LONG-TERM CARE OMBUDSMAN WITNESSING OF AN ADVANCE HEALTH CARE DIRECTIVE

Intake Date:	Completed Date:
Activity Time: __ HR __ MIN	

Ombudsman Representative Name:
Resident Name:
Facility Name:

Individual requesting LTC Ombudsman to witness AHCD, if other than resident

Name:	Phone: ( ) -
Relationship to Resident:	

Witnessing Status *(Check appropriate box)*

☐ Not attempted ☐ Completed ☐ Attempted, Not Completed

Comments:

Ombudsman Witness Statement

1. At the time of my witnessing visit with this resident, he or she demonstrated the ability to understand, and the intent to sign, the AHCD document voluntarily and without undue influence by others. *(Check the appropriate box below.)*

   ☐ Yes

   ☐ Yes, but the resident was unable to sign due to physical limitations. *(Explain below.)*

   ☐ No *(Explain below.)*

2. Comments *(Document special circumstances, such as existence of a POLST or other physician's orders, multiple attempts to complete the witnessing of the AHCD, including dates and reasons witnessing was not completed, etc.)*

3. This resident has signed the AHCD document or acknowledged the signature on the document as his or her own in my presence. ☐ Yes ☐ No

4. I signed the AHCD document and indicated that I was serving as a LTC Ombudsman witness. ☐ Yes ☐ No

Answer Questions 5 and 6 if an AHCD Contains Other Powers of Attorney

5. I signed the *Long-Term Care Ombudsman Witness Addendum to an Advance Health Care Directive* (OSLTCO S102) to indicate that I only witnessed the portion of the document that pertains to the AHCD. ☐ Yes ☐ No

6. This resident has initialed the AHCD addendum in my presence. ☐ Yes ☐ No

Ombudsman Representative Signature **Date**

Printed Name of Ombudsman Representative Witnessing AHCD