DOWNLOAD COVERSHEET:

This is a standard advance directive for your state, made available to you as a courtesy by Lifecare Directives, LLC. You should be aware that extensive research has demonstrated that there are significant drawbacks to using a very brief state-standard document. As one researcher has noted, “the development of statutory forms occurs in the legislative arena, [so] their content is the result of a political rather than a ‘scientific’ process.” Because of “political compromise, ...many of the forms ultimately passed by the legislatures are not optimal from a consumer perspective” (see: Hoffmann, Diane E; Zimmerman, S; Tompkins, C. The dangers of directives, or the false security of forms. *Journal of Law, Medicine & Ethics*. 1996;24(1) (Spring):5-17).

American Bar Association concurs, noting that “The statutory advance directive is not necessarily the exclusive, or even the best, pathway for individuals to follow,” and suggesting that revised and enhanced documents “may be especially helpful as a...replacement for statutory forms where restrictions in a statutory directive prevents the individual from fully expressing his or her wishes” (see: American Bar Association. (1991). *Patient Self Determination Act State Law Guide*. Government printing office, Washington, DC).

Lifecare Directives staff have reviewed more than 6,000 medical, legal, academic, and news media articles on advance directives, as well as reviewing hundreds of document forms. They have also conducted formal research with scores of medical, legal, and academic processionals along with more than 1,000 lay public participants. From this process, more than 30 additional key living will and medical power of attorney enhancements have been identified that should be included in any living will (or “health care instruction” or “declaration”) and medical power of attorney (or “proxy”) forms that you may use.

Please consider obtaining the *Lifecare Advance Healthcare Directive* to obtain these important additions and benefits. To better understand the important enhancements available through this combined living will and medical power of attorney, you may wish to obtain the booklet, “*Should I Use a Shorter Standard Directive?*” available through Lifecare Directives, LLC.

If you have any other questions about this document or other Lifecare resources, please do not hesitate to contact our staff who will make every effort to fully respond your inquiries and address any questions you may have. We can be reached at the following:

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~ Lifecare Directives ~

Advance Health Care Directive

For

California Residents

Standard State Statutory
Advance Directive for
Health Care Choices

~ Lifecare Directives ~

Advance Health Care Directive

For

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Standard State Statutory
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Important Notice:

An advance directive is not a substitute for medical, legal or other necessary advice or direction. This document should not be construed as offering counseling, medical, legal, financial, or estate planning or advice, nor any other similar guidance or direction. Such counsel should be obtained from qualified, certified, and licensed professionals in your locale who are experienced in the specific areas of concern. Completion of this document constitutes acceptance of its content both in whole and in part, as well as a determination of its utility for the purposes indicated. Lifecare Directives, LLC, and all involved in this document's design, publication, and distribution assume no liability for its use, including that which may arise from omissions, technical inaccuracies, and typographical errors. Diligent efforts notwithstanding, this document is not warrantied to be in compliance with state and local laws. All warranties, including those of merchantability, fitness for a particular purpose, and non-infringement are expressly disclaimed. The utilizer agrees to seek appropriate outside review prior to completion. The utilizer and all heirs, assigns, designees, devisees, representatives, and all others involved, agree to assume all liability for its use and any subsequent outcomes, and to release and hold harmless all involved in its design, publication, advertising and distribution. The utilizer also agrees that any physician, health care provider, agent, proxy, surrogate, representative, mediator, court officer, and all others relying on the document's content are similarly free of all liability, when they act in good faith and with due diligence to follow the recorded wishes and directions.

Statutory
Advance Health Care Directive
For California Residents

______________________________ _______________________

Print Full Name *Date of Birth*

Your right *(when age 18 or older): To Document Your Personal Wishes,*
and to have these wishes followed ~~

The California state legislature has designed a combined Power of Attorney for Health Care and Living Will (health care instruction) for use by the public. As a document drawn from the Uniform Health Care Decisions Act, it is in compliance with all applicable statutes and laws.

The statutes note, "The form provided in Section 4701 may, but need not, be used to create an advance health care directive." Further, "An individual may complete or modify all or any part of the form in Section 4701." Should you want to complete a more comprehensive advance directive, or to enhance the content of this directive, you should contact the staff at Lifecare Directives, LLC, in order to obtain the necessary documents.

There is an introduction that summarizes the scope and purpose of the document, as well as providing directions for its completion. Read it carefully to ensure that your Advance Directive is fully and properly filled out.

By completing your advance directive, you can have the peace of mind that many of your wishes are known and can be followed. It is also a meaningful gift to those you love. Your completed directive will help ensure that your loved ones will have to make fewer difficult choices for you without having an understanding of what you would want done.

***Understanding Your Directive*:**

The California state legislature produced the following extended preface to your statutory advance directive:

You have the right to give instructions about the kind of health care that you would, or would not want provided to you. You also have the right to name someone else to make health care decisions in your behalf, if you are ever unable to make them for yourself. This form lets you do either or both of these things. It also lets you express your wishes regarding donation of organs and the designation of your primary physician. If you use this form, you may complete or modify all or any part of it. You are free to use a different form.

Part 1 of this form is a power of attorney for health care. Part 1 lets you name another individual as agent to make health care decisions for you if you become incapable of making

your own decisions or if you want someone else to make those decisions for you now even though you are still capable. You may 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, or your supervising health care provider or employee of the health care institution where you are receiving care, unless your agent is related to you or is a coworker.)

Unless the form you sign limits the authority of your agent, your agent may make all health care decisions for you. This form has a place for you to limit the authority of your agent. You need not limit the authority of your agent if you wish to rely on your agent for all health care decisions that may have to be made. If you choose not to limit the authority of your agent, your agent will have the right to:

a. Consent or refuse consent to any care, treatment, service, or procedure to maintain, diagnose, or otherwise affect a physical or mental condition.
b. Select or discharge health care providers and institutions.
c. Approve or disapprove diagnostic tests, surgical procedures, and programs of medication.
d. Direct the provision, withholding, or withdrawal of artificial nutrition and hydration and all other forms of health care, including cardiopulmonary resuscitation.
e. Make anatomical gifts, authorize an autopsy, and direct disposition of remains.

Part 2 of this form lets you give specific instructions about any aspect of your health care, whether or not you appoint an agent. Choices are provided for you to express your wishes regarding the provision, withholding, or withdrawal of treatment to keep you alive, as well as the provision of pain relief. Space is also provided for you to add to the choices you have made or for you to write out any additional wishes. If you are satisfied to allow your agent to determine what is best for you in making end-of-life decisions, you need not fill out Part 2 of this form.

Part 3 of this form lets you express an intention to donate your bodily organs and tissues following your death.

Part 4 of this form lets you designate a physician to have primary responsibility for your health care.

After completing this form, sign and date the form at the end. The form must be signed by two qualified witnesses, or else acknowledged before a notary public. Give a copy of the signed and completed form to your physician, to any other health care providers you may have, to any health care institution at which you are receiving care, and to any health care agents you have named. You should talk to the person you have named as agent to make sure that he or she understands your wishes and is willing to take the responsibility to follow them. You have the right to revoke this advance health care directive or replace this form at any time.

* * * * * * * * * * * * * * * * *

PART 1:
DURABLE POWER OF ATTORNEY
FOR HEALTH CARE

(Pursuant to Probate Code, Div.4.7, §4701)

(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*)

____
(*address, city, state, zip code*)

____
(*home phone and work phone*)

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 first alternate agent*)

____
(*address, city, state, zip code*)

____
(*home phone and work phone*)

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, city, state, zip code*)

____
(*home phone and work phone*)

(1.2) **AGENT'S AUTHORITY**: My agent is authorized to make all health care decisions for me, including decisions to provide, withhold, or withdraw artificial nutrition and hydration and all other forms of health care to keep me alive, 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 space.

_____ My agent's authority to make health care decisions for me shall take 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 in 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, in the order designated.

* * * * * * * * * * * * * * * * * *

PART 2:
INSTRUCTIONS FOR HEALTH CARE

If you fill out this part of the form, you may strike (line 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 choice I have initialed below:

(*Initial only one*)

_____ (a) Choice Not To Prolong Life I do not want my life to be 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, or (3) the likely risks and burdens of treatment would outweigh the expected benefits,

OR

_____ (b) Choice To Prolong Life I want my life to be prolonged as long as possible within the limits of generally accepted health care standards.

(2.2) **RELIEF FROM PAIN**: Except as I state in the following space, I direct that treatment for alleviation of pain or discomfort be provided at all times, even if it hastens my death:

____
____
____
____
____
____
____
____

(*Add additional sheets if needed*.)

(2.3) **OTHER WISHES**: (If you do not agree with any of the optional choices above and wish to write your own, or if you wish to add to the instructions you have given above, you may do so here.) I direct that:

____
____
____
____
____
____
____
____
____

(*Add additional sheets if needed*.)

* * * * * * * * * * * * * * * * * *

PART 3:
DONATION OF ORGANS AT DEATH
(*Optional*)

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

(*Initial only one*)

_____ (a) I wish to give any needed organs, tissues, or parts.

OR,

_____ (b) I give the following organs, tissues, or parts only:

____

(c) My gift is for the following purposes (strike any of the following you do not want):

_____ (1) Transplant
_____ (2) Therapy
_____ (3) Research
_____ (4) Education

PART 4:
PRIMARY PHYSICIAN DESIGNATION
(*Optional*)

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

____
(*name of physician*)

____
(*address, city, state, zip code*)

____
(*telephone*)

OPTIONAL: If the physician I have designated above is not willing, able, or reasonably available to act as my primary physician, I designate the following physician as my primary physician:

____
(*name of physician*)

____
(*address, city, state, zip code*)

____
(*telephone*)

* * * * * * * * * * * * * * * * * *

PART 5:
GENERAL EFFECT AND WITNESSING

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

(5.2) **SIGNATURE**: Sign and date the form here:

______________________________ ______________________________
(*sign your name*) (*date*)

____
(*print your name*)

____
(*address, city, state, zip*)

(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 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.

42. First Witness: ____

Printed Name:____

Address: ____

Date: ____

43. Second Witness: ____

Printed Name:____

Address: ____

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 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 of witness*) (*signature of witness*)

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* * * * * * * * * * * * * * * * * *

PART 6
SPECIAL WITNESSING REQUIREMENT

(6.1) 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. In such a setting, a "patient advocate" or designated "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.

____

(*sign your name*)

____

(*print your name*)

____

(*address, city, state, zip*)

____

(*telephone*)

INDIVIDUALS AND INSTITUTIONS WHO HAVE BEEN GIVEN COPIES OF THIS ADVANCE DIRECTIVE

Name:	______________________________	Name:	______________________________
Address	______________________________	Address:	______________________________
	______________________________		______________________________
Phone	(_____) ______ - _______________	Phone	(_____) ______ - _______________
Fax:	(_____) ______ - _______________	Fax:	(_____) ______ - _______________
E-mail:	______________________________	E-mail:	______________________________
Name:	______________________________	Name:	______________________________
Address	______________________________	Address:	______________________________
	______________________________		______________________________
Phone	(_____) ______ - _______________	Phone	(_____) ______ - _______________
Fax:	(_____) ______ - _______________	Fax:	(_____) ______ - _______________
E-mail:	______________________________	E-mail:	______________________________
Name:	______________________________	Name:	______________________________
Address	______________________________	Address:	______________________________
	______________________________		______________________________
Phone	(_____) ______ - _______________	Phone	(_____) ______ - _______________
Fax:	(_____) ______ - _______________	Fax:	(_____) ______ - _______________
E-mail:	______________________________	E-mail:	______________________________
Name:	______________________________	Name:	______________________________
Address	______________________________	Address:	______________________________
	______________________________		______________________________
Phone	(_____) ______ - _______________	Phone	(_____) ______ - _______________
Fax:	(_____) ______ - _______________	Fax:	(_____) ______ - _______________
E-mail:	______________________________	E-mail:	______________________________

For additional copies of this directive, or other related materials, please contact Lifecare Directives, LLC, at:

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