Advance Health Care Directive

State of California

Life Care Planning:
Values, Choices, Care

kp.org/lifecareplan

There are two versions of this document. This version lets you give more detail. You can view the two versions on kp.org/lifecareplan or ask your health care team for a copy. Choose the one that meets your needs the best.

Complete this document by:

1. Signing and dating where needed.
2. Having it witnessed or notarized. Your health care agent (decision maker) **cannot** sign as a witness.
3. Remember to return a **copy** to Kaiser Permanente and give a **copy** to your health care agent. Keep the **original** form.

KAISER PERMANENTE®

Advance Health Care Directive

What is an Advance Health Care Directive?

The Advance Health Care Directive (AHCD) is a legal form that will let your health care teams know how you want to be cared for if you are not able to make health care decisions for yourself.

The AHCD allows you to:

- Choose a health care agent (decision maker) to make health care decisions for you if you are unable to do so AND/OR
- Express your values, beliefs, and health care preferences

The AHCD helps your health care agent (decision maker) and health care team develop a treatment plan for you.

You can update ANY of your preferences in your AHCD at any time by completing a new document. This new AHCD will replace any AHCD you have completed in the past.

You have the right to share your preferences about your own health care.

Why is an AHCD important?

It is also a chance to reflect on what quality of life means to you and how your preferences may impact your loved ones. We recommend talking with your loved ones about what you write in this form. This will help them feel more confident about making decisions for you.

Who is the AHCD for?

Any adult of sound mind 18 and older should consider completing an Advance Health Care Directive no matter their health status.

Other references:

Life Care Planning:
Values, Choices, Care
kp.org/lifecareplan

KAISER PERMANENTE®

My first name: _____

My last name: _____

My medical record number: _____

KP use: patient label

What is in this document?

You can fill out **as much or as little** of this document as you would like.

If you decide to not complete a section, draw a line through the page and initial it. This will let us know it was left blank on purpose.

Part 5 is required for this document to be legal in the State of California.

The Kaiser Permanente Advance Health Care Directive has 5 parts, including how to make it a legal document:

Part 1: Choosing my health care agent(s) (decision makers)
Allows you to name someone to make health care decisions for you if you are unable to make them for yourself.

Part 2: My values and beliefs
Gives you a chance to reflect on what quality of life and living well mean to you. Completing this section will help you think through the rest of the document.

Part 3: Choosing my health care preferences
Allows you to write down your preferences for health care if you are unable to make your own health care decisions due to an injury or illness.

Part 4: After-death preferences
Allows you to write down any after-death wishes you have, including organ donation, funeral wishes, etc.

Part 5: Making it legal
Completing this section makes this document legal in the State of California.

This document also includes a checklist to help you share your preferences with Kaiser Permanente and others.

This Advance Health Care Directive belongs to:

Full name

Medical record number

Date of birth

Mailing address

City

State

Zip code

Primary phone number

Secondary phone number

Email

KAISER PERMANENTE®

My first name: _____

My last name: _____

My medical record number: _____

KP use: patient label

Choosing my health care agent(s) (decision maker)

This section names someone I trust to make health care decisions for me if I am unable to make them for myself.

Part 1

Choosing your **health care agent** also means sharing your values and beliefs with them. Tell them what medical care you would want if you were unable to make decisions for yourself.

If my doctor has determined that I am not able to make my own health care decisions, this form names the person(s) I choose to make health care decisions for me.

My health care agent (decision maker) will speak for me to make health care decisions based on my preferences or what they believe to be in my best interest, considering what they know about my personal values and beliefs.

Note: Talk to your agent about what is most important to you and make sure they feel able to do this role. Tell those closest to you who you have chosen to be your agent.

Who should I choose to be my health care agent?

When choosing your health care agent, choose a person who is important to you and could make hard decisions in a difficult time. Your agent cannot be your doctor or another health care professional who cares for you as part of your treatment team.[1]

You cannot know every health care situation that might happen. Your agent will have to make decisions in real time based on information shared by the medical team. Talking with your agent about the kind of care you want and do not want will give you both a shared understanding and peace of mind.

Sometimes, a spouse or family member may be the best choice. Sometimes, they are not the best choice. You know best.

A good health care agent is someone who:

- Is willing to be your health care agent and can be reasonably available
- Knows your values and beliefs well
- Is willing to follow your wishes even if they are different from their own
- Is not afraid to ask doctors questions and speak up about your wishes, even if it goes against the wishes of others
- Is able to make decisions under stress
- Will check in with you about your preferences over time

Notes: Your health care agent *may or may not* be the same person you choose as an emergency contact in your medical chart.

This form does not give your agent permission to make financial or other business decisions for you.

[1] California Probate Code Section 4659

My first name: _____

My last name: _____

My medical record number: _____

KP use: patient label

Speak with your **agent** about the kinds of decisions or tasks they might have to make or do. Use the questions in **Part 2** to guide your conversation.

My health care agent may make health care decisions for me if I am unable to make them for myself. **Unless I limit my agent's authority, decisions they can make include:**

- Say **yes/no** to medications, tests, and treatments. Choose or change health care providers and decide where I will get care
- **Start, not start, or stop** interventions to keep me alive
- Arrange for and make decisions about the care of my body after death (including autopsy, organ donation, and what happens to my remains)

I choose the following person to be my health care agent and make health care decisions for me if I am unable to make them for myself.

Choosing a health care agent.

My health care agent:

Full name

Relationship

Mailing address

City | *State* | *Zip code*

Primary phone number | *Secondary phone number*

Email

If your spouse is your agent, and later you divorce or annul the marriage, that person will no longer be your agent.

If you would like your ex-spouse to be your agent, please complete a new advance health care directive.

My first name: _____

My last name: _____

My medical record number: _____

KP use: patient label

If the first person cannot be my health care agent, then I choose the following person(s) to be my alternate agent(s) in the order listed below.

[Optional] Add a first and/or second alternate health care agent.

If no one comes to mind, continue on the next page.

First alternate health care agent:

Full name

Relationship

Mailing address

City | *State* | *Zip code*

Primary phone number | *Secondary phone number*

Email

Second alternate health care agent:

Full name

Relationship

Mailing address

City | *State* | *Zip code*

Primary phone number | *Secondary phone number*

Email

My first name: _____

My last name: _____

My medical record number: _____

KP use: patient label

If you do not want certain people involved in making health care decisions for you, please list their name(s).

I DO NOT want the following people to make health care decisions for me (use the space below).

My values and beliefs

This section lets me reflect on what quality of life and living well mean to me.

Part 2

Completing the **my values and beliefs** section allows you to write down what is most important in your life. Take your time with these questions. They will help you think through **Part 3** of this form.

Check all that apply and use the space below to describe more.

1. For me to live well, the following matter most to me:

- ❑ Spending time and connecting with loved ones
- ❑ Recognizing friends and family
- ❑ Making my own decisions
- ❑ Communicating meaningfully
- ❑ Being physically active
- ❑ Being socially active
- ❑ Living independently
- ❑ Feeding myself without help
- ❑ Taking care of my personal hygiene (bathing, dressing myself)
- ❑ Living in my home
- ❑ Working and/or volunteering
- ❑ Participating in hobbies or interests
- ❑ Honoring my spiritual beliefs and/or religion
- ❑ Other (say more below)

My first name: _____

My last name: _____

My medical record number: _____

KP use: patient label

2. How do my culture, spirituality, religion, and/or belief system influence my health care decisions? How important is this to me?

Only answer if this is relevant to you.

Choosing my health care preferences

This section, along with **Part 2: My values and beliefs**, describes my preferences to guide **my agent(s) and doctors** to make medical decisions for me if I am unable to make them myself.

Part 3

Choosing your **health care preferences** might feel uncomfortable. Doing so while you can gives you a voice to express your preferences in case you won't be able to later.

What are life-sustaining treatments?

Life-sustaining treatments are designed to keep a person alive when their body is no longer able to function on its own.

Examples:

- **Cardiopulmonary resuscitation (CPR):** an attempt to restart the heart with chest compressions if your heart and breathing stop.
- **Ventilator:** a machine that breathes for you when your lungs are not working.
- **Tube feeding:** also called artificial nutrition, provides liquid food (nutrition) to the body. This is done when a person cannot eat enough by mouth or has problems swallowing.
- **Dialysis:** a machine that removes waste from your blood if your kidneys are not working.

Share your values and health care preferences with your agent. Talk about why your choices are important to you.

Now that you have learned about life-sustaining treatments, consider the following. You can choose as many as you would like, or not choose any if none of these apply to you.

I would decline or stop life-sustaining treatments if I would not recover enough to:

- ❑ **Make my own decisions**
- ❑ **Communicate meaningfully**
- ❑ **Recognize friends and family**
- ❑ **Feed myself without help or tube feeding**
- ❑ **Take care of my personal hygiene (bathing, dressing myself)**
- ❑ **Engage with the community**

My first name: _____

My last name: _____

My medical record number: _____

KP use: patient label

In the situation described, you may not have the ability to recognize yourself or loved ones. The doctors have told your agent and/or family that **you are not expected to recover these abilities.**

Based on your answers in the last section, consider the following scenarios as you choose your health care preferences below:

A. I have advanced dementia or severe brain damage that is not expected to get better. I am not able to function in a way that is acceptable to me.

Based on my values and beliefs:

- ❑ **I do not want any life-sustaining treatments.** I would either stop or not start these treatments.
- ❑ **I want life-sustaining treatments to start or continue,** as long as they are within the limits of generally accepted health care standards.
- ❑ **I want a time-limited trial of life-sustaining treatments,** as long as they are within the limits of generally accepted health care standards.

My preferences for a trial period are...

Examples of a serious, progressing illness may include congestive heart failure, end-stage kidney disease, cancer, liver cirrhosis, and/or chronic lung disease.

B. I have a serious, progressing illness that is nearing its final stage. I am not able to function in a way that is acceptable to me.

Based on my values and beliefs:

- ❑ **I do not want any life-sustaining treatments.** I would either stop or not start these treatments.
- ❑ **I want life-sustaining treatments to start or continue,** as long as they are within the limits of generally accepted health care standards.
- ❑ **I want a time-limited trial of life-sustaining treatments,** as long as they are within the limits of generally accepted health care standards.

My preferences for a trial period are...

My first name: _____

My last name: _____

My medical record number: _____

KP use: patient label

[Optional] Decision to decline specified medical treatment.

Blood transfusions are the process of transferring blood or blood products into your body through a narrow tube placed in a vein in your arm. Some people feel strongly about not receiving blood transfusions or blood products no matter their medical condition. If this applies to you and you would like to complete a form, please do any of the following:

- Ask your doctor's office for a Kaiser Permanente Life Care Planning Blood Management form **OR**
- Go to kp.org/lifecareplan, click Advance Health Care Directive, and download the Blood Management form

If you have completed a Blood Management form or have your own, please:

- Bring it to your next scheduled appointment **OR**
- Send a copy by mail to Kaiser Permanente Central Scanning, 1011 S. East Street, Anaheim, CA 92805 **OR**
- Email it to SCALCentralized-Scanning-Center@kp.org

Only answer if this is relevant to you.

If I want to add any other health care preferences, or if I wish to limit any life-sustaining treatments because of my cultural, religious, or personal beliefs, I will include these below.

Do I need another form?

If you currently have a serious, progressing illness that is nearing its final stage, please discuss with your doctor or health care team whether you should complete a POLST (Physician Orders for Life-Sustaining Treatment) document.

My first name: _____

My last name: _____

My medical record number: _____

KP use: patient label

After-death preferences

This section allows you to write down your preferences for how you want your body to be treated after death, along with your funeral, memorial, or burial wishes. You can also include your preferences for organ donation.

Part 4

Writing down your **after-death preferences** might feel difficult, but it will help your loved ones follow through on your wishes during an emotional time.

Writing down your preferences for what happens to you at death and after will help the people closest to you honor what is most important to you.

Take some time to reflect on these statements. If it helps, you can refer to **Part 2: My values and beliefs.**

If you are struggling or don't have all the answers, write down what you know and move forward.

A. After death, my preferences for how I want my body to be treated (autopsy, funeral, memorial, burial, or any religious or spiritual traditions) are listed below.

Please also **include any arrangements** (such as mortuary, cemetery, donation of your body to science) you may have already made.

Preferences for organs, tissues, and/or body parts donation.

B. Upon my death, I want to donate my organs, tissues, and/or body parts.
Choose **one** option for organ donation.

❑ **Yes**

By checking the box above, and regardless of my choice in **Part 3: Choosing my health care preferences** for end of life, I authorize my health care agent to consent to any temporary medical procedure necessary solely to evaluate and/or maintain my organs, tissues, and/or body parts for purposes of donation.

Choose **as many** as you wish.

I want to donate my organs, tissues, and/or body parts for:

❑ **Transplant**
❑ **Research**
❑ **Therapy**
❑ **Education**

My first name: _____

My last name: _____

My medical record number: _____

KP use: patient label

I want to restrict my donation of organs, tissues, and/or body parts as indicated below:

❑ **No**

❑ **I'm not sure**

If I leave this part blank, it is not a refusal to donate my organs, tissues, and/or body parts. My state-authorized donor registration should be followed, or, if none, my legally recognized decision maker listed in Part 1 may make a donation upon my death. If no health care agent is named, I acknowledge that California law permits an authorized individual to make such a decision on my behalf.

My first name: _____

My last name: _____

My medical record number: _____

KP use: patient label

Making this document legally valid

This section makes your Advance Health Care Directive legally valid in the State of California. For it to be legally valid, **(1) you must sign and date it AND (2) it must be signed by two witnesses OR acknowledged before a notary public.**

Part 5

Following legal requirements makes sure that all the work and thinking you put into this Advance Health Care Directive will be valid. Remember, if you want to change something later, complete a new form.

Sign at the bottom of this page AND choose ONE of the following to make this document legally valid in the State of California:

TWO WITNESSES

- The witnesses must be adults.
- One of your witnesses **cannot be related to you (by blood, marriage, or adoption)** and cannot be entitled to any part of your estate.
- Your **primary and alternate health care agents (decision makers) CANNOT sign** as witnesses.
- Your **health provider or an employee of the health care provider CANNOT sign** as a witness.
- The **operator or employee of a community care or residential care facility for the elderly CANNOT sign** as a witness.
- Witnesses will sign on page 13.

OR

NOTARY PUBLIC

- Do **NOT** sign this document unless you are with a notary public.
- The notary public will sign on page 14.

Your signature here.

Keep going! For this document to be legally valid in the State of California, **you also have to get this document witnessed or notarized.**

My signature

My name printed

My signature

Date

If you are physically unable to sign any mark you make that you intend to be your signature is acceptable.

Continue to the next page for witnessing and notary requirements.

My first name: _____

My last name: _____

My medical record number: _____

KP use: patient label

Choosing TWO WITNESSES.

I choose TWO WITNESSES to make this document legally valid in California.

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 Health Care 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 Health Care 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.

Witness number one signature.

Remember, your **health care agent cannot be a witness.**

Witness number one:

Name

Address

Signature *Date*

Witness number two signature.

Witness number two:

Name

Address

Signature *Date*

Legally, one of your witnesses **cannot be related to you.**

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 *Date*

My first name: _____

My last name: _____

My medical record number: _____

KP use: patient label

Choosing a NOTARY PUBLIC.

I choose a NOTARY PUBLIC instead of two witnesses to make this document legally valid in California.

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)

Additional signature required only if you are a patient in a skilled nursing facility.

Special witness requirement

If you are a patient in a skilled nursing facility, 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 an ombudsman as designated by the State Department of Aging and that I am serving as a witness as required by Section 4675 of the California Probate Code.

Signature *Date*

Congratulations! You're almost there. Here are a few more things to do to finish up the process.

Next Steps

Now that you have completed your Advance Health Care Directive (AHCD), use this checklist to make sure that you follow up on these last few steps.

❑ **Give copies of your AHCD**

- To your **health care agent** (decision maker), and alternate agent(s)
- **Bring it to your next scheduled appointment OR**
- **Send a copy by mail to** Kaiser Permanente Central Scanning, 1011 S. East Street, Anaheim, CA 92805 **OR**
- **Email it to** SCALCentralized-Scanning-Center@kp.org
- Keep the original

❑ **Discuss your AHCD**

- **Talk to your health care agent (decision maker)** about your values, beliefs, and health care preferences. Use your AHCD to guide the conversation and make sure they feel able to do this role.
- **Let your loved ones, family, and/or close friends** know who you have chosen to be your health care agent and what your health care preferences are and why.

❑ **Take your AHCD with you**

- If you go to a hospital or nursing home, take a copy of your AHCD and ask that it be placed in your medical record.

❑ **Review your AHCD regularly, especially at these times:**

- **Decade –** when you start a new decade of your life
- **Death –** when a loved one dies
- **Divorce/Marriage –** when you experience a divorce, marriage, or other major family change
- **Diagnosis –** when you are diagnosed with a serious health condition
- **Decline –** when you have a significant decline or deterioration of an existing health condition, especially if you are unable to live on your own

Remember: You can cancel or change ANY of your preferences in your AHCD at any time. As things change in your life or with your health, you can change your health care agent (decision maker) and your medical preferences. You must do so in writing and sign the new document, or you can tell your health care provider in person.

KAISER PERMANENTE®

KAISER PERMANENTE®

This information is not intended to diagnose health problems or to take the place of medical advice or care you receive from your doctor or other health care professional. If you have persistent health problems, or if you have additional questions, please consult with your doctor.

© 2025 Southern California Permanente Medical Group.
All rights reserved.
SCAL-LCP 032 (07/25)
kp.org/lifecareplan