her request and may decide not to ingest the drug. If the patient does decide to ingest the drug, he/she must complete a "Final Attestation for an Aid-in-Dying Drug to End my life in a Humane and Dignified Manner" form within 48 hours of taking it. The patient's family (or representative) is required to return that form to the physician who includes it in the patient's health record.

For additional information and resources:

California Medical Association Document 4459 The California End of Life Option Act *www.cmanet.org*

Compassion & Choices *https://www.compassionandchoices.org*

Paramedics and the Right to Die

A paramedic will perform life-sustaining treatment, unless the paramedic is shown that the individual has signed a "Pre-Hospital Do Not Resuscitate" form developed by the California Medical Association, or unless the individual is wearing a "Do Not Resuscitate" bracelet or medallion approved by a paramedic agency.

"Do Not Resuscitate" bracelets and medallions can be obtained from the MedicAlert Foundation ((888) 633-4298). These forms, bracelets, and medallions are honored by paramedics throughout California.

Refusing Teratment on Behalf of an Incapacitated Individual Without Written Advance Directive

A court-appointed conservator or the individual's nearest relative may be given authority to halt an individual's life-sustaining medical treatment. In addition, health care providers may accept informal, non-binding indications of an individual's treatment desires, although certainly many health care providers will demand formal written authority.

The Documentation of Preferred Intensity of Care Form is sometimes used by doctors to summarize the patient's or family's wishes about end-of-life care, especially if there is no legally designated agent or conservator. A preferred intensity of care form can be obtained through the California Medical Association by calling 1-800-882-1262.

Financial Decisions

Powers of Attorney for Finances

In a power of attorney for finances, an individual of sound mind selects an agent who will have authority to make the individual's financial decisions. Powers of attorney for finances should be signed and notarized.

It is best if a power of attorney for finances is prepared by an attorney as part of the estate planning process. Broad powers of attorney for finances are sold in stationery stores, but they can easily be abused by an unscrupulous agent. With the involvement of an attorney during the drafting process, the power of attorney can more accurately direct the agent, and protect the individual from agent misconduct. If a form is to be used, the best form is the Uniform Statutory Form Power of Attorney found in California Probate Code § 4401.

In planning for incapacity, it is best to write a "springing" document, i.e., one that springs into effect only at a future time when the individual loses capacity. A springing document then can be used when the individual no longer has the ability to make her own decisions. However, the power of attorney must contain "durable" language, so that it is effective if the principal becomes incapacitated.

Unfortunately, some banks do not honor a power of attorney for finances unless it was prepared on the bank's power of attorney form. The bank's position is legally wrong but, as a practical matter, it is best if an individual supplements a power of attorney for finances by also designating the same agent on the power of attorney form used by the individual's bank.

Remember—a power of attorney can be revoked as long as the individual retains the mental capacity to do so. A power of attorney ceases to be valid upon an individual's death.

NOTE: *Powers of attorney for finances are very powerful documents, and should be tailored carefully to the individual's needs.*

Wills

Wills by themselves are not useful in planning for incapacity, although they can be used in conjunction with powers of attorney and trusts.

Wills pass property to specified heirs after the individual's death. In the absence of a will or any other estate planning, the individual's property is distributed among family members based on a priority system set by California law.

A downside of a will is the required payment of probate fees, although small estates are exempted from probate. A benefit of the probate process is the certainty that it offers: the court's order at the conclusion of probate settles the distribution of property, and bars creditors from filing subsequent claims.

TIP: *Don't be too stingy in developing an estate plan. A few thousand dollars is a small investment to make sure that a home and savings are handled and distributed appropriately.*

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Trusts

Trusts are commonly used both to distribute an individual's property after her death, and to manage her property if and when she becomes incapable of handling her own affairs. The trust document appoints a trustee for managing the individual's property.

It is important that the individual make sure that the trust is properly funded – for example, that the individual's bank accounts are listed as belonging to the trust, and that the title to the individual's home be held by the trust.

Trusts are drafted by attorneys as part of an estate plan. There are both advantages and disadvantages to using a trust, rather than a will. An advantage is that administration of a trust does not require Probate Court administration and does not incur statutory probate fees. A disadvantage is that a trustee is not monitored, and therefore there is a greater risk that property will not be distributed properly.

Newspapers frequently run ads for trust seminars, which promise trusts for $500 or less. These seminars should be avoided at all costs. Trusts should be personalized by an attorney and, in many cases, the trust seminars are designed to attract customers for annuity sales.

Supplemental Materials

CALIFORNIA POWER OF ATTORNEY FOR HEALTH CARE
AND HEALTH CARE INSTRUCTION FORM

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: _____.

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 mental capacity to make my own health care decisions. My primary care physician will determine when I am unable to make health care decisions for myself.

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

*The following persons **cannot** be selected as your agent or alternate agent:*
- *Your primary physician.*
- *An employee of the health care institution or residential care facility where you receive care (unless you are related to that person).*

AGENT

Name: _____

Address: _____
City *State* *Zip*

Home Phone: (____) _____ Work Phone: (____) _____

1ST ALTERNATE AGENT (If Agent is unavailable or unwilling to serve.)

Name: _____

Address: _____
City *State* *Zip*

Home Phone: (____) _____ Work Phone: (____) _____

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

Name: _____

Address: _____
City *State* *Zip*

Home Phone: (_____) _____ Work Phone: (_____) _____

AGENT'S AUTHORITY

Except as limited by this document, my agent will have authority to make health care decisions for me to the extent that I now have authority to make my own health care decisions. 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.

Also, except as limited by this document, this authority includes the authority to authorize an autopsy, donate all or part of my body, and/or determine the disposition of my remains. The agent's actions must be consistent with my will or trust, and with any funeral arrangements or other 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 CMIA and shall have the same rights to inspect, obtain and disclose my protected health information as I have.

I make the following instructions to my 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 to consider the relief of suffering and the quality of my life as well as the extent of the possible prolongation of my life.

If this statement reflects your desires, initial here: _____

Other health care instruction to my agent: _____

_____

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. (Cross out if not desired.)

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, the agent shall make decisions consistent with my best interest, taking into account my personal values to the extent they are known to 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.

Part 2 - HEALTH CARE INSTRUCTIONS (For individuals without an agent or for when no agent is available.)

If I am in an irreversible coma or persistent vegetative state; or if I am terminally ill and the provision of life sustaining procedures would serve to artificially delay the moment of my death; then, I make the following instruction, by placing my signature in front of my request:

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

_____ I authorize the treatment needed to provide me with food, water, and pain control, and to keep me comfortable, but otherwise do not authorize active treatment for my medical conditions.

_____ I authorize the treatment needed to provide me with pain control and to keep me comfortable, but do not authorize the provision of food or water through a tube or an intravenous line, and do not authorize active treatment for my medical conditions.

Other health care instructions: _____

_____

_____

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)
State of California, County of _____
On this _____ day of _____ , _____ , before me, the undersigned, a Notary Public in and for said State, personally appeared _____,
personally known to me or proved to me on the basis of satisfactory evidence to be the person whose name is subscribed to the within instrument, and acknowledged to me that he/she executed it in his/her authorized capacity and that by his/her signature on the instrument he/she executed the instrument.

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.

CALIFORNIA POWER OF ATTORNEY FOR HEALTH CARE
AND HEALTH CARE DIRECTIVE

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- **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.