CALIFORNIA POWER OF ATTORNEY FOR HEALTH CARE DECISIONS AND DIRECTIVE

NOTE: COMPLETION OF THIS FORM IS ONLY THE FIRST STEP
It is important to choose someone to make healthcare decisions for you when you cannot make or communicate decisions for yourself. Tell the person you choose what healthcare treatments you want. The person you choose will be your agent. He or she will have the right to make decisions for your healthcare. If you DO NOT choose someone to make decisions for you, write NONE on the line for the agent's name.

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.

I, _____, SS#_____

Address_____,

appoint the person named in this document to be my agent(s) to make my health care decisions.

This document is a Durable Power of Attorney for Healthcare Decisions and Directive Decisions. My agent's power shall not end if I become incapacitated or if there is uncertainty that I am dead. This document revokes any prior Durable Power of Attorney for Healthcare Decisions. My agent may not appoint anyone else to make decisions for me. My agent and caregivers are protected from any claims based on following this Durable Power of Attorney for Healthcare. My agent shall not be responsible for any costs associated with my care. I give my agent full power to make all decisions for me about my healthcare, including the power to direct the withholding or withdrawal of life-prolonging treatment, including artificially supplied nutrition and hydration/tube feeding.

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,

- Consent, refuse, or withdraw consent to any care, procedure, treatment, or service to diagnose, treat, or maintain a physical or mental condition, including artificial nutrition and hydration. Unless clarification is stated on Page 3.
- Permit, refuse, or withdraw permission to participate in federally regulated research related to my condition or disorder. Unless clarification is stated on Page 3.
- Make all necessary arrangements for any hospital, psychiatric treatment facility, hospice, nursing home, or other healthcare organization; and, employ or discharge healthcare personnel (any person who is authorized or permitted by the laws of the state to provide healthcare services) as he or she shall deem necessary for my physical, mental, or emotional well-being;
- Request, receive, review medical records and authorize sending any medical information regarding my physical or mental health, or my personal affairs, including X-Rays, CT Scans, MRI's, Lab Results, Doctor Reports, Medical Records and Hospital Records; and execute any releases that may be required to obtain such information;
- Move me into or out of any Public, Private, State Institution Facility, Hospital or Nursing Facility;
- Take legal action(s), if needed;
- Make decisions about autopsy, tissue and organ donation, and the disposition of my body in conformity with state law and
- Approval to become my Guardian or Conservator if one is needed. If a guardian or 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)

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AGENT(S) OBLIGATIONS:

1. My agent(s) 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. The agent's actions must be consistent with my will or trust, and with any funeral arrangements or other arrangements which I have made.

3. My agent(s) shall provide a copy of this advance health care directive to any health care provider or facility that takes on responsibility for my care.

AGENT(S) AUTHORITY UNDER HIPAA & CMIA:

My agent(s) 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.

If you DO NOT want the person (agent) you name to be able to do any of the above things, draw a line through the statement and put your initials at the end of the line.

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(S):

Agent's name _____

Address_____

Home Phone: _____ Work Phone: _____

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

Agent's name _____

Address_____

Home Phone: _____ Work Phone: _____

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

Agent's name _____

Address_____

Home Phone: _____ Work Phone: _____

CALIFORNIA POWER OF ATTORNEY FOR HEALTH CARE DECISIONS AND DIRECTIVE

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: _____

_____

_____

_____

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: _____

_____

_____

_____

CALIFORNIA POWER OF ATTORNEY FOR HEALTH CARE DECISIONS AND DIRECTIVE

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:_____ **Date:** _____
(Sign and date form in front of witnesses or a notary.)
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.

_____	_____
[Signature of Witness #1]	*[Signature of Witness #2]*
_____	_____
[Printed or typed name of Witness #1]	*[Printed or typed name of Witness #2]*
_____	_____
[Address of Witness #1, Line 1]	*[Address of Witness #2, Line 1]*
_____	_____
[Address of Witness #1, Line 2]	*[Address of Witness #2, Line 2]*

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.

*Signature:*_____ *Date:* _____

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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.

*Signature:*_____ *Date:* _____

PREPARATION STATEMENT

This document was prepared by the following individual:

_____ _____

[Typed or Printed Name] [Signature]

_____

[Date]

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.