ADVANCE HEALTH CARE DIRECTIVE
California Probate Code § 4600 - 4805

This form serves as an instrument to convey your instructions about your own health care and/or to name someone else to make health care decisions for you. Due to the special witnessing requirements, this form is particularly designed for residents in skilled nursing facilities. You have the option to use a different statutory Advance Health Care Directive form.

You have the right to change or revoke this Advance Health Care Directive at any time. (optional)

PART 1 – POWER OF ATTORNEY FOR HEALTH CARE

This part allows you to appoint an agent, someone to make certain health care decisions for you when you cannot. Your agent must be an adult. Even if you do not name an agent, you may prohibit certain individuals from making such decisions for you. (See section 1-4 below)

(1-1) I, _____, wish to appoint a health care agent.
(Print your full name)

- OR -

(1-2) I, _____, **do not** wish to appoint a health care agent.
(Print your full name)

(1-3) **DESIGNATION OF AGENT**: I designate the following individual as my health care agent:

Agent's Name: _____

Address: _____

Telephone: _____ _____ _____
(Home) (Work) (Cellular)

ALTERNATE AGENT (optional): If agent is unavailable or unwilling to serve.

First Alternate Agent's Name: _____

Address: _____

Telephone: _____ _____ _____
(Home) (Work) (Cellular)

Second Alternate Agent's Name: _____

Address: _____

Telephone: _____ _____ _____
(Home) (Work) (Cellular)

(1-4) **PROHIBITION OF INDIVIDUALS TO SERVE AS SURROGATE**

I forbid the following to make health care decisions for me. (*Please enter names(s) and relationship(s)*

_____

(1-5) **AGENT'S AUTHORITY**: Except as stated below, my agent will have authority to make health care decisions for me including, but not limited to, the authority (1) to accept or refuse treatment, nutrition or hydration, (2) to choose a physician or health care facility, and (3) to receive, or consent to the release of, medical information and records.

_____

_____

(1-6) **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.

(1-7) **AGENT'S OBLIGATION**: My agent shall make health care decisions for me in accordance with this power of attorney, other instructions I make in this form and my personal wishes, and to the extent my agent knows them. If my wishes on a subject are unknown, the agent shall made decisions consistent with my best interest, taking into account my personal values to the extent they are known to my agent.

(1-8) **AGENT'S POST DEATH AUTHORITY**: My initial indicates that my agent is authorized to make anatomical gifts, authorize an autopsy, and direct disposition of my remains, except as I state below.
_____ (Initial)

_____

(Add additional sheets if needed)

(1-9) **LIMITATIONS ON MY AGENTS AUTHORITY:** In addition to limitations under current law, I do not give permission to do the following;

_____

(1-10**)** **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 Agent(s) whom I have named, in order of designation.

PART 2 – INSTRUCTIONS FOR HEALTH CARE (optional)

If you fill out this part of the form, you may strike out 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 ***one*** choice I have marked below:

☐ **Choice Not To Prolong Life. _____** (Initial)

I do not want my life 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,
3. The likely risks and burdens of treatment would outweigh the expected benefits.

- OR -

☐ **Choice To Prolong Life. _____** (Initial)

I want my life to be prolonged as long as possible within the limits of generally accepted health care standards.

- OR -

☐ **I Choose Not To Make An End-Of-Life Decision At This Time. _____** (Initial)

(2-2) **RELIEF FROM PAIN** – I direct that treatment for alleviation of pain or discomfort be provided at all times, even if it hastens my death. _____ (Initial)

(2-3) **OTHER WISHES:** If you do not agree with any of the optional choices above, you may add your own choices and instructions:

_____

_____

(Add additional sheets if needed, dated and signed)

PART 3 – DONATION OF ORGANS (optional)

Upon my death I donate any needed organs, tissues, or parts. _____ (Initial)

PART 4 – PRIOR DIRECTIVES REVOKED

You may revoke any part of or this entire Advance Health Care Directive at any time. To revoke the appointment of an agent, you must inform your treating health care provider personally or in writing.Completing a new Advance Health Care Directive will revoke all previous directives. If you revoke a prior directive, notify all those who have copies and give them a copy of your new directive.

I revoke any prior Power of Attorney for Health Care or Natural Death Act Declaration

Signature of Principal:_____ **Date** _____

Print Name _____

_____

Address City State

PART 5 - WITNESS

(5-2) **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 Health Care Directive, and any attachments, 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 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: _____ _____ _____

Print Name Signature Date

_____

Address City State

Second Witness: _____ _____ _____

Print Name (Ombudsman) Signature Date

Address: 400 Contra Costa Vallejo, CA 94590.

(5-3) **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.

_____ _____

(Ombudsman Signature) Date

PART 6 – SPECIAL WITNESS REQUIREMENT (Probate Code §4675)

The following statement is required only if you are a resident in a skilled nursing facility – a health care facility that provides the following services: skilled nursing care and supportive care to residents whose primary need is for availability of skilled nursing care on an extended basis. The Long-Term Care Ombudsman must sign the following statement:

STATEMENT OF OMBUDSMAN – I declare under penalty of perjury under the laws of California that I am an Ombudsman, designated by the California State Department of Aging and that I am serving as a witness as required by §4675 of the Probate Code.

_____ _____

(Ombudsman Signature) Date

PART 7 – COPIES

(7-1) **EFFECT OF A COPY**: A copy of this form has the same effect as the original.

(7-2) **SUGGESTED DISTRIBUTION:** Resident (Principal), Agent, Alternate Agent(s), Physician, Facility or Hospital

I have added a total of ____ page(s) with specific health care instructions to this directive. Each page is signed and dated on the same day I signed this directive.

This Advance Health Care Directive form and Witness Service is provided to you by:
Solano Ombudsman Long Term Care