Advance Health Care Directive

State of California

Life Care Planning:
Values, Choices, Care

kp.org/lifecareplan

Be sure to 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. You keep the **original** form.

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Advance Health Care Directive

What is an Advance Health Care Directive?

The Advance Health Care Directive (AHCD) is a legal document that provides your health care teams with guidance about what to do in the event 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 on your behalf if you are unable to do so AND/OR
- Express your values, beliefs, and health care preferences

The AHCD provides guidance to both your health care agent (decision maker) and health care team in developing a treatment plan for you. **It does NOT tell emergency personnel what treatments you want during a medical emergency.**

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.

Why is an AHCD important?

You have the right to share your preferences about your own health care. This document provides guidelines to your health care agent (decision maker) and doctors to provide care that is right for you.

It is also an opportunity to reflect on what quality of life means to you, and how your preferences may impact your loved ones. **By completing this document while you are able and talking about it with your loved ones, it may help reduce confusion and disagreement about what you may or may not want.**

Who is the AHCD for?

Any adult over the age of 18 of sound mind should consider completing an Advance Health Care Directive regardless of their health status.

Other references:

Life Care Planning:
Values, Choices, Care

kp.org/lifecareplan

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Full Name: _____

Medical Record #: _____

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, simply draw a line through the page and initial it. This will let us know it was intentionally left blank.

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

The Kaiser Permanente Advance Health Care Directive (AHCD) contains five 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 on your behalf if you are unable to make them for yourself.

Part 2: My Values & Beliefs
Gives you an opportunity to reflect on what quality of life and living well mean to you. We encourage you to complete this section as it will help you think through the rest of the document.

Part 3: Choosing My Health Care Preferences
Allows you to document 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 communicate any after-death wishes you may 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

Secondary phone

Email

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Full Name: _____

Medical Record #: _____

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 & beliefs with them and telling them what medical care you would want if you are unable to make decisions for yourself.

If my health care provider 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 on my behalf to make health care decisions for me based on the preferences I have shared with them 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 perform this role. Be sure to let those closest to you know who you have chosen to be your agent.

Who should I choose to be my health care agent?

When choosing your health care agent, consider selecting a person who is important to you and has the ability to make hard decisions in a difficult time. Legally, your agent cannot be your doctor or another health care professional who cares for you as part of your treatment team.

You cannot anticipate every health care situation; your agent will have to make decisions in real-time based on information shared by the medical team. Having discussions 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 & beliefs well
- Is willing to honor and represent your preferences even if they are different from their own
- Will not be afraid to ask questions and speak on your behalf, even if it goes against convention or the wishes of loved ones
- Is able to make decisions under stress
- Will continue to check-in with you about your preferences over time

Note: Your health care agent *may* or *may not* be the same person you would choose as an emergency contact.

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

Full Name: _____

Medical Record #: _____

Talk with your **Agent** about the kinds of responsibilities they might have to take on in this role. Use the questions in **Part 2** to guide your conversation.

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

- Say **yes/no** to medications, tests, treatments. Select or change health care providers and decide where I will receive care
- **Start, not start, or stop** all forms of life sustaining 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)

Choosing a Primary health care agent.

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

My Primary (main) health care agent:

Full name

Relationship

Mailing address

City | *State* | *Zip code*

Primary phone | *Secondary phone*

Email

My agent's authority becomes effective when my physician determines that I am unable to make my own health care decisions.

Please mark an "X" to select one of the following:

- ❑ I understand and accept that my agent will become active when I can **no longer** make my own decisions, OR
- ❑ I prefer that my agent make decisions on my behalf **immediately,** even though I am currently able to make my own decisions

Note: If your agent is a spouse or domestic partner, the agent designation is revoked in the event of a dissolution, annulment, or termination of the marriage or domestic partnership.

Full Name: _____

Medical Record #: _____

First & Second Alternate health care agent.

This section is recommended but optional. If no one comes to mind, **move forward**.

If my Primary health care agent is not willing, able, or reasonably available to make health care decisions for me, I choose the following to be my First and Second Alternate agents.

First Alternate health care agent:

Full name

Relationship

Mailing address

City | *State* | *Zip code*

Primary phone | *Secondary phone*

Email

Second Alternate health care agent:

Full name

Relationship

Mailing address

City | *State* | *Zip code*

Primary phone | *Secondary phone*

Email

Full Name: _____

Medical Record #: _____

Health care agent limitations.

If nothing comes to mind for either of these statements, **move forward.**

If I wish to limit my health care agent's authority, I will write below what health care decisions **I DO NOT** want my agent to make.

I will also write below the names of any individuals, if any, who **I DO NOT** want to make health care decisions for me.

Full Name: _____

Medical Record #: _____

My Values & Beliefs

This section lets me reflect on what quality of life and living well mean to me. It serves as a foundation for my responses to the rest of this document.

Part 2

Completing **My Values & Beliefs** section allows you to write down what is most important in your life. Take your time with these questions as they will help you think through **Part 3** of this document.

It is important to understand and reflect on what matters most so I can make decisions in advance about my health care that match who I am. It is also important for my health care agent (decision maker) to understand my values and what matters most to me.

I will share some things about myself, such as what is most important in my life, what living well means to me, and what abilities I value. I will also share how my belief system may influence my health care.

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
- ❑ Making my own decisions
- ❑ Communicating meaningfully
- ❑ Being physically active
- ❑ Recognizing friends and family
- ❑ Being socially active
- ❑ Living independently
- ❑ Feeding myself without assistance
- ❑ 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)

It also matters to me that...

Full Name: _____

Medical Record #: _____

2. This is WHY the choices I made in Question 1 matter to me. I will also share additional thoughts about what brings meaning to my life.

Think about what you value most. What does quality of life mean to you? These might feel like big questions, but **you already know more than you think.**

Why are these important to you?

Only answer if this is relevant to you.

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

It is important to me that...

Full Name: _____

Medical Record #: _____

Choosing My Health Care Preferences

This section along with **Part 2: My Values & Beliefs** describes my preferences to guide **my doctors and health care agent** to make medical decisions for me if I am unable to make my own health care decisions **AND** life sustaining interventions are needed to keep me alive.

Part 3

Choosing your **Health Care Preferences** might feel uncomfortable, but doing so while you are healthy gives you a voice for a time when you might not have one.

This document represents my health care preferences:

If I am unable to make my own health care decisions and life sustaining interventions are needed to keep me alive, I ask that my health care agent represent my health care preferences as described below.

I know that decisions will be made in partnership with my doctors and care team and they will consider my values & beliefs, my health care preferences, and my medical condition at the time decisions need to be made.

Note: By documenting your health care preferences in this directive, your health care agent and doctors can make decisions based on what you have written rather than guessing, assuming, or trying to remember. Discuss your preferences and your values and beliefs with your agent and doctors.

What are life sustaining interventions?

Life sustaining interventions include any medical procedures, devices, or medications that may be used to keep me alive.

These interventions may or may not work, and they do not treat the underlying condition or cause of illness.

Life sustaining interventions include the following:

- **Cardiopulmonary resuscitation (CPR):** an attempt to restart the heart with chest compressions if your heart and breathing were to stop.
- **Ventilator:** a machine that breathes for you when your lungs are not working. A tube is inserted either through your mouth or an incision in your neck into your airway. The tube connects to the machine.
- **Tube feeding:** also called artificial nutrition, is a medical treatment that provides liquid food (nutrition) to the body. This is done when a person cannot eat enough by mouth or they have problems swallowing.
- **Dialysis:** a machine that removes waste from your blood if your kidneys are not working.
- **Blood transfusions or use of blood products for treatments:** the process of transferring blood or blood products into your body through a narrow tube placed within a vein in your arm.

Full Name: _____

Medical Record #: _____

Share your values and health care preferences with your agent. Talk about why your choices are important to you. **Make sure they will honor your wishes even if they might be different from their own.**

Now that you have learned about life sustaining interventions, consider the following (select as many abilities below as you would like).

A. I would decline or stop life sustaining interventions if I was not able to:

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

Based on your answers above, consider the following as you choose your health care preferences below:

My health care agent is being asked to make medical decisions for me because a serious medical event, illness, or injury has left me unable to make my own decisions and life sustaining interventions are needed to keep me alive. Life sustaining interventions include: CPR, ventilator, tube feeding, dialysis, blood transfusions or blood products, etc.

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.**

B. 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 interventions.** I would either stop or not start life sustaining interventions.

☐ **I would want life-sustaining interventions to start or continue,** as long as medically appropriate.

☐ **I want a limited trial of life-sustaining interventions,** as long as medically appropriate. Typically, a trial is less than two weeks.

My preferences for a trial period are...because...

Full Name: _____

Medical Record #: _____

Examples of a serious, progressing illness may include heart, kidney, and lung disease.

C. 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 interventions.** I would either stop or not start life sustaining interventions.

☐ **I would want life-sustaining interventions to start or continue,** as long as medically appropriate.

☐ **I want a limited trial of life-sustaining interventions,** as long as medically appropriate. Typically, a trial is less than two weeks.

My preferences for a trial period are...because...

Only answer if this is relevant to you.

If I want to add any additional health care preferences, or if I wish to limit any life sustaining interventions because of my cultural, religious, or personal beliefs, I will write these limitation(s) in the space below.

I want...because...

Full Name: _____

Medical Record #: _____

[Optional] Decision to decline specified medical treatment.

Initial below if you want to decline blood transfusions or blood products for treatment (select the option that is true for you).

..... **I DECLINE blood transfusions or blood products and will fill out the Kaiser Permanente Blood Declaration form.**

..... **I DECLINE blood transfusions or blood products and I have completed a Kaiser Permanente Blood Declaration form.**

Do I need another form?

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

Full Name: _____

Medical Record #: _____

After-Death Preferences

This section allows you to record your preferences for how you want your body to be treated after death and what your funeral, memorial or burial wishes may be. You can also document your preferences for organ donation.

Part 4

Recording your **After-Death Preferences** might feel difficult, but it will help your loved ones follow through on your wishes during an emotional time.

Documenting 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 and if it helps, you can refer back to **Part 2: My Values & Beliefs.**

Remember: If you are struggling or don't have all the answers, document what you know and move forward.

1. If I am at the end of my life, I want my loved ones to know that I would like the following around me (for example, rituals, spiritual support, people, music, food, pets, etc.):

My preferences are...

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

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

My preferences are...

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

Choose **one** option for organ donation.

3. Upon my death, I want to donate my organs, tissues, and/or body parts.

- ❑ **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** options as applies:

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

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

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

  I would like to restrict...

- ❑ **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.

Full Name: _____

Medical Record #: _____

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 (2) it must be signed by two witnesses OR acknowledged before a Notary Public.**

Part 5

Following legal requirements ensures that all the work and thinking you put into this AHCD will be valid. Remember, if you want to change something later, just complete another AHCD.

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

- 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) can NOT sign** as witnesses.
- Your **health provider, or an employee of the health care provider CANNOT sign** as a witness
- When you are with your witnesses, sign or acknowledge your signature.
- Witnesses will sign on page 16.

OR

NOTARY PUBLIC

- Do **NOT** sign this document unless you are with a Notary Public.
- Notary Public will sign on page 17.

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.

Full Name: _____

Medical Record #: _____

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.

Witness number one:

Name

Address

Signature *Date*

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

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*

Full Name: _____

Medical Record #: _____

Only sign if this is relevant to you.

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*

Choosing a NOTARY PUBLIC.

I choose a NOTARY PUBLIC instead of two witnesses.

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)

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

Next Steps

Now that you have completed your Advance Health Care Directive (AHCD), use this checklist to ensure 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 to your next scheduled appointment OR**
  Send in a copy by mail to: Kaiser Permanente Central Scanning, 1011 S. East Street, Anaheim, CA 92805 **OR**
  Email: SCALCentralized-Scanning-Center@kp.org
- Keep **the original**

❑ **Discuss your AHCD**

- **Talk to your health care agent (decision maker)** about your values, beliefs, and your health care preferences. Use your AHCD to guide the conversation and make sure they feel able to perform this role.
- **Be sure to 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**

Review your AHCD whenever any of the following occur:

Decade – when you start a new decade of your life

Death – whenever you experience the death of a loved one

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 experience 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 who your health care agent (decision maker) is and what your medical preferences are. You must do so in writing and sign the new document, or you can inform your health care provider in-person.

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

Developed by Spark, a KPIT Innovation team in partnership with the regional Life Care Planning team. Special thanks to Bioethics, SCPMG Legal, and other key contributors for their guidance.

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