

IT IS IMPORTANT FOR YOU TO LET US KNOW YOUR HEALTH CARE PREFERENCES



- You can insure the quality of life that is important to you
- This packet will help answer your questions and guide you in filling out the form. Your doctor cannot provide advice to you on this form



- The Advance Health Care Directive will allow us to provide you with the health care you desire. It will ensure that you have a voice even when you cannot communicate for yourself



California Advance Health Care Directive Kit
Provided by Indian Health Council, INC



Your California Advance Health Care Directive Kit Provided by Indian Health Council



Your packet contains:

- ❖ Questions and Answers about your Advance Health Care Directive Kit
- ❖ What is important to you?
- ❖ Instructions on how to fill out your Advance Health Care Directive Kit.
- ❖ Your Advance Health Care Directive Legal Form.
- ❖ Keeping Track of Your Advance Health Care Directive Kit.



Questions You May Ask

Where should I keep my completed advance health care directive form?

What is an Advanced Health Care Directive (AHCD)?

Why is it so important to have a signed Advanced Health Care Directive?

May I change or revoke my advance health care directive form?

When should I complete an advance health care directive form?

Do I need an attorney to complete an advance health care directive?

What if I don't choose a health care agent?

How do I choose a health care agent to speak for me?



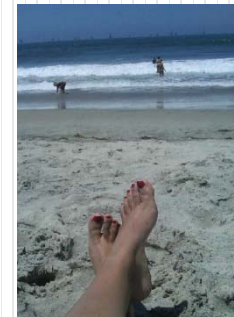
What is an Advance Health Care Directive (AHCD)?

The Advance Health Care Directive (AHCD) is a legal document.

- **It give you the right to give instructions about your own health care.**
- **It gives you the right to name someone else to make health care decisions for you if you are unable to make them yourself.**
- **The AHCD does not expire. It will stay in effect until you revoke or change it.**

AHCD forms are not complicated, but the content can be complex and should be thought through very carefully. It's important to discuss these wishes with family members and other appropriate professionals when preparing such a document. It is particularly important to talk with everyone who might be involved about your wishes because in times of stress, others may confuse their own wishes with your wishes.

An AHCD lets your physician, family and friends know your health care preferences. This includes any types of special treatments choices such as your desire for diagnostic testing, surgical procedures, cardiopulmonary resuscitation (CPR). The AHCD gives you the right to select a primary physician and it allows you to decide on you wishes about organ donation.



An AHCD gives you and your family peace of mind because you decide your quality of life, your choices of treatment, how and where you want to spend your final days.

Why is it so important to have a signed Advance Health Care Directive?

One of the best parts about an AHCD is that it prohibits friends and family members from becoming embroiled in bitter arguments about what is best for you. Some examples include:

Decisions about what the best treatment plan might be for you and all the side effects it might involve, especially if it prologs the dying process if you are seriously ill.

Where your last days should be spent such as a nursing home, hospital or at home.

Your wishes in regards to the refusal or acceptance of pain medication, antibiotics, respirator or cardiopulmonary resuscitation.

Today many families are left with the stress and heartache of trying to agree on the best way to care for a terminally-ill loved one who is unable to make his or her wishes known. In these cases the closest people consequently miss sharing the final stage of life with their loved one while the opinions and wishes of the dying person are often lost in all the chaos.

An AHCD can avoid all this for you and your loved ones. Nobody wants to make critical medical care decisions for you under stress and emotional turmoil. When you are clear about your preferences for treatment, they are free to devote their energy to care and compassion for you.



When should I complete an Advance Health Care Directive form?



Anyone age 18 or older who is able to make his or her health decisions can establish a AHCD. Younger adults actually have more at stake, because, if stricken by serious disease or accident, medical technology may keep them alive but insentient for decades.

Remember AHCD can always be changed if/when your wishes or circumstances change.

Every person aged 18 or over should prepare an AHCD.

How do I choose a Health Care Agent to speak for me?

Your Health Care Agent cannot be your doctor who is managing your care, an operator or employee of a health care facility where you are receiving care unless you are related to them through blood, marriage or adoption.

Talk with your relatives and your close friends about your values, and your spiritual preferences. Choose someone who will honor your wishes even if those request may not be the ones they would make for themselves. The more conversations you have about the type of health care treatment plans you want, and by having an AHCD the better your agent is to assist you in managing your care if your are unable to make your own decisions.

Remember, your health care agent's decisions take priority over all other people's opinions.

Your Health Care Agent deals only with medical decisions relating to your health care and has no effect on the financial responsibility for the same

If you do not want your Health Care Agent to make certain decisions or have certain powers, you can limit their authority in your AHCD form.

You can also appoint one or more "alternate agents" in the event that the person you selected as your primary Health Care Agent is unavailable or unwilling to make a decision

When you become incapacitated, your Health Care Agent is required to make decisions that are consistent with any instructions you have set forth in your AHCD form. They are free to dismiss demands and recommendations made by family members, friends, and even your doctor. If you have not made your wishes known, your Health Care Agent will be left to decide what is in your best interest.

What if I don't choose a health care agent?

A family member will be asked to act on your behalf. If family members don't agree and decision cannot be made in a timely fashion this can add to emotional stress and family conflicts could arise. If a family member is not available or willing to act on your behalf a court appointed representative may be assigned to you. This person would not know your values or wishes and may be in a position to make critical decision for you.

Do I need an attorney to complete an advance health care directive?

The forms were designed for people to complete without a lawyer and the law does not require that a lawyer be involved in the creation of the form. The law does not prohibit lawyers from helping to complete the forms.

May I change or revoke my advance health care directive form?

Yes! You can change or cancel your AHCD at any time.

Executing a new AHCD will automatically revoke your previous AHCD.

To avoid possible confusion, you should notify anyone who has a copy of your AHCD of any changes or revocations and replace all old forms with your newly revised form.

An AHCD remains valid forever unless you revoke your AHCD, execute a new AHCD, or specify a date on which you would like your AHCD to expire.

Where should I keep my completed advance health care directive form?

You will want to keep your original copy in a place where family or friends will find it if needed.

Helpful Hints

You should also give a copy of the AHCD to your primary physician, your agent, your alternate agent(s), family members, and any health facilities where you are receiving care.

Make a list with the names and phone numbers of persons to whom you have given a copy of your AHCD so you can easily notify them if you make any changes.

Put a card or notation in your wallet or purse stating that you have an AHCD. Some people take a copy of their AHCD when they travel. If you spend extended time in another state, you should also complete advance directives there, using that state's forms and rules. If you are going to be admitted to a hospital or institution, be sure to bring a copy of your AHCD.

All copies of the AHCD have the same effect as the original.

Advance Health Care Directive Form Instructions

Part 1: Power of Attorney

Part 1 lets you:

- name another person as agent to make health care decisions for you if you are unable to make your own decisions. You can also have your agent make decisions for you right away, even if you are still able to make your own decisions.
- 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.
- your supervising health care provider (the doctor managing your care)
- an employee of the health care institution where you are receiving care, unless your agent is related to you or is a coworker.
- Your agent may make all health care decisions for you, unless you limit the authority of your agent. You do not need to limit the authority of your agent.
- If you want to limit the authority of your agent the form includes a place where you can limit the authority of your agent.

A photograph of the 'Advance Health Care Directive' form, specifically the 'Part 1: Power of Attorney' section. The form is tilted and shows fields for Name, Date, and sections for Designation of Agent and Alternate Agent. The text on the form includes: 'Name: _____ Date: _____', 'Part 1 -- Power of Attorney for Health Care', '(1) DESIGNATION OF AGENT', 'Name of individual you choose as agent: _____ Relationship: _____ Address: _____ Telephone numbers (indicate home, work, cell): _____', 'ALTERNATE AGENT (Optional)', 'Name of individual you choose as alternate agent: _____ Relationship: _____ Address: _____ Telephone numbers (indicate home, work, cell): _____', and 'SECOND ALTERNATE AGENT (Optional)', 'Name of individual you choose as second alternate agent: _____ Relationship: _____ Address: _____ Telephone numbers (indicate home, work, cell): _____'. There are also checkboxes for 'I do not want expected benefits come a reality' and 'I want to... treatment alternatives'.

If you choose not to limit the authority of your agent, your agent will have the right to:

- Consent or refuse consent to any care, treatment, service, or procedure to maintain, diagnose, or otherwise affect a physical or mental condition.

Choose or discharge health care providers (i.e. choose a doctor for you) and institutions.

Agree or disagree to diagnostic tests, surgical procedures, and medication plans.

Agree or disagree with providing, withholding, or withdrawal of artificial feeding and fluids and all other forms of health care, including cardiopulmonary resuscitation (CPR).

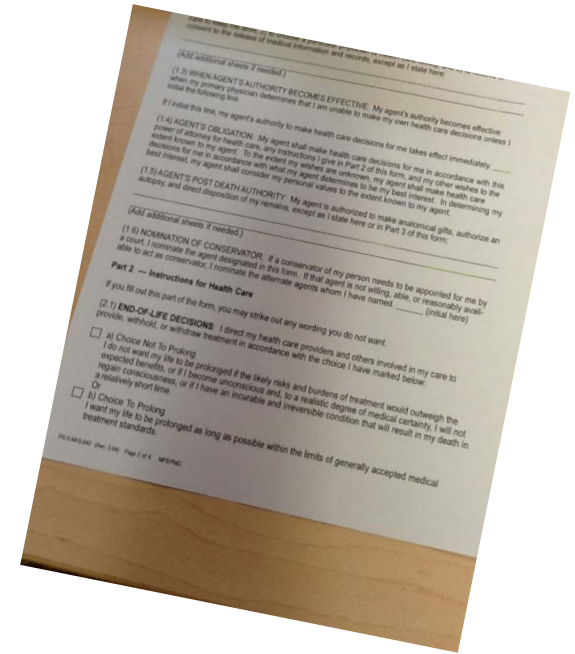
After your death make anatomical gifts (donate organs/tissues), authorize an autopsy, and make decisions about what will be done with your body.

Advance Health Care Directive Form

Instructions

Part 2: Instructions for Health Care

- You can give specific instructions about any aspect of your health care, whether or not you appoint an agent.
- There are choices provided on the form to help you write down your wishes regarding providing, withholding or withdrawal of treatment to keep you alive.
- You can also add to the choices you have made or write out any additional wishes.
- You do not need to fill out part 2 of this form if you want to allow your agent to make any decisions about your health care that he/she believes best for you without adding your specific instructions.



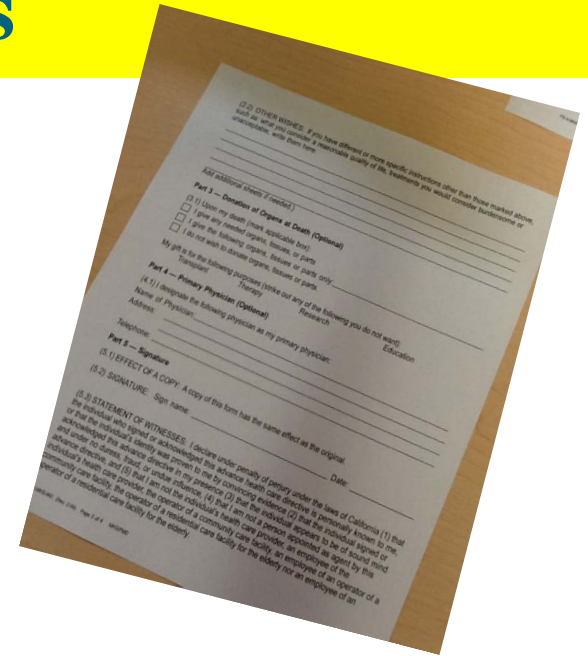
Advance Health Care Directive Form Instructions

Part 3: Donation of Organs

- You can write down your wishes about donating your bodily organs and tissues following your death.

Part 4: Primary Physician

- You can select a physician to have primary or main responsibility for your health care.



Part 5: Signature and Witnesses

After completing the form, sign and date it in the section provided.

The form must be signed by two qualified witnesses (see the statements of the witnesses included in the form) or acknowledged before a notary public.

Remember!

- A notary is not required if the form is signed by two witnesses.
- The witnesses must sign the form on the same date it is signed by the person making the Advance Directive.

Advance Health Care Directive Form

Instructions

This part of the form is only if you are in a skilled nursing facility

Part 6: Special Witness Requirement

- A Patient Advocate or Ombudsman must witness the form *if you are a patient in a skilled nursing facility (a health care facility that provides skilled nursing care and supportive care to patients)*. See *Part 6 of the form*.

The image shows a photograph of the Advance Health Care Directive Form, tilted at an angle. The form is white with black text and lines. The visible sections include:

- FIRST WITNESS**: Fields for First Name, Address, and Signature of Witness.
- SECOND WITNESS**: Fields for First Name, Address, Signature of Witness, and Date.
- (3) ADDITIONAL STATEMENT OF WITNESSES**: A section for additional witnesses, including fields for Name, Address, Signature of Witness, and Date.
- Part 6 — Special Witness Requirement if in a Skilled Nursing Facility**: A section for a Patient Advocate or Ombudsman, including a statement of declaration, fields for First Name and Address, and a signature line.
- Certificate of Acknowledgment of Notary Public**: A section for a notary public, including fields for State, County, Signature, and Date.

Advance Health Care Directive

Name _____

Date _____

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 also lets you write down your wishes regarding donation of organs and the designation of your primary physician. If you use this form, you may complete or change all or any part of it. You are free to use a different form.

You have the right to change or revoke this advance health care directive at any time.

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: _____

Relationship _____ Address: _____

Telephone numbers: (Indicate home, work, cell) _____

ALTERNATE AGENT (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: _____

Relationship _____ Address: _____

Telephone numbers: (Indicate home, work, cell) _____

SECOND ALTERNATE AGENT (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: _____

Telephone numbers: (Indicate home, work, cell) _____

(1.2) AGENT'S AUTHORITY: My agent is authorized to 1) make all health care decisions for me, including decisions to provide, withhold, or withdraw artificial nutrition and hydration and all other forms of healthcare to keep me alive, 2) to choose a particular physician or health care facility, and 3) to receive or consent to the release of medical information and records, 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 initial the following line.

If I initial this line, my agent's authority to make health care decisions for me takes effect immediately. _____

(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 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 POST DEATH 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 3 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. _____ (initial here)

Part 2 — Instructions for Health Care

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 my health care providers and others involved in my care to provide, withhold, or withdraw treatment in accordance with the choice I have marked below:

•a) Choice Not To Prolong I do not want my life to be prolonged if the likely risks and burdens of treatment would outweigh the expected benefits, or if I become unconscious and, to a realistic degree of medical certainty, I will not regain consciousness, or if I have an incurable and irreversible condition that will result in my death in a relatively short time.

•Or

•b) Choice To Prolong I want my life to be prolonged as long as possible within the limits of generally accepted medical treatment standards.

(2.2) OTHER WISHES: If you have different or more specific instructions other than those marked above, such as: what you consider a reasonable quality of life, treatments you would consider burdensome or unacceptable, write them here.

Add additional sheets if needed.)

Part 3 — Donation of Organs at Death (Optional)

(3.1) Upon my death (mark applicable box):

• I give any needed organs, tissues, or parts

• I give the following organs, tissues or parts only: _____

• I do not wish to donate organs, tissues or parts.

My gift is for the following purposes (strike out any of the following you do not want): Transplant Therapy
Research Education

Part 4 — Primary Physician (Optional)

(4.1) I designate the following physician as my primary physician:

Name of

Physician: _____

Address: _____

Telephone: _____

Part 5 — Signature

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

(5.2) SIGNATURE: Sign name: _____ Date: _____

(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

Print Name: _____

Address: _____

Signature of Witness: _____ Date: _____

SECOND WITNESS

Print Name: _____

Address: _____

Signature of Witness: _____ Date: _____

(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 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 on his or her death under a will now existing or by operation of law.

Signature of Witness: _____

Signature of Witness: _____

Part 6 — Special Witness Requirement if in a Skilled Nursing Facility

(6.1) The patient advocate or ombudsman must sign the following statement: STATEMENT OF PATIENT ADVOCATE OF 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:

Print Name: _____ Signature: _____

Address: _____ Date: _____

Certificate of Acknowledgement of Notary Public (Not required if signed by two witnesses) State of

California, County of _____ On this _____ day of

_____, _____, before me, the undersigned, a Notary Public in and for said State, personally appeared _____, personally known to me or proved to me on the basis of satisfactory evidence to be the person whose name is subscribed to the within instrument, and acknowledged to me that he/she executed it.

Seal WITNESS my hand an official seal.

Signature _____

Reminder!

**All copies of
the AHCD
have the
same effect
as the
original.**

Copies of my Advance Directive given to:

- ✓ Primary Physician
- ✓ My Health Care Agent
- ✓ My alternate agent(s)
- ✓ Mom
- ✓ Dad
- ✓ Sister/Sister in Law
- ✓ Brother/Brother in law
- ✓ Aunt
- ✓ Uncle
- ✓ Grandkids
- ✓ Nieces
- ✓ Nephews
- ✓ IHC
- ✓ Other Health Facility
- ✓ Purse/Wallet
- ✓ Health care facility in other states where I frequently travel(snow bird travelers...etc)

