Durable Power Of Attorney For Health Care
(California)

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California Durable Power Of Attorney for Health Care

This California Durable Power Of Attorney for Health Care is based in part on the California Advance Health Care Directive (California Probate Code Section 4701 et. Seq.) The following are useful excerpts from California Probate Code Sections 4673 to 4690, relating to the Power Of Attorney for Health Care Form.

4673. A written advance health care directive is legally sufficient if all of the following requirements are satisfied: (a) The advance directivecontains the date of its execution. (b) The advance directive is signed either (1) by the patient or (2) in the patient's name by another adult in the patient's presence and at the patient's direction. (c) The advance directive is either (1) acknowledged before a notary public or (2) signed by at least two witnesses who satisfy the requirements of Sections 4674 and 4675.

4674. If the written advance health care directive is signed by witnesses, as provided in Section 4673, the following requirements shall be satisfied: (a) The witnesses shall be adults. (b) Each witness signing the advance directive shall witness either the signing of the advance directive by the patient or the patient's acknowledgment of the signature or the advance directive. (c) None of the following persons may act as a witness: (1) The patient's health care provider or an employee of the patient's health care provider. (2) The operator or an employee of a community care facility. (3) The operator or an employee of a residential care facility for the elderly. (4) The agent, where the advance directive is a power of attorney for health care. (d) Each witness shall make the following declaration in substance:

"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."

(e) At least one of the witnesses shall be an individual who is neither related to the patient by blood, marriage, or adoption, nor entitled to any portion of the patient's estate upon the patient's death under a will existing when the advance directive is executed or by operation of law then existing. (f) The witness satisfying the requirement of subdivision (e) shall also sign the following declaration in substance:

"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."

(g) The provisions of this section applicable to witnesses do not apply to a notary public before whom an advance health care directive is acknowledged.

4675. (a) If an individual is a patient in a skilled nursing facility when a written advance health care directive is executed, the advance directive is not effective unless a patient advocate or ombudsman, as may be designated by the Department of Aging for this purpose pursuant to any other applicable provision of law, signs the advance directive as a witness, either as one of two witnesses or in addition to notarization. The patient advocate or ombudsman shall declare that he or she is serving as a witness as required by this subdivision. It is the intent of this subdivision to recognize that some patients in skilled nursing facilities are insulated from a voluntary decision making role, by virtue of the custodial nature of their care, so as to require special assurance that they are capable of willfully and voluntarily executing an advance directive. (b) A witness who is a patient advocate or ombudsman may rely on the representations of the administrators or staff of the skilled nursing facility, or of family members, as convincing evidence of the identity of the patient if the patient advocate or ombudsman believes that the representations provide a reasonable basis for determining the identity of the patient.

4680. A power of attorney for health care is legally sufficient if it satisfies the requirements of Section 4673.

4681. (a) Except as provided in subdivision (b), the principal may limit the application of any provision of this division by an express statement in the power of attorney for health care or by providing an inconsistent rule in the power of attorney. (b) A power of attorney for health care may not limit either the application of a statute specifically providing that it is not subject to limitation in the power of attorney or a statute concerning any of the following: (1) Statements required to be included in a power of attorney. (2) Operative dates of statutory enactments or amendments. (3) Formalities for execution of a power of attorney for health care. (4) Qualifications of witnesses. (5) Qualifications of agents. (6) Protection of third persons from liability.

4682. Unless otherwise provided in a power of attorney for health care, the authority of an agent becomes effective only on a determination that the principal lacks capacity, and ceases to be effective on a determination that the principal has recovered capacity.

4683. Subject to any limitations in the power of attorney for health care: (a) An agent designated in the power of attorney may make health care decisions for the principal to the same extent the principal could make health care decisions if the principal had the capacity to do so.

(b) The agent may also make decisions that may be effective after the principal's death, including the following: (1) Making a disposition under the Uniform Anatomical Gift Act (Chapter 3.5 (commencing with Section 7150) of Part 1 of Division 7 of the Health and Safety Code). (2) Authorizing an autopsy under Section 7113 of the Health and Safety Code. (3) Directing the disposition of remains under Section 7100 of the Health and Safety Code.

4684. An agent shall make a health care decision in accordance with the principal's individual health care instructions, if any, and other wishes to the extent known to the agent. Otherwise, the agent shall make the decision in accordance with the agent's determination of the principal's best interest. In determining the principal's best interest, the agent shall consider the principal's personal values to the extent known to the agent.

4685. Unless the power of attorney for health care provides otherwise, the agent designated in the power of attorney who is known to the health care provider to be reasonably available and willing to make health care decisions has priority over any other person in making health care decisions for the principal.

4686. Unless the power of attorney for health care provides a time of termination, the authority of the agent is exercisable notwithstanding any lapse of time since execution of the power of attorney.

4687. Nothing in this division affects any right the person designated as an agent under a power of attorney for health care may have, apart from the power of attorney, to make or participate in making health care decisions for the principal.

4688. Where this division does not provide a rule governing agents under powers of attorney, the law of agency applies.

4689. Nothing in this division authorizes an agent under a power of attorney for health care to make a health care decision if the principal objects to the decision. If the principal objects to the health care decision of the agent under a power of attorney, the matter shall be governed by the law that would apply if there were no power of attorney for health care.

4690. If the principal becomes wholly or partially incapacitated, or if there is a question concerning the capacity of the principal, the agent may consult with a person previously designated by the principal for this purpose, and may also consult with and obtain information needed to carry out the agent's duties from the principal' s spouse, physician, attorney, a member of the principal's family, or other person, including a business entity or government agency, with respect to matters covered by the power of attorney for health care. A person from whom information is requested shall disclose relevant information to the agent. Disclosure under this section is not a waiver of any privilege that may apply to the information disclosed.

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POWER OF ATTORNEY FOR HEALTH CARE

(Based on California Probate Code Section 4701)

You have the right to give instructions about your own health care. You also have the right to name someone else to make health-care decisions for you. This form lets you nominate another person to make health-care decisions for you. 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 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. Additionally, you should consult an attorney before designating your conservator 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 to 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.
(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 disposition of 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 also 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.

Initials _____

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:

Name of individual you choose as agent: _____

Address: _____

City, State, Zip Code: _____

Phone Home _____ Work: _____

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 alternate agent: _____

Address: _____

City, State, Zip Code: _____

Phone Home _____ Work: _____

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: _____

Phone Home _____ Work: _____

(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 health care to keep me alive, except as I state here:

_____

_____

_____

(Add additional sheets if needed.)

(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 mark the following box. If I mark this box ☐ my agent's authority to make health care decisions for me takes effect immediately.

Initials _____

(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 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 2 of this form:

_____

_____

_____

(Add additional sheets if needed.)

(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 - INSTRUCTIONS FOR HEALTH CARE

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:

☐ (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.

(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:

_____

_____

(Add additional sheets if needed.)

Initials _____

(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:

_____

_____

_____

(Add additional sheets if needed.)

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

(3.1) 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)

(4.1) 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: _____

Initials _____

PART 5

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

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

Sign your name _____ Date: _____

Print your name _____

Street Address _____

City _____ State _____ ZIP_____

(5.3) 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 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:

Signature of Witness _____ Date: _____

Name: _____

Address: _____

SECOND WITNESS:

Signature of Witness _____ Date: _____

Name: _____

Address: _____

(5.4) 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.

Signature of Witness: _____ Date: _____

Signature of Witness: _____ Date: _____

Initials _____

PART 6 - SPECIAL WITNESS REQUIREMENT

(6.1) The following statement is required only if you are a patient in a skilled nursing facility--a health care facility that provides the following basic services: skilled nursing care and supportive care to patients whose primary need is for availability of skilled nursing care on an extended basis. The patient advocate or ombudsman must sign the following statement:

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 a witness as required by Section 4675 of the Probate Code.

Dated this _____ day of_____ 20____.

Sign your name _____

Print your name: _____

Address: _____

City: _____ State: _____

Initials _____

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

STATE OF CALIFORNIA

COUNTY OF _____

On _____ (Date) before me, _____ (Name and title of the officer), personally appeared _____ (Name of person signing), 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.

_____

Notary Public's Signature

(Seal)