

CALIFORNIA Advance Directive Planning for Important Healthcare Decisions

Caring Connections

1700 Diagonal Road, Suite 625, 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, supported by a grant from The Robert Wood Johnson Foundation.

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

Please call the HelpLine at 800/658-8898 to learn more about the LIVE campaign, obtain free resources, or join the effort to improve community, state and national end-of-life care.

If you would like to make a contribution to help support our work, please visit www.nationalhospicefoundation.org/donate. Contributions to national hospice programs can also be made through the Combined Health Charities or the Combined Federal Campaign by choosing #11241.

**Support for this program is provided by a grant from
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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.
 - Your state-specific advance directive forms, which are the pages with the gray instruction bar on the left side.

PREPARING TO COMPLETE YOUR ADVANCE DIRECTIVE

3. Read the HIPAA Privacy Rule Summary on page 4.
4. Read all the instructions, on pages 6, as it will give you specific information about the requirements in your state.
5. Refer to the Glossary located in Appendix A if any of the terms are unclear.

ACTION STEPS

6. You may want to photocopy these forms before you start so you will have a clean copy if you need to start over.
7. When you begin to fill out the forms, refer to the gray instruction bars - they will guide you through the process.
8. 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.
9. 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.

If you have questions or need guidance in preparing your advance directive or about what you should do with it after you have completed it, please refer to the state-specific contacts for Legal & End-of-Life Care Resources Pertaining to Healthcare Advance Directives, located in Appendix B.

Summary of the HIPAA Privacy Rule

HIPAA is a federal law that gives you rights over your health information and sets rules and limits on who can look at and receive your health information.

Your Rights

You have the right to:

- Ask to see and get a copy of your health records.
- Have corrections added to your health information.
- Receive a notice that tells you how your health information may be used and shared.
- Decide if you want to give your permission before your health information can be used or shared for certain purposes, such as marketing.
- Get a report on when and why your health information was shared for certain purposes.
- If you believe your rights are being denied or your health information isn't being protected, you can:
 - File a complaint with your provider or health insurer, or
 - File a complaint with the U.S. Government.

You also have the right to ask your provider or health insurer questions about your rights. You also can learn more about your rights, including how to file a complaint from the Web site at www.hhs.gov/ocr/hipaa/ or by calling 1-866-627-7748.

Who Must Follow this Law?

- Doctors, nurses, pharmacies, hospitals, clinics, nursing homes, and many other healthcare providers.
- Health insurance companies, HMOs, most employer group health plans.
- Certain government programs that pay for healthcare, such as Medicare and Medicaid.

What Information is Protected?

- Information your doctors, nurses, and other healthcare providers put in your medical record.
- Conversations your doctor has had about your care or treatment with nurses and other healthcare professionals.
- Information about you in your health insurer's computer system.
- Billing information about you from your clinic/healthcare provider.
- Most other health information about you, held by those who must follow this law.

Summary of the HIPAA Privacy Rule (continued)

Providers and health insurers who are required to follow this law must keep your information private by:

- Teaching the people who work for them how your information may and may not be used and shared.,
- Taking appropriate and reasonable steps to keep your health information secure.

To make sure that your information is protected in a way that does not interfere with your healthcare, your information can be used and shared:

- For your treatment and care coordination,
- To pay doctors and hospitals for your healthcare,
- With your family, relatives, friends or others you identify who are involved with your healthcare or your healthcare bills, unless you object,
- To protect the public's health, such as reporting when the flu is in your area, or
- To make required reports to the police, such as reporting gunshot wounds.

Your health information cannot be used or shared without your written permission unless this law allows it. For example, without your authorization, your provider generally cannot:

- Give your information to your employer,
- Use or share your information for marketing or advertising purposes, or
- Share private notes about your mental health counseling sessions.

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)

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ADD PERSONAL INSTRUCTIONS ONLY IF YOU WANT TO LIMIT THE POWER OF YOUR AGENT

INITIAL THE BOX IF YOU WISH YOUR AGENT'S AUTHORITY TO BECOME EFFECTIVE IMMEDIATELY

CROSS OUT AND INITIAL ANY STATEMENTS IN PARAGRAPHS 4, 5, OR 6 THAT DO NOT REFLECT YOUR WISHES

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(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.)

(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.

(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.

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.)

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

ADDITIONAL INSTRUCTIONS (IF ANY)

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

ORGAN
DONATION
(OPTIONAL)

MARK THE BOX
THAT AGREES WITH
YOUR WISHES
ABOUT ORGAN
DONATION

(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)

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)

PRINT THE NAME,
ADDRESS AND
TELEPHONE
NUMBER OF YOUR
ALTERNATE
PRIMARY
PHYSICIAN
(OPTIONAL)

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

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

(date) (sign your name)

(print your name)

(address)

(city) (state) (zip code)

(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.

**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.

First Witness:

(date) (signature of witness)

(printed name of witness)

(address)

(city) (state) (zip code)

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

WITNESSING PROCEDURE

BOTH OF YOUR WITNESSES MUST AGREE WITH THIS STATEMENT

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

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Second Witness:

(date) (signature of witness)

(printed name of witness)

(address)

(city) (state) (zip code)

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.

(date) (signature of witness)

(printed name of witness)

(address)

(city) (state) (zip code)

ALTERNATIVE NO. 2: NOTARY PUBLIC

State of California)
) SS.
County of _____)
On _____ before me, _____
(insert name of notary public)
personally appeared _____,
(insert the name of principal)
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 that he/she executed the same in his/her authorized capacity and that by his/her signature on the instrument the person upon behalf of which the person acted, executed the instrument.

WITNESS my hand and official seal.

NOTARY SEAL _____
(signature of notary)

ONE OF YOUR WITNESSES MUST ALSO AGREE WITH THIS STATEMENT

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

OR

A NOTARY PUBLIC SHOULD FILL OUT THIS SECTION OF YOUR DOCUMENT

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)

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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.**

Appendix A

Glossary

Advance directive - A general term that describes two kinds of legal documents, living wills and medical powers of attorney. These documents allow a person to give instructions about future medical care should he or she be unable to participate in medical decisions due to serious illness or incapacity. Each state regulates the use of advance directives differently.

Artificial nutrition and hydration – Artificial nutrition and hydration supplements or replaces ordinary eating and drinking by giving a chemically balanced mix of nutrients and fluids through a tube placed directly into the stomach, the upper intestine or a vein.

Brain death – The irreversible loss of all brain function. Most states legally define death to include brain death.

Capacity - In relation to end-of-life decision-making, a patient has medical decision making capacity if he or she has the ability to understand the medical problem and the risks and benefits of the available treatment options. The patient's ability to understand other unrelated concepts is not relevant. The term is frequently used interchangeably with competency but is not the same. Competency is a legal status imposed by the court.

Cardiopulmonary resuscitation - Cardiopulmonary resuscitation (CPR) is a group of treatments used when someone's heart and/or breathing stops. CPR is used in an attempt to restart the heart and breathing. It may consist only of mouth-to-mouth breathing or it can include pressing on the chest to mimic the heart's function and cause blood to circulate. Electric shock and drugs also are used frequently to stimulate the heart.

Do-Not-Resuscitate (DNR) order - A DNR order is a physician's written order instructing healthcare providers not to attempt cardiopulmonary resuscitation (CPR) in case of cardiac or respiratory arrest. A person with a valid DNR order will not be given CPR under these circumstances. Although the DNR order is written at the request of a person or his or her family, it must be signed by a physician to be valid. A non-hospital DNR order is written for individuals who are at home and do not want to receive CPR.

Emergency Medical Services (EMS): A group of governmental and private agencies that provide emergency care, usually to persons outside of healthcare facilities; EMS personnel generally include paramedics, first responders and other ambulance crew.

Healthcare agent: The person named in an advance directive or as permitted under state law to make healthcare decisions on behalf of a person who is no longer able to make medical decisions.

Hospice - Considered to be the model for quality, compassionate care for people facing a life-limiting illness or injury, hospice and palliative care involve a team-oriented approach to expert medical care, pain management, and emotional and spiritual support expressly tailored to the person's needs and wishes. Support is provided to the persons loved ones as well.

Intubation- Refers to "endotracheal intubation" the insertion of a tube through the mouth or nose into the trachea (windpipe) to create and maintain an open airway to assist breathing.

Life-sustaining treatment - Treatments (medical procedures) that replace or support an essential bodily function (may also be called life support treatments). Life-sustaining treatments include cardiopulmonary resuscitation, mechanical ventilation, artificial nutrition and hydration, dialysis, and other treatments.

Living will - A type of advance directive in which an individual documents his or her wishes about medical treatment should he or she be at the end of life and unable to communicate. It may also be called a "directive to physicians", "healthcare declaration," or "medical directive."

Mechanical ventilation - Mechanical ventilation is used to support or replace the function of the lungs. A machine called a ventilator (or respirator) forces air into the lungs. The ventilator is attached to a tube inserted in the nose or mouth and down into the windpipe (or trachea).

Medical power of attorney - A document that allows an individual to appoint someone else to make decisions about his or her medical care if he or she is unable to communicate. This type of advance directive may also be called a healthcare proxy, durable power of attorney for healthcare or appointment of a healthcare agent. The person appointed may be called a healthcare agent, surrogate, attorney-in-fact or proxy.

Palliative care - A comprehensive approach to treating serious illness that focuses on the physical, psychological, spiritual, and existential needs of the patient. Its goal is to achieve the best quality of life available to the patient by relieving suffering, and controlling pain and symptoms.

Power of attorney – A legal document allowing one person to act in a legal matter on another's behalf regarding to financial or real estate transactions.

Respiratory arrest: The cessation of breathing - an event in which an individual stops breathing. If breathing is not restored, an individual's heart eventually will stop beating, resulting in cardiac arrest.

Surrogate decision-making - Surrogate decision-making laws allow an individual or group of individuals (usually family members) to make decisions about medical treatments for a patient who has lost decision-making capacity and did not prepare an advance directive. A majority of states have passed statutes that permit surrogate decision making for patients without advance directives.

Ventilator – A ventilator, also known as a respirator, is a machine that pushes air into the lungs through a tube placed in the trachea (breathing tube). Ventilators are used when a person cannot breathe on his or her own or cannot breathe effectively enough to provide adequate oxygen to the cells of the body or rid the body of carbon dioxide.

Withholding or withdrawing treatment - Forgoing life-sustaining measures or discontinuing them after they have been used for a certain period of time.

Appendix B

Legal & End-of-Life Care Resources Pertaining to Healthcare Advance Directives

LEGAL SERVICES

California seniors seeking legal advice can contact the Senior Legal Service Hotline from 9-12 PM and 1-4 PM Monday through Friday until 7 p.m.

General legal aid programs are available to individuals of all ages with low incomes.

Individuals can get legal information and advice about most issues, including:

- Medicare drug plan
 - Healthcare planning
 - Civil matters
 - Advance Directives
 - Living Wills
 - Education programs and much more
-
- Must be 18 or older
 - Free for individuals with low to moderate incomes

For more information call toll free:

1-800-222-1753 in California or 916-551-2140 in Sacramento

You can also visit the Senior Legal Services Hotline website for locations and phone numbers in your county, click on the following link:

<http://www.seniorlegalhotline.org/6-offices.html>

END-OF-LIFE SERVICES

Individuals can contact California Area Agencies on Aging (AAA) for other senior services, including, but not limited to:

- Home Healthcare
- Meals
- Adult Daycare
- community Services
- Volunteering
- Legal Assistance
- Information and referrals to other resources

To locate an AAA in your region please click on the following link:

<http://www.calregistry.com/resources/aaa.htm>

OR

Call toll free: 1-800-510-2020