

# **CALIFORNIA**

## **Advance Directive**

### **Planning for Important Healthcare Decisions**

Courtesy of CaringInfo

[www.caringinfo.org](http://www.caringinfo.org)

CaringInfo, a program of the National Alliance for Care at Home (the Alliance), is a national consumer engagement initiative to improve care and the experience of caregiving during serious illness and at the end of life. As part of that effort, CaringInfo provides detailed guidance for completing advance directive forms in all 50 states, the District of Columbia, and Puerto Rico.

This package includes:

- Instructions for preparing your advance directive. Please read all the instructions.
- Your state-specific advance directive forms, which are the pages with the gray instruction bar on the left side.

#### **BEFORE YOU BEGIN**

Check to be sure that you have the materials for each state in which you may receive healthcare. Because documents are state-specific, having a state-specific document for each state where you may spend significant time can be beneficial. A new advance directive is not necessary for ordinary travel into other states. The advance directives in this package will be legally binding only if the person completing them is a competent adult who is 18 years of age or older, or an emancipated minor.

#### **ACTION STEPS**

1. You may want to photocopy or print a second set of these forms before you start so you will have a clean copy if you need to start over.
2. When you begin to fill out the forms, refer to the gray instruction bars — they will guide you through the process.
3. Talk with your family, friends, and physicians about your advance directive. Be sure the person you appoint to make decisions on your behalf understands your wishes.
4. Once the form is completed and signed, photocopy, scan, or take a photo of the form and give it to the person you have appointed to make decisions on your behalf, your family, friends, healthcare providers, and/or faith leaders so that the form is available in the event of an emergency.

5. You may also want to save a copy of your form in your electronic healthcare record, or an online personal health records application, program, or service that allows you to share your medical documents with your physicians, family, and others who you want to take an active role in your advance care planning.
6. California maintains an Advance Directive Registry. By filing your advance directive with the registry, your healthcare provider and loved ones may be able to find a copy of your advance directive in the event you are unable to provide one. You can read more about the registry, including instructions on how to file your advance directive, at <http://www.sos.ca.gov/registries/advance-health-care-directive-registry/>.

## **INTRODUCTION TO YOUR CALIFORNIA ADVANCE HEALTH CARE DIRECTIVE**

This packet contains a legal document, a **California Advance Health Care Directive**, that protects your right to refuse medical treatment you do not want, or to request treatment you do want, in the event you lose the ability to make decisions yourself.

Your California Advance Directive has five parts. Depending on your advance planning needs, you may complete any or all of the first four parts. However, **you must complete part 5.**

### **How do I make my California advance health care directive legal?**

You must sign and date your advance directive or direct an adult to do so for you if you are unable to sign it yourself, either of which must be witnessed before a notary public or two adult witnesses.

Your two adult witnesses cannot be:

- your healthcare provider or an employee of your healthcare provider,
- the operator or an employee of a community care facility,
- the operator or an employee of a residential care facility for the elderly, or
- the person you have appointed as an agent, if you have appointed an agent.

In addition, one of your witnesses must be unrelated to you by blood, marriage, or adoption and not entitled to any portion of your estate.

If you are a patient in a skilled nursing facility when you execute your advance directive, one of your witnesses must be a patient advocate or ombudsman.

### **Whom should I appoint as my agent?**

Your agent is the person you appoint to make decisions about your healthcare if you become unable to make those decisions yourself. Your agent may be a family member or a close friend whom you trust to make serious decisions. The person you name as your agent should clearly understand your wishes and be willing to accept the responsibility of making healthcare decisions for you.

Your agent cannot be:

- your supervising healthcare provider,
- the operator of a community care facility or residential care facility where you are receiving care, or
- the employee of a healthcare institution where you are receiving care or employee of a community care facility or residential care facility where you are receiving care, unless:
  - the employee is related to you by blood, marriage, or adoption,
  - the employee is your registered domestic partner, or
  - the employee is your coworker at the facility or institution.

You can appoint a second and third person as your alternate agents. An alternate agent will step in if the person(s) you name as agent is/are unable, unwilling, or unavailable to act for you.

### **Should I add personal instructions to my advance directive?**

Yes! One of the most important reasons to execute an advance directive is to have your voice heard. When you name an agent and clearly communicate to them what you want and don't want, they are in the strongest position to advocate for you. Because the future is unpredictable, be careful that you do not unintentionally restrict your agent's power to act in your best interest. Be especially careful with the words "always" and "never." In any event, be sure to talk with your agent and others about your future healthcare and describe what you consider to be an acceptable "quality of life."

### **When does my agent's authority become effective?**

Ordinarily, your advance directive only becomes effective when you have been determined by your medical team to be unable to make your own decisions. In California, however, you have a choice between making your agent's authority effective immediately or only after a physician determines and documents that you are unable to make decision on your own behalf. Even when you make your agent's authority immediate, you retain the primary authority for your healthcare decisions as long as you are able to make your wishes known.

### **Agent Limitations**

Your agent, if you appoint one, does not have authority to authorize convulsive treatment, psychosurgery, sterilization, or abortion, or to have you committed or placed in a mental health treatment facility.

Your agent will be bound by the current laws of California as they regard pregnancy and termination of pregnancies.

### **What if I change my mind?**

Except for the appointment of your agent, you may revoke any portion or this entire advance directive at any time and in any way that communicates your intent to revoke. This could be by telling your agent or physician that you revoke, by signing a revocation, or simply by tearing up your advance directive.

In order to revoke your agent's appointment, you must either tell your supervising healthcare provider of your intent to revoke or revoke your agent's appointment in a signed writing.

If you execute a new advance directive, it will revoke the old advance directive to the extent of any conflict between the two documents.

Unless you specify otherwise, if you designate your spouse as your agent, that designation will automatically be revoked by divorce or annulment of your marriage.

## **Mental Health Issues**

These forms do not *expressly* address mental illness, although you can state your wishes and grant authority to your agent regarding mental health issues. The National Resource Center on Psychiatric Advance Directives maintains a website (<https://nrc-pad.org/>) with links to each state's psychiatric advance directive forms. If you would like to make more detailed advance care plans regarding mental illness, you could talk to your physician and an attorney about a durable power of attorney tailored to your needs.

## **What other important facts should I know?**

Be aware that your advance directive will not be effective in the event of a medical emergency, except to identify your agent. Ambulance and hospital emergency department personnel are required to provide cardiopulmonary resuscitation (CPR) unless you have a separate physician's order, which are typically called "prehospital medical care directives" or "do not resuscitate orders." DNR forms may be obtained from your state health department or department of aging (<https://www.hhs.gov/aging/state-resources/index.html>). Another form of orders regarding CPR and other treatments are state-specific POLST (portable orders for life sustaining treatment) (<https://polst.org/form-patients/>). Both a POLST and a DNR form **MUST** be signed by a healthcare provider and **MUST** be presented to the emergency responders when they arrive. These directives instruct ambulance and hospital emergency personnel not to attempt CPR (or to stop it if it has begun) if your heart or breathing should stop.

**Explanation**

You have the right to give instructions about your own physical and mental health care. You also have the right to name someone else to make health care decisions for you. 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 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 an employee of the health care institution where you are receiving care, unless your agent is related to you, is your registered domestic partner, or is a co-worker. Your supervising health care provider can never act as your agent.)

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) For all physical and mental health care, 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; and
- (e) Donate your organs, tissues and parts, authorize an autopsy, and direct the disposition of your remains.

**Explanation Continued**

**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 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, tissues and parts 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 in **Part 5**. The form must be signed by two qualified witnesses or 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 and alternate agent(s) to make sure that he or she understands your wishes and is willing to take the responsibility.

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

**INSTRUCTIONS**

PRINT THE NAME,  
HOME ADDRESS  
AND HOME AND  
WORK TELEPHONE  
NUMBERS OF YOUR  
PRIMARY

AGENT

PRINT THE NAME,  
HOME ADDRESS  
AND HOME AND  
WORK TELEPHONE  
NUMBERS OF YOUR  
FIRST ALTERNATE  
AGENT  
(OPTIONAL)

PRINT THE NAME,  
HOME ADDRESS  
AND HOME AND  
WORK TELEPHONE  
NUMBERS OF YOUR  
SECOND  
ALTERNATE

AGENT  
(OPTIONAL)

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**PART 1: POWER OF ATTORNEY FOR HEALTH CARE**

(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) (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) (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) (work phone)

ADD  
INSTRUCTIONS  
HERE ONLY IF YOU  
WANT TO LIMIT  
THE POWER OF  
YOUR AGENT

INITIAL THE BOX IF  
YOU WISH YOUR  
AGENT'S  
AUTHORITY TO  
BECOME EFFECTIVE  
IMMEDIATELY

CROSS OUT AND  
INITIAL ANY  
STATEMENTS IN  
PARAGRAPHS 4, 5,  
OR 6 THAT DO NOT  
REFLECT YOUR  
WISHES

(2) AGENT'S AUTHORITY: My agent is authorized to make all physical and mental 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:

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(Add additional sheets if needed.)

(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 mark the following box. If I mark this box [ ☐ ], my agent's authority to make health care decisions for me takes effect immediately.

(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.

(5) AGENT'S POSTDEATH AUTHORITY: My agent is authorized to donate my organs, tissues and parts, authorize an autopsy, and direct disposition of my remains, except as I state here, in paragraph (2) above, or in Part 3 of this form:

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(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 any wording you do not want.

(7) 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 marked below: (**Initial only one box**)

☐ (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.

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

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INITIAL THE  
PARAGRAPH  
THAT BEST  
REFLECTS YOUR  
WISHES  
REGARDING  
LIFE-SUPPORT  
MEASURES

ADD INSTRUCTIONS  
HERE ONLY IF YOU  
WANT TO LIMIT  
PAIN RELIEF OR  
COMFORT CARE

[illegible]

(Add additional sheets if needed.)

**PART 3: DONATION OF ORGANS AT DEATH**

(OPTIONAL)

ORGAN  
DONATION  
(OPTIONAL)

INITIAL THE BOX  
THAT AGREES  
WITH YOUR  
WISHES ABOUT  
ORGAN  
DONATION

(10) Upon my death (initial applicable box):

[ ☐ ] (a) I do not give any of my organs, tissues, or parts and do not want my agent, conservator, or family to make a donation on my behalf,

[ ☐ ] (b) I give any needed organs, tissues, or parts,

OR

[ ☐ ] (c) I give the following organs, tissues, or parts only

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

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

By checking the box above to give any organs, tissues or parts, or to give specified organs, tissues or parts only, I authorize my agent to consent to any temporary medical procedure necessary solely to evaluate and/or maintain my organs, tissues, and/or parts for purposes of donation.

If I leave this part blank, it is not a refusal to make a donation. My state-authorized donor registration should be followed, or, if none, my agent may make a donation upon my death. If no agent is named above, I acknowledge that California law permits an authorized individual to make such a decision on my behalf.

STRIKE  
THROUGH ANY  
USES YOU DO  
NOT AGREE TO

PRINT THE NAME,  
ADDRESS AND  
TELEPHONE  
NUMBER OF YOUR  
PRIMARY  
PHYSICIAN  
(OPTIONAL)

PRINT THE NAME,  
ADDRESS AND  
TELEPHONE  
NUMBER OF YOUR  
ALTERNATE  
PRIMARY  
PHYSICIAN  
(OPTIONAL)

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PART 4: PRIMARY PHYSICIAN

(OPTIONAL)

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

_____		
(name of physician)		
_____		
(address)		
_____	_____	_____
(city)	(state)	(zip code)
_____		
(phone)		

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)
_____		
(phone)		

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

**PART 5: EXECUTION**

This Health Care Directive will not be valid unless it is EITHER:

(A) Signed by two (2) qualified adult witnesses who are personally known to you or to whom you have proven your identity by convincing evidence and who are present when you sign or acknowledge your signature. Your witnesses may not be

- your health care provider or an employee of your health care provider,
- the operator or an employee of a community care facility,
- the operator or an employee of a residential care facility for the elderly, or
- the person you have appointed as an agent, if you have appointed an agent.

In addition, one of your witnesses must be unrelated to you by blood, marriage, or adoption and not entitled to any portion of your estate. (Use Alternative 1, below, if you decide to have your signature witnessed.)

OR

(B) Witnessed by a notary. (Use Alternative 2, below (page 12), if you decide to have your signature notarized.)

IF YOU CHOOSE TO  
SIGN WITH  
WITNESSES, USE  
ALTERNATIVE 1,  
BELOW

IF YOU CHOOSE TO  
HAVE YOUR  
SIGNATURE  
NOTARIZED, USE  
ALTERNATIVE 2,

BELOW (PAGE 12)

THERE ARE SPECIAL  
WITNESSING  
REQUIREMENTS IF  
YOU LIVE IN A  
SKILLED NURSING  
FACILITY

If you are a patient in a skilled nursing facility when you execute your advance directive, one of your witnesses must be a patient advocate or ombudsman. This witness must sign the statement on page 13, even if you have had your advance directive notarized.

SIGN AND DATE  
THE DOCUMENT  
AND THEN PRINT  
YOUR NAME AND  
ADDRESS

WITNESSING  
PROCEDURE

BOTH OF YOUR  
WITNESSES MUST  
AGREE WITH THIS  
STATEMENT

ONE WITNESS  
MUST ALSO SIGN  
THE STATEMENT  
ON PAGE 11

HAVE YOUR  
WITNESSES SIGN  
AND DATE THE  
DOCUMENT AND  
THEN PRINT THEIR  
NAME AND  
ADDRESS

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OPTION 1: Sign before a Witness

\_\_\_\_\_  
(date) (sign your name)

\_\_\_\_\_  
(print your name)

\_\_\_\_\_  
(address)

\_\_\_\_\_  
(city) (state) (zip code)

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 an 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:

\_\_\_\_\_  
(date) (signature of witness)

\_\_\_\_\_  
(printed name of witness)

\_\_\_\_\_  
(address)

\_\_\_\_\_  
(city) (state) (zip code)

Second Witness:

\_\_\_\_\_  
(date) (signature of witness)

\_\_\_\_\_  
(printed name of witness)

\_\_\_\_\_  
(address)

\_\_\_\_\_  
(city) (state) (zip code)

ONE OF YOUR  
WITNESSES MUST  
ALSO SIGN THIS  
STATEMENT

**ADDITIONAL WITNESS STATEMENT**

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.

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(date)

---

(signature of witness)

SIGN AND DATE  
THE DOCUMENT  
AND THEN PRINT  
YOUR NAME AND  
ADDRESS

A NOTARY PUBLIC  
MUST FILL OUT  
THIS PORTION OF  
THE FORM

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## ACKNOWLEDGMENT

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, \_\_\_\_\_

(insert name and title of the officer)

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.

Signature \_\_\_\_\_ (Seal)

THIS SECTION  
MUST BE  
COMPLETED  
BY A PATIENT  
ADVOCATE OR

OMBUDSMAN IF  
YOU ARE A  
RESIDENT IN A  
SKILLED NURSING  
FACILITY

**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 witness as required by section 4675 of the Probate Code.

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(date)

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(signature)

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(printed name)

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(address)

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(city)

(state)

(zip code)