Advance Directive

What is an advance directive?

An advance directive is a legal document you complete to make sure you get the healthcare you want. In an advance directive, you can choose someone to make healthcare decisions for you, if you are ever unable to make them yourself. This person is called your healthcare agent. You also can give information about the medical treatments and other care you would and would not want if you became very sick.

Every adult should have an advance directive. It is especially important for adults who are older or have serious illnesses. Completing an advance directive helps you know that your values and goals will be honored. It also gives your healthcare agent the peace of mind of knowing what you would want them to do if they need to make healthcare decisions for you.

An advance directive only deals with healthcare decisions. You must complete a different document to give someone authority to handle your finances or property.

First Name Last Name

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Information and Instructions

How do I complete this advance directive?

We encourage you to complete the entire form, but it is okay if you only want to complete part of it. Just cross out any parts you do not want to fill out. It is a good idea to complete this form with your healthcare agent (if you choose to name one) and loved ones so they clearly understand your preferences. A doctor, nurse, social worker, chaplain, or other healthcare professional also can help you.

In **PART 1: Choosing A Decisionmaker** (page 1), you name your healthcare agent. This is the person you trust to make your healthcare decisions for you if you are ever unable to make them yourself. You choose one primary healthcare agent and up to two alternate (backup) healthcare agents.

It is a good idea to talk with your healthcare agent before you list them on this form. Make sure they are willing to help and see if they have any questions about your healthcare preferences. It is very important to choose a healthcare agent you trust as your decisionmaker. It will be up to them to make decisions with your healthcare team based on the information you provide in the rest of the form. If you are worried that your healthcare agent will not follow your wishes, you should consider choosing someone else.

A good healthcare agent:

- ✓ Is 18 years old or older
- ✓ Knows you well
- ✓ Understands what's important to you
- ✓ Is easy for the healthcare team to contact (in person, by phone, through an interpreter, etc.)
- ✓ Makes good decisions under pressure

Your healthcare agent cannot be:

- × Under 18 years old
- × Your doctor, nurse practitioner, or physician assistant*
- × An employee of the hospital where you are receiving care*
- × The owner or operator of a community care facility or residential care facility where you receive care
- × The healthcare agent for more than 10 other people

In **PART 2: My Healthcare Preferences** (pages 2-3), you write down your healthcare preferences, so your healthcare agent understands the choices you want them to make. This includes what a meaningful quality of life looks like for you and what medical treatments and other care you do and do not want.

In **PART 3: Sign and Complete** (pages 4-6), you sign** the advance directive form either in front of two witnesses or a notary public. Once you fill out the form and follow the instructions in Part 3, this will be a legally binding form in the state of California. Part 3 also gives instructions for what to do with this form after it is completed.

PART 4: My Values (pages 8-9) is an optional section where you can tell your healthcare team and loved ones what else matters to you. This includes your preferences about spirituality, what would make a long hospital stay easier for you, and what you want to happen in your final days. Part 4 lets your agent, healthcare team and loved ones know what excellent care looks like for you.

* These restrictions do not apply if this person is your family member or coworker.

** If you are physically unable to sign, you may select another adult to sign at your direction and in your presence.

PART 1: Choosing a Decisionmaker

Durable Power of Attorney for Healthcare

If I am unable to make decisions for myself, my healthcare agent will be able to:

- *Decide which medical treatments and procedures I do or do not receive, including artificial life support.*
- *Choose which healthcare providers and facilities are involved in my care.*
- *See my medical records and receive information about my current medical status.*
- *Work with health insurance companies or other healthcare programs on my behalf.*
- *Direct the disposition of my remains after my death.*

*I want this person to be my **PRIMARY HEALTHCARE AGENT**. They will make my healthcare decisions if I cannot make them for myself:*

Name _____ Phone Number _____

Address _____ City _____ State _____ ZIP _____

Relationship _____ Email Address _____

*I want this person to be my **FIRST ALTERNATE HEALTHCARE AGENT**. They will make my healthcare decisions if I cannot make them for myself and my primary healthcare agent is unavailable:*

Name _____ Phone Number _____

Address _____ City _____ State _____ ZIP _____

Relationship _____ Email Address _____

*I want this person to be my **SECOND ALTERNATE HEALTHCARE AGENT**. They will make my healthcare decisions if I cannot make them for myself and my other healthcare agents are unavailable:*

Name _____ Phone Number _____

Address _____ City _____ State _____ ZIP _____

Relationship _____ Email Address _____

Optional

If you want your healthcare agent to be able to make decisions for you **right now**, after you complete this form, check the box below. Otherwise, they will only be able to make decisions for you if you are not able to make them yourself.

❑ *I want my healthcare agent to be able to make decisions for me **right now**. However, I understand that I can tell my healthcare provider at any time that I no longer want my healthcare agent to make decisions for me.*

Optional

You also can choose how much flexibility to give your healthcare agent in carrying out your medical wishes. (Check **one**):

❑ *My healthcare agent should follow my instructions exactly as I have written them in this advance directive, even if it makes them uncomfortable.*

❑ *My healthcare agent can change my medical decisions if they think it would be best for me. If I have certain decisions I never want changed, I have written them on page 2.*

PART 2: My Healthcare Preferences

Living Will/Healthcare Directive

Artificial Life Support

If you are seriously ill, your doctors may offer artificial life support. This includes treatments like a ventilator (breathing machine), artificial nutrition (feeding tube), and other medications or machines that keep you alive past the point when you would have died naturally. Artificial life support gives other treatments time to work but does not help you get better by itself.

*If I am so sick that I need artificial life support to keep me alive (Check **ONE**):*

- ❑ *I want to receive artificial life support for as long as possible, even if there is little or no chance of recovering to live a life that is meaningful for me.*
- ❑ *I want to receive artificial life support if there is a good chance of recovering to live a life that is meaningful for me. But, if my doctors do not think I will recover, I want to stop life support, focus on being comfortable, and be allowed to die a natural death.*
- ❑ *I never want artificial life support. If I become so sick that I need life support to keep me alive, I want to focus on being comfortable and be allowed to die a natural death.*
- ❑ *I want to leave it up to my healthcare agent and my treatment team.*

These are other specific instructions regarding my healthcare (for example, if there are specific treatments I would never want, or certain situations when I would never want artificial life support):

PART 2: My Healthcare Preferences [continued]

Quality of Life

It is important for your healthcare agent(s) and your healthcare team to know what makes life meaningful for you. With this information, they can make sure your treatment plan meets your goals.

For me, my life is only meaningful if I can (Check all that apply):

- ❑ *Live without being permanently hooked up to a machine*
- ❑ *Recognize family and friends*
- ❑ *Communicate with family and friends*
- ❑ *Live without severe pain or discomfort*
- ❑ *Get out of bed*
- ❑ *Move well enough to leave my home (walk, use a wheelchair, etc.)*
- ❑ *Eat my favorite food*
- ❑ *Bathe and take care of myself*
- ❑ *Think clearly enough to know what is going on around me*
- ❑ *Live in my own home*
- ❑ *Do my favorite hobby:* _____

OR

- ❑ *None of the above. My life is always worth living no matter how sick I am.*

OR

- ❑ *I am not sure.*

These things also are very important for me in living a meaningful life:

PART 3: Sign and Complete

Read this entire section carefully before signing.

In California, there are **two ways** to make this form legal.
You only need to choose **ONE** of the options below.

OPTION 1

Sign* in front of **two witnesses**, and then have your witnesses sign the form on page 5. When your witnesses sign the form, they are promising that it is really you that is signing this advance directive and that nobody is forcing you to sign.

Your witnesses **must be** at least 18 years old.

Your witnesses **must not be**:

- *A healthcare agent or alternate agent designated in this form*
- *Your healthcare provider*
- *Anyone who owns, operates, or works at a licensed facility where you live or receive healthcare*

Only one of your witnesses may be related to you or be included in your will.

If you are using witnesses, sign the form at the bottom of this page, and have your witnesses sign on **page 5**.

OPTION 2

Sign* in front of a **notary public**. To have this form notarized, you will need current, government issued photo identification (like a driver's license or passport). If you are using a notary, sign the form at the bottom of this page, and then have the notary complete the acknowledgment on **page 6**.

WAIT until you are with your two witnesses or a notary, then sign below.

YOUR SIGNATURE

Signature _____ Date _____

Name (Printed) _____ Phone Number _____

Address _____ City _____ State _____ ZIP _____

* If you are unable to physically sign, you may have another adult sign in your presence and on your behalf.

PART 3: Sign and Complete [continued]

OPTION 1 – Witnesses

If you are witnessing this document, read the following statement. If you agree with the statement, sign below.

STATEMENT OF WITNESSES: I declare under penalty of perjury under the laws of California that

(1) The individual who signed/acknowledged this advance directive is personally known to me or that their identity was proven to me by convincing evidence;

(2) The individual signed or acknowledged this advance directive in my presence;

(3) The individual appears to be of sound mind and under no duress, fraud, or undue influence;

(4) **I am not a person appointed as agent by this advance directive**; and

(5) 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 _____ Date _____

Name (Printed) _____ Phone Number _____

Address _____ City _____ State _____ ZIP _____

Second Witness:

Signature _____ Date _____

Name (Printed) _____ Phone Number _____

Address _____ City _____ State _____ ZIP _____

One of the two witnesses also must read the following statement carefully and sign below:

ADDITIONAL STATEMENT OF ONE WITNESS:

I further declare under penalty of perjury under the laws of California that I am not related to the individual executing this advance 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 _____

PART 3: Sign and Complete [continued]

OPTION 2 - Notarization

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 _____ before me _____ , personally appeared _____

_____ , 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 Signature

Notary Public Seal

Additional Requirement Only for Residents of Skilled Nursing Facilities

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. If you are completing this form in another location, like a hospital, doctor's office, or your home, this section is not required. 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.

_____ _____

Signature Date

_____ _____

Name (Printed) Phone Number

Next Steps

Congratulations!

You have completed your advance directive. Here's what to do next:

- Take this document home and keep it somewhere safe where your loved ones can easily access it if needed.
- Make copies and give them to your healthcare agents, your doctor, and any hospital or facility where you receive treatment. Copies of this document are just as valid as the original.
- Talk with your family, healthcare agents, your doctors and other healthcare providers about your advance directive. Make sure they understand what's important for your healthcare.
- If you have a myChart account, you can upload this advance directive. For more information go to memorialcare.org/acp.
- If you want to provide more information, complete Part 4 – My Values.

Here's how to update or change your advance directive:

- If you change your mind about anything you have written in this advance directive while you are in the hospital, make sure to tell your doctor and have them document any changes in your medical record.
- Once you have signed this document with two witnesses or a notary, this advance directive is valid until you revoke it. If you want to revoke this advance directive, you can either write "REVOKED" in large letters across the front of the document and sign it or tell your primary doctor. If you complete a new advance directive, it will automatically revoke any previous advance directives.
- Make sure to provide the updated documents to your family, healthcare agents, your doctor, and anywhere else your previous advance directive was stored.
- As time goes on, things change. This advance directive does not expire, but it is a good idea to review it and see if it needs updating:
    - Every 10 years
    - If you get married or divorced
    - If you are diagnosed with a new health condition
    - If your health declines
    - After the death of a loved one

PART 4 (Optional): My Values

Good healthcare is about more than medical treatment. In this optional addition to your advance directive, tell your loved ones and your care team what is most important to you if you become seriously ill. Complete as much or as little of this section as you want. If you choose to complete this section, keep it attached to the rest of your advance directive.

When I am Seriously Ill

- ❑ *I want to be kept comfortable and free from pain, even if my pain medicine makes me too sleepy to stay awake.*
- ❑ *I want my family and loved ones to visit me and talk with me.*
- ❑ *Comforting touches (handholding, stroking my hair, etc.) are welcome.*
- ❑ *I want my favorite music to be played. My favorite music includes:* _____
- ❑ *If I am able, I want to be involved in making my own treatment decisions. I want my treatment team to talk to me and tell me what they are doing, even if I don't seem aware.*

If possible, I would like the following things in my room:

If spirituality and/or religion is important to me, here is what my care team should know:

If I am very sick, I want to make sure the following things DO NOT happen:

If I am very sick, I want to make sure the following things DO happen:

PART 4 (Optional): My Values [continued]

At the End of Life

If possible, I would like to spend my final days:

- ❑ *At home*
- ❑ *In the hospital*
- ❑ *At a nursing home or other facility*
- ❑ *Other:* _____
- ❑ *No preference*

If possible, I would like my remains to be:

- ❑ *Buried*
- ❑ *Cremated*
- ❑ *Other:* _____

These are my specific wishes for my funeral or memorial service:

I want my family and loved ones to know: