



LIFE CARE planning

my values, my choices, my care

kp.org/lifecareplan



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my values, my choices, my care

Full name: _____

Medical record number: _____

Introduction

Thank you for taking time to review and complete your advance directive for health care. At Kaiser Permanente, we believe this is an important first step in your life care planning journey.

Completion of this document can inform your health care team of your values, your choices for health care, and identifies who you wish to speak for you if you are unable.

This advance health care directive will replace any advance health care directive you have completed in the past. In the future, if you want to cancel or change your named health care representative, you must do so in writing and sign that document, or you can inform your health care provider in person.

If you have questions while completing this document, the following assistance is available:



Online – kp.org/lifecareplan



Classes – advance care planning classes provided through health engagement and wellness services, call 1-866-301-3866 (toll free)



To speak to a person, contact our health coaches at 1-866-301-3866 (toll free)

Oregon Advance Directive for Health Care

This Advance Directive form allows you to:

- Share your values, beliefs, goals and wishes for health care if you are not able to express them yourself.
- Name a person to make your health care decisions if you could not make them for yourself. This person is called your health care representative and they must agree to act in this role.

Be sure to discuss your Advance Directive and your wishes with your health care representative.

This will allow them to make decisions that reflect your wishes. It is recommended that you complete this entire form.

The Oregon Advance Directive for Health Care form and Your Guide to the Oregon Advance Directive are available on the Oregon Health Authority's website.

- In sections 1, 2, 5, 6 and 7 you appoint a health care representative.
- In sections 3 and 4 you provide instructions about your care.

The Advance Directive form allows you to express your preferences for health care. It is not the same as Portable Orders for Life Sustaining Treatment (POLST) as defined in ORS 127.663. You can find more information about the POLST in Your Guide to the Oregon Advance Directive.

This form may be used in Oregon to choose a person to make health care decisions for you if you become too sick to speak for yourself or are unable to make your own medical decisions.

The person is called a health care representative. If you do not have an effective health care representative appointment and you become too sick to speak for yourself, a health care representative will be appointed for you in the order of priority set forth in ORS 127.635 (2) and this person can only decide to withhold or withdraw life sustaining treatments if you meet one of the conditions set forth in ORS 127.635 (1).

This form also allows you to express your values and beliefs with respect to health care decisions and your preferences for health care.

If you have completed an advance directive in the past, this new advance directive will replace any older directive.

You must sign this form for it to be effective. You must also have it witnessed by two witnesses or a notary. Your appointment of a health care representative is not effective until the health care representative accepts the appointment.

If your advance directive includes directions regarding the withdrawal of life support or tube feeding, you may revoke your advance directive at any time and in any manner that expresses your desire to revoke it.

In all other cases, you may revoke your advance directive at any time and in any manner as long as you are capable of making medical decisions.

Document type: Advance Directive

Full name: _____ Medical record number: _____

1. About me

Name (first, middle, last): _____
Date of birth: _____ Medical record number: _____
Home phone: _____ Cell phone: _____
Work phone: _____ Email: _____
Mailing address: _____

2. My health care representatives

I choose the following person as my health care representative to make health care decisions for me if I can't speak for myself.

Primary health care representative

Name (first, middle, last): _____
Relationship: _____
Home phone: _____ Cell phone: _____
Work phone: _____ Email: _____
Mailing address: _____

I choose the following people to be my alternate health care representatives if my first choice is not available to make health care decisions for me, or if I cancel the first health care representative's appointment.

First alternate health care representative

Name (first, middle, last): _____
Relationship: _____
Home phone: _____ Cell phone: _____
Work phone: _____ Email: _____
Mailing address: _____

Second alternate health care representative

Name (first, middle, last): _____
Relationship: _____
Home phone: _____ Cell phone: _____
Work phone: _____ Email: _____
Mailing address: _____

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Full name: _____ Medical record number: _____

3. My health care instructions

This section is the place for you to express your wishes, values and goals for care. Your instructions provide guidance for your health care representative and health care providers.

You can provide guidance on your care with the choices you make below. This is the case even if you do not choose a health care representative or if they cannot be reached.

A. My health care decisions

There are three situations below for you to express your wishes. They will help you think about the kinds of life support decisions your health care representative could face. For each, choose the one option that most closely fits your wishes.

a. Terminal condition

This is what I want if:

- I have an illness that cannot be cured or reversed

AND

- My health care providers believe it will result in my death within six months, regardless of any treatments.

Initial one option only	
☐	I want to try all available treatments to sustain my life, such as artificial feeding and hydration with feeding tubes, IV fluids, kidney dialysis and breathing machines.
☐	I want to try to sustain my life with artificial feeding and hydration with feeding tubes and IV fluids. I do not want other treatments to sustain my life, such as kidney dialysis and breathing machines.
☐	I do not want treatments to sustain my life, such as artificial feeding and hydration with feeding tubes, IV fluids, kidney dialysis or breathing machines. I want to be kept comfortable and be allowed to die naturally.
☐	I want my health care representative to decide for me, after talking with my health care providers and taking into account the things that matter to me. I have expressed what matters to me in section B below.

b. Advanced progressive illness

This is what I want if:

- I have an illness that is in an advanced stage

AND

- My health care providers believe it will not improve and will very likely get worse over time and result in death

AND

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Full name: _____ Medical record number: _____

- My health care providers believe I will never be able to:
 - Communicate
 - Swallow food and water safely
 - Care for myself
 - Recognize my family and other people

Initial one option only	
	I want to try all available treatments to sustain my life, such as artificial feeding and hydration with feeding tubes, IV fluids, kidney dialysis and breathing machines.
	I want to try to sustain my life with artificial feeding and hydration with feeding tubes and IV fluids. I do not want other treatments to sustain my life, such as kidney dialysis and breathing machines.
	I do not want treatments to sustain my life, such as artificial feeding and hydration with feeding tubes, IV fluids, kidney dialysis or breathing machines. I want to be kept comfortable and be allowed to die naturally.
	I want my health care representative to decide for me, after talking with my health care providers and taking into account the things that matter to me. I have expressed what matters to me in section B below.

c. Permanently unconscious

This is what I want if:

- I am not conscious

AND

- If my health care providers believe it is very unlikely that I will ever become conscious again

Initial one option only	
	I want to try all available treatments to sustain my life, such as artificial feeding and hydration with feeding tubes, IV fluids, kidney dialysis and breathing machines.
	I want to try to sustain my life with artificial feeding and hydration with feeding tubes and IV fluids. I do not want other treatments to sustain my life, such as kidney dialysis and breathing machines.
	I do not want treatments to sustain my life, such as artificial feeding and hydration with feeding tubes, IV fluids, kidney dialysis or breathing machines. I want to be kept comfortable and be allowed to die naturally.
	I want my health care representative to decide for me, after talking with my health care providers and taking into account the things that matter to me. I have expressed what matters to me in section B below.

Document type: Advance Directive

Full name: _____ Medical record number: _____

You may write in the space below or attach pages to say more about what kind of care you want or do not want.

B. What matters most to me and for me

This section only applies when you are in a terminal condition, have an advanced progressive illness or are permanently unconscious. If you wish to use this section, you can communicate the things that are really important to you and for you. This will help your health care representative.

This is what you should know about what is important to me about my life:

This is what I value the most about my life:

This is what is important for me about my life:

I do not want life-sustaining procedures if I can not be supported and be able to engage in the following ways:

Initial all that apply	
	Express my needs
	Be free from long-term severe pain and suffering
	Know who I am and who I am with
	Live without being hooked up to mechanical life support
	Participate in activities that have meaning to me, such as:

If you want to say more to help your health care representative understand what matters most to you, write it here. (For example: I do not want care if it will result in...)

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C. My spiritual beliefs

Do you have spiritual or religious beliefs you want your health care representative and those taking care of you to know? They can be rituals, sacraments, denying blood product transfusions and more.

You may write in the space below or attach pages to say more about your spiritual or religious beliefs.

4. More information

Use this section if you want your health care representative and health care providers to have more information about you.

A. Life and values

Below you can share about your life and values. This can help your health care representative and health care providers make decisions about your health care. This might include family history, experiences with health care, cultural background, career, social support system and more.

You may write in the space below or attach pages to say more about your life, beliefs and values.

B. Place of care

If there is a choice about where you receive care, what do you prefer? Are there places you want or do not want to receive care? (For example, a hospital, a nursing home, a mental health facility, an adult foster home, assisted living, your home.)

You may write in the space below or attach pages to say more about where you prefer to receive care or not receive care.

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C. Other

You may attach to this form other documents you think will be helpful to your health care representative and health care providers. What you attach will be part of your Advance Directive.

You may list documents you have attached in the space below.

D. Inform others

You can allow your health care representative to authorize your health care providers to the extent permitted by state and federal privacy laws to discuss your health status and care with the people you write in below. Only your health care representative can make decisions about your care.

Name (first, middle, last): _____

Relationship: _____

Home phone: _____ Cell phone: _____

Work phone: _____ Email: _____

Mailing address: _____

5. My signature

My signature: _____

Date: _____

6. Witness

Complete either A or B when you sign.

A. Notary

State of: _____ County of: _____

Signed or attested before me on _____ (date) by

_____ (name), Notary Public – State of Oregon

Signature: _____

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B. Witness declaration

The person completing this form is personally known to me or has provided proof of identity, has signed or acknowledged the person's signature on the document in my presence and appears to be not under duress and to understand the purpose and effect of this form. In addition, I am not the person's health care representative or alternative health care representative, and I am not the person's attending health care provider.

Witness Name (print): _____

Signature: _____

Date: _____

Witness Name (print): _____

Signature: _____

Date: _____

7. Acceptance by my health care representative

I accept this appointment and agree to serve as health care representative.

Health care representative:

Printed name: _____

Signature or other verification of acceptance: _____

Date: _____

First alternate health care representative:

Printed name: _____

Signature or other verification of acceptance: _____

Date: _____

Second alternate health care representative:

Printed name: _____

Signature or other verification of acceptance: _____

Date: _____

Document accessibility: For individuals with disabilities or individuals who speak a language other than English, OHA can provide information in alternate formats such as translations, large print, or braille. Contact the Health Information Center at 1-971-673-2411, 711 TTY or

COVID19.LanguageAccess@dhsosha.state.or.us.

Document type: Advance Directive

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Next Steps

Now that you have completed your advance directive for health care, you should also take the following steps.

Discuss:

- Review your health care wishes with the person you have asked to be your representative (if you haven't already done so). Make sure he or she feels able to perform this important job for you in the future.
- Talk to the rest of your family and close friends who might be involved if you have a serious illness or injury. Make sure they know who your health care representative/agent is and what your wishes are.

Give copies:

- Your health care representative(s)
- Your health care team or
- Submit directly to your medical record
 - Use your kp.org account – go to the medical records section and select the life care planning tile
 - Mail to: Kaiser Permanente
Medical Records, Advance Directive
500 NE Multnomah St. - Floor 11, Portland, OR 97232

Take with you:

- If you go to a hospital or nursing home, take a copy of your advance directive for health care and ask that it be placed in your medical record.
- Take a copy with you any time you will be away from home for an extended period of time.

Review regularly:

- Review your health care wishes whenever any of the "Five D's" occur:

Decade – when you start each new decade of your life

Death – whenever you experience the death of a loved one

Divorce – when you experience a divorce 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 when you are unable to live on your own

Changing your advance directive for health care:

If your wishes change, fill out a new advance directive for health care, tell your representative and your family, and provide a copy to Kaiser Permanente.

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Nondiscrimination Notice

Kaiser Foundation Health Plan of the Northwest (Kaiser Health Plan) complies with applicable federal and state civil rights laws and does not discriminate, exclude people or treat them differently on the basis of race, color, national origin (including limited English proficiency), age, disability, or sex (including sex characteristics, intersex traits; pregnancy or related conditions; sexual orientation; gender identity, and sex stereotypes).

Kaiser Health Plan:

- Provides people with disabilities reasonable modifications and free appropriate auxiliary aids and services to communicate effectively with us, such as:
 - Qualified sign language interpreters
 - Written information in other formats, such as large print, audio, braille, and accessible electronic formats
- Provides no cost language services to people whose primary language is not English, such as:
 - Qualified interpreters
 - Information written in other languages

If you need these services, call Member Services at **1-800-813-2000** (TTY: **711**).

If you believe that Kaiser Health Plan has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, sex, gender identity, or sexual orientation, you can file a grievance with our Civil Rights Coordinator, by mail, phone, or fax. If you need help filing a grievance, our Civil Rights Coordinator is available to help you. You may contact our Civil Rights Coordinator at:

Member Relations Department
Attention: Kaiser Civil Rights Coordinator
500 NE Multnomah St., Suite 100
Portland, OR 97232-2099
Fax: **1-855-347-7239**

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint portal, available at **<https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>**, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue SW
Room 509F, HHH Building
Washington, DC 20201
Phone: **1-800-368-1019**
TDD: **1-800-537-7697**

Complaint forms are available at **www.hhs.gov/ocr/office/file/index.html**.

For Washington Members:

You can also file a complaint with the Washington State Office of the Insurance Commissioner, electronically through the Office of the Insurance Commissioner Complaint portal, available at **<https://www.insurance.wa.gov/file-complaint-or-check-your-complaint-status>**, or by phone at **1-800-562-6900**, or **360-586-0241** (TDD). Complaint forms are available at **<https://fortress.wa.gov/oic/online-services/cc/pub/complaintinformation.aspx>**.

Help in Your Language

ATTENTION: If you speak English, language assistance services including appropriate auxiliary aids and services, free of charge, are available to you. Call **1-800-813-2000** (TTY: **711**).

አማርኛ (Amharic) ትኩረት: አማርኛ የሚናገሩ ከሆነ ተገቢ የሆኑ ረዳት መርጃዎችን እና አገልግሎቶችን ጨምሮ የቋንቋ እርዳታ አገልግሎቶች በነጻ ይገኛሉ። በ **1-800-813-2000** ይደውሉ (TTY: **711**)።

العربية (Arabic) توجّه: إذا كنت تتحدث لغة عربية متوفرة لك خدمات للمساعدة في التغلب على حاجتك من وسائل المساعدة والخدمة التي تطلبها بالمجان. اتصل بالرقم **1-800-813-2000** (TTY: **711**).

中文 (Chinese) 注意事項: 如果您說中文，您可獲得免費語言協助服務，包括適當的輔助器材和服務。致電 **1-800-813-2000** (TTY: **711**)。

فارسی (Farsi) توجه: اگر به زبان فارسی صحبت میکنید، «تسهیلات زبانی»، از جمله کمک‌ها و خدماتی که به شما برای استفاده از خدمات و خدمات به صورت رایگان در دسترس است. **1-800-813-2000** (TTY: **711**) را تماس بگیرید.

Français (French) ATTENTION : si vous parlez français, des services d'assistance linguistique comprenant des aides et services auxiliaires appropriés, gratuits, sont à votre disposition. Appelez le **1-800-813-2000** (TTY: **711**).

Deutsch (German) ACHTUNG: Wenn Sie Deutsch sprechen, steht Ihnen die Sprachassistenten mit entsprechenden Hilfsmitteln und Dienstleistungen kostenfrei zur Verfügung. Rufen Sie **1-800-813-2000** an (TTY: **711**).

日本語 (Japanese) 注意 : 日本語を話す場合、適切な補助機器やサービスを含む言語支援サービスが無料で提供されます。 **1-800-813-2000**までお電話ください (TTY: **711**)。

ខ្មែរ (Khmer) យកចិត្តទុកដាក់: បើអ្នកនិយាយខ្មែរ សេវាជំនួយភាសា រួមទាំងជំនួយនិងសេវាសម្រួលដោយឥតគិតថ្លៃ មានចំពោះអ្នក។ ហៅ **1-800-813-2000** (TTY: **711**)។

한국어 (Korean) 주의: 한국어를 구사하실 경우, 필요한 보조 기기 및 서비스가 포함된 언어 지원 서비스가 무료로 제공됩니다. **1-800-813-2000**로 전화해 주세요 (TTY: **711**).

ລາວ (Laotian) ເອົາໃຈໃສ່: ຖ້າທ່ານເວົ້າພາສາລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ ລວມທັງອຸປະກອນ ແລະ ການບໍລິການຊ່ວຍເຫຼືອທີ່ເໝາະສົມ ຈະມີໃຫ້ທ່ານໂດຍບໍ່ເສຍຄ່າ. ໂທ **1-800-813-2000** (TTY: **711**).

Afaan Oromoo (Oromo) XIYYEEFFANNOO: Yoo Afaan Oromo dubbattu ta'e, Tajaajila gargaarsa afaanii, gargaarsota dabalataa fi tajaajiloota barbaachisoo kaffaltii irraa bilisa ta'an, isiniif ni jira. **1-800-813-2000** irratti bilbilaa (TTY:- **711**)

ਪੰਜਾਬੀ (Punjabi) ਧਿਆਨ ਦਿਓ: ਜੇ ਤੁਸੀਂ ਪੰਜਾਬੀ ਬੋਲਦੇ ਹੋ, ਤਾਂ ਤੁਹਾਡੇ ਲਈ ਮੁਫਤ ਉਪਲਬਧ ਭਾਸ਼ਾ ਸਹਾਇਤਾ ਸੇਵਾਵਾਂ, ਜਿਨ੍ਹਾਂ ਵਿੱਚ ਯੋਗ ਸਹਾਇਕ ਸਹਾਇਤਾਵਾਂ ਅਤੇ ਸੇਵਾਵਾਂ ਸ਼ਾਮਲ ਹਨ। ਕਾਲ ਕਰੋ **1-800-813-2000** (TTY:- **711**)।

Română (Romanian) ATENȚIE: Dacă vorbiți română, vă sunt disponibile gratuit servicii de asistență lingvistică, inclusiv ajutoare și servicii auxiliare adecvate. Sunați la **1-800-813-2000** (TTY: **711**).

Русский (Russian) ВНИМАНИЕ! Если вы говорите по-русски, вам доступны бесплатные услуги языковой поддержки, включая соответствующие вспомогательные средства и услуги. Позвоните по номеру **1-800-813-2000** (TTY: **711**).

Español (Spanish) ATENCIÓN: Si habla español, tiene a su disposición servicios de asistencia lingüística que incluyen ayudas y servicios auxiliares adecuados y gratuitos. Llame al **1-800-813-2000** (TTY: **711**).

Tagalog (Tagalog) PAALALA: Kung nagsasalita ka ng Tagalog, available sa iyo ang serbisyo ng tulong sa wika kabilang ang mga naaangkop na karagdagang tulong at serbisyo, nang walang bayad. Tumawag sa **1-800-813-2000** (TTY: **711**).

ไทย (Thai) โปรดทราบ: หากท่านพูดภาษาไทย ท่านสามารถขอรับบริการช่วยเหลือด้านภาษา รวมทั้งเครื่องช่วยเหลือและบริการเสริมที่เหมาะสมได้ฟรี โทร **1-800-813-2000** (TTY: **711**).

Українська (Ukrainian) УВАГА! Якщо ви володієте українською мовою, вам доступні безкоштовні послуги з мовної допомоги, включно із відповідною додатковою допомогою та послугами. Зателефонуйте за номером **1-800-813-2000** (TTY: **711**).

Tiếng Việt (Vietnamese) CHÚ Ý: Nếu bạn nói tiếng Việt, bạn có thể sử dụng các dịch vụ hỗ trợ ngôn ngữ miễn phí, bao gồm các dịch vụ và phương tiện hỗ trợ phù hợp. Xin gọi **1-800-813-2000** (TTY: **711**).

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