



LIFE CARE **planning**

my values, my choices, my care

kp.org/lifecareplan

LIFE CARE planning

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Full name: _____

Medical record number: _____

Introduction

This advance health care directive lets you share your values, your choices, and your instructions about your future health care. This form may be used to:

- Name someone you trust to make health care choices for you (your health care agent), OR
- Provide written instructions about your future health care, OR
- Both name a health care agent AND give written instructions for future health care.

Part 1 names a health care agent.

Part 2 gives you a chance to share what is of great value to you.

Part 3 gives written instructions about your future health care.

Part 4 lets you guide your agent's decision-making by stating your hopes and wishes.

Part 5 makes your advance health care directive legally valid in the state of Virginia.

Part 6 prepares you to share your wishes and this record with others.

Individuals with a terminal condition can perform an oral advance directive in the presence of an attending physician and two witnesses.

This advance health care directive will replace any advance health care directive you have filled out in the past. In the future, if you want to cancel or change your named agent, you must sign and date a written cancellation, physically cancel or destroy your record, or direct someone to do so in your presence, or orally express your wishes to cancel the document. Your cancellation becomes effective when you tell your attending physician.

Full name: _____

Medical record number: _____ Date of birth: _____

Mailing address: _____

Home phone: _____ Cell phone: _____

Work phone: _____ Email: _____



Part 1. My Health Care Agent

Choosing a health care agent: Choose someone who knows you well, whom you trust to honor your views and values, and who is able to make hard choices in stressful situations. Once you have picked your health care agent, take the time to talk about your views and care goals with that person.

If I am not able to communicate my wishes and health care decisions and my doctor and one other skilled doctor or clinical psychologist declare in writing that I am not able to make an informed decision regarding health care, I choose the following person(s) to honor my wishes and make my health care decisions.

My health care agent must make health care choices that are the same as my instructions in this document and my known desires. If my agent does not know my wishes, my agent must make health care decisions that he or she believes to be in my best interest, considering what he or she knows about my personal values.*

This form does not give my health care agent the power to make financial or other business decisions.

My main health care agent is:

Full name: _____ Relationship to me: _____

Home phone: _____ Cell phone: _____

Work phone: _____ Email: _____

Mailing address: _____

If I cancel my main health care agent's power or if my main agent is not willing, able, or reasonably available to make a health care decision for me, I name the people below as my first and second alternate agents.

First alternate health care agent:

Full name: _____ Relationship to me: _____

Home phone: _____ Cell phone: _____

Work phone: _____ Email: _____

Mailing address: _____

Second alternate health care agent:

Full name: _____ Relationship to me: _____

Home phone: _____ Cell phone: _____

Work phone: _____ Email: _____

Mailing address: _____

* The preceding authorization to make health care decisions does not involve the following absent a court order:

1. Nontherapeutic sterilization
2. Surgery only for psychosurgery
3. Abortion



Powers of my health care agent:

Unless I state otherwise, my health care agent has the following power when I am not able to speak for myself or make my own decisions:

- A. Make choices for me about my health care. This includes choices about tests, medicine, and surgery. It also involves decisions to provide, not provide, or stop all forms of health care to keep me alive, including tube feedings and IV fluids.
- B. Review and release my health records as needed to make decisions.
- C. Decide which doctor, health providers, and organizations provide my health care.
- D. Arrange for and make decisions about whole body, organ, tissue, and/or eye donation for research and education.

Additional powers of my health care agent:

Check the box below if you want your agent to have the following power:

- ☐ I want my agent to remain as my health care agent even if a dissolution, annulment, or termination of our marriage or domestic union has been completed.

Please provide any additional comments or restrictions to the previous section. (For example, you may name people you would or would not want to be involved in decisions on your behalf. You may also specify decisions you would not want your agent to make.) Attach additional pages if necessary.



Part 2. My Values

I want my agent and loved ones to know what matters most to me, so that they can make choices about my health care that match who I am and what is of great value to me.

To give you a sense of what matters most to me, I'd like to tell you some things about myself, such as how I enjoy spending my time, whom I like to be with, and what I like to do. I'd also like to tell you about the circumstances that would make life no longer worthwhile for me.

1. If I were having a really good day, I would be doing the following:

2. What matters most to me is:

3. Life would no longer be worth living if I were not able to:



Part 3. My Health Care Instructions: My Choices, My Care

In the situation below, we ask you to consider a sudden unexpected event. You will always speak for yourself if you are able; in this situation, you are not able to speak for yourself.

If I become not able to communicate or make my own choices, I ask that my health care agent represent my choices as listed below and that my doctors and health care team honor them. If my health care agent or alternate agents are not available or are not able to make decisions on my behalf, this document acts as my wishes.

Note: If you choose not to give written instructions, your health care agent will make decisions based on your spoken wishes. If your wishes are unknown, your agent will make decisions based on what he or she believes is in your best interest, considering your values.

1. Care to prolong life

Keep in mind these situations:

You have a sudden accident or stroke.

Doctors have diagnosed you with a brain injury, leaving you not able to recognize yourself or your loved ones. The doctors have told your agent and/or family that you are not expected to regain these abilities. Life-sustaining treatments, such as a ventilator (i.e., breathing machine) or a feeding tube are needed to keep you alive. In this situation, what would you want?

I would want to be kept comfortable and:

- choose one** { ☐ I would want to STOP life-sustaining treatment. I realize this would likely lead me to die sooner than if I were to continue treatment.
- ☐ I would want life-sustaining treatments to continue as long as possible.

Please give any additional instructions about life-sustaining treatments. For example, you may want to state a set time period that you would want to be kept alive if there were no change to your health.



2. CPR (Cardiopulmonary Resuscitation)

CPR is an attempt to bring you back to life when your heart and breathing have stopped. It may involve chest compressions (forceful pushing on the chest to make the heart contract), medicines, electrical shocks, and a breathing tube.

You have a choice about CPR. CPR can save lives. It is not as effective as most people think. CPR works best if done quickly, within a few minutes, on a healthy adult. When CPR is performed, it can result in broken ribs, punctured lungs, or brain damage from lack of oxygen.* If you would like more information about CPR, please request the brochure called **CPR: My Choice**.

If your heart and breathing stop, what would you want?

choose
one

- ☐ I always want CPR attempted.
- ☐ I never want CPR attempted, but rather, want to permit a natural death.†
- ☐ I want CPR attempted unless the doctor treating me determines any of the following:
 - I have an incurable illness or injury and am dying, OR
 - I have no reasonable chance of survival if my heart or breathing stops, OR
 - I have little chance of survival if my heart or breathing stops and the process of resuscitation would cause major pain.

* Research shows that if you are in a hospital and get CPR, you have a 22% chance of it working and you leaving the hospital alive.

Ehlenbach, W., Barnato, A. E., Curtis, J. R., et al (2009). Epidemiologic study of in-hospital cardiopulmonary resuscitation in the elderly. *New England Journal of Medicine*, 361:22-31. Girotra, S., Brahmajee K., Nallamothu, M.D., et al (2012). Trends in survival after cardiac arrest. *New England Journal of Medicine*, 167:1912-20.

† If you are certain you do not want CPR, please discuss other documents you may want to fill out with your doctor.



Part 4. My Hopes and Wishes (Optional)

1. My thoughts and feelings about where I would prefer to die:

2. I want my loved ones to know that if I am nearing my death, I would appreciate the following for comfort and support (prayers, rituals, music, etc.):

3. Religious or spiritual affiliation:

I am of the _____ faith, and am a member of (faith/spiritual group) _____
_____ in (city) _____,
(phone number) _____. I would like my agent to tell them if
I am seriously ill or dying. I would like to include in my funeral, if possible, the following (people, music,
rituals, etc.):

4. Other wishes/instructions:

Organ donation

If you are interested in donating organs when you die, you can declare your donor status when getting or renewing a driver's license or by registering through the donor registry found at <http://www.donatelifevirginia.org/>.



Part 5. Making This Document Legally Valid

To make your advance health care directive legally valid in Virginia, it must be signed by two adult witnesses.

Two Witnesses

1. Any person over the age of 18, a spouse, other family member, or health care provider.
2. When you are with your witnesses, sign or acknowledge your signature.
3. You will sign below.
4. Witnesses will sign on page 9.

MY SIGNATURE

Print Full Name: _____

Signature: _____ Date: _____



STATEMENT OF WITNESSES:

I declare under penalty of perjury under the laws of Virginia:

1. That the person who signed or approved this advance health care directive is personally known to me or that the individual's identity was proven to me by convincing proof,
2. That the person signed or approved this advance health care directive in my presence, and
3. That the person appears to be of sound mind and under no force, fraud, or undue influence.

Witness Number One:

Print full name: _____

Address: _____

Signature: _____ Date: _____

Witness Number Two:

Print full name: _____

Address: _____

Signature: _____ Date: _____



Part 6. Next Steps

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

Discuss:

1. Review your health care wishes with the person you have asked to be your agent (if you haven't already done so). Make sure he or she feels able to do this important job for you in the future.
2. 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 agent is and what your wishes are.

Give copies:

1. Give your health care agent a copy of your advance health care directive.
2. Give a copy of your advance health care directive to your doctor or your local Kaiser Permanente Medical Records Department.
3. Make a copy for yourself and keep it where it can be easily found.

Take with you:

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

Review often:

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

Decade – when you start each new decade of your life

Death – when you experience the death of a loved one

Divorce – when you go through a divorce or other major family change

Diagnosis – when you are diagnosed with a serious health condition

Decline – when you feel a major decline or deterioration of an existing health condition, especially when you are not able to live on your own

Changing your advance health care directive:

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

Copies of this document have been given to:

- | | | |
|------------------------------------|------------------|------------------|
| • Primary (main) health care agent | Full name: _____ | Telephone: _____ |
| • Alternate health care agent #1 | Full name: _____ | Telephone: _____ |
| • Alternate health care agent #2 | Full name: _____ | Telephone: _____ |
| • Health care provider/clinic | Name: _____ | Telephone: _____ |
| • Others: | Name: _____ | Telephone: _____ |



Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc. (Kaiser Health Plan) complies with applicable federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Kaiser Health Plan does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex. We also:

- Provide no cost aids and services to people with disabilities to communicate effectively with us, such as:
 - Qualified sign language interpreters
 - Written information in other formats, such as large print, audio, and accessible electronic formats
- Provide 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 the number provided below.

District of Columbia	1-800-777-7902
Maryland	1-800-777-7902
Virginia	1-800-777-7902
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, or sex, you can file a grievance with the Kaiser Civil Rights Coordinator, 2101 East Jefferson Street, Rockville, MD 20852, telephone number: 1-800-777-7902. You can file a grievance by mail or phone. If you need help filing a grievance, the Kaiser Civil Rights Coordinator is available to help you. 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, 1-800-368-1019, 1-800-537-7697 (TDD). Complaint forms are available at <http://www.hhs.gov/ocr/office/file/index.html>.

Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc (Kaiser Health Plan) cumple con las leyes federales de derechos civiles aplicables y no discrimina por motivo de la raza, color, nacionalidad de origen, edad, discapacidad o sexo. El Kaiser Health Plan no excluye a las personas o las trata de forma diferente por motivo de la raza, color, nacionalidad de origen, edad, discapacidad o sexo. Recuerde también:

- Nosotros les brindamos ayuda y servicios sin costo alguno a las personas que tienen una discapacidad que les impide comunicarse con nosotros en forma eficaz, tales como:
 - Intérpretes calificados de lenguaje de señas
 - Información por escrito en otros formatos, tales como letra grande, audio y otros formatos electrónicos accesibles
- Brindamos servicios de idiomas sin costo alguno a personas cuyo idioma principal no sea el inglés, tales como:
 - Intérpretes calificados
 - Información por escrito en otros idiomas

Si necesita dichos servicios, llame al número proporcionado a continuación.

District of Columbia	1-800-777-7902
Maryland	1-800-777-7902
Virginia	1-800-777-7902
Línea TTY	711

Si cree que el Kaiser Health Plan no le ha brindado dichos servicios o ha incurrido en discriminación en contra suya de otra manera por motivo de la raza, color, nacionalidad de origen, edad, discapacidad o sexo, usted puede presentar una queja ante el Kaiser Civil Rights Coordinator, 2101 East Jefferson Street, Rockville, MD 20852, número de teléfono: 1-800-777-7902. Puede presentar una queja por correo o por teléfono. Si necesita ayuda para presentar una queja, el Kaiser Civil Rights Coordinator está disponible para ayudarlo. También puede presentar una queja de derechos civiles ante el Departamento de Salud y Servicios Humanos de los Estados Unidos (U.S. Department of Health and Human Services), la Oficina de Derechos Civiles (Office for Civil Rights) a través del Portal de Quejas de la Oficina de Derechos Civiles, disponible en <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>, o por correo electrónico o por teléfono: Departamento de Salud y Servicios Humanos de los Estados Unidos, 200 Independence Avenue SW., Room 509F, HHH Building, Washington, DC 20201, 1-800-368-1019, 1-800-537-7697 (TDD). Los formularios de queja están disponibles en <http://www.hhs.gov/ocr/office/file/index.html>.

Help in your Language

English: You have the right to get help in your language at no cost. If you have questions about your application or coverage through Kaiser Permanente, or if this is a notice that requires you to take action by a specific date, call the number provided for your state or region to talk to an interpreter.

አማርኛ (Amharic): ያለምንም ከፍተኛ በራስዎ ቋንቋ እገዛ የማግኘት መብት አለዎት። ስለ ማመልከቻዎ ወይም ከኢሰር ፕሮግራም Kaiser Permanente ስለሚያገኙት ሽፋን ማንኛውም ጥያቄዎች ካሉዎት፣ ወይም ይህ ማሳወቂያ በግልፅ በተጠቀሰ ቀን ማድረግ ያለብዎ ነገር እንዳለ የሚያስገድድዎ ከሆነ፣ በተጠቀሰው የሰላሳ ሰዓት ለስራት ወይም ለክልል ደውለው ከአስተርጓሚ ጋር ይነጋግሩ።

العربية (Arabic): لك الحق في الحصول على المساعدة بلغتك دون تحمل أي تكاليف. إذا كانت لديك استفسارات بشأن طلبك أو تغطيتك التي تقدمها Kaiser Permanente، أو إذا كان هذا الإشعار الذي يتطلب منك اتخاذ إجراء خلال تاريخ محدد، يُرجى الاتصال بالرقم المخصص لولايتك أو منطقتك للتحدث إلى مترجم فوري.

Հայերեն (Armenian): Դուք ունեք Ձեր լեզվով անվճար օգնություն ստանալու իրավունք: Եթե Դուք հարցեր ունեք Ձեր դիմումի կամ Kaiser Permanente-ի վիճուցով Ձեր ծածկույթի վերաբերյալ, կամ եթե սա ծանուցում է, որը պարտադրում է Ձեզ, որպեսզի գործուղություններ ձեռնարկեք մինչև որոշակի ամսաթիվ, ապա զանգահարեք Ձեր նահանգի կամ շրջանի համար տրամադրված հեռախոսահամարով՝ թարգմանչի հետ խոսելու համար:

Bàsɔ̀ò Wùdù (Bassa): Ɔ mò nì kpé bé m̃ ké gbo-kpá-kpá dyé dé nì m̃òùn ñiìn bídí-wùdù mú pídyi. Ɔ jũ ké m̃ dyi dyi-diè-dè bé bédé bá nì céè-dè m̃ tò bó dè zò jè dyíé ní, m̃ò jũ bá nì kũùn kpɔ́ jè dyí dyiìn dé Kaiser Permanente múé ní, m̃ò Ɔ dyi b̃́ dò jũ bé m̃ ké dè dò nyu bó wé jéé dò kɔ́ nì, níí, d́á ñòbà bé wa tòà bó nì bódóò m̃ò nì gbě̀èò bíìe, ké nì mu nyo-wuquún-zà-nyò dò gbo wùdùùn.

বাংলা (Bengali): বিনা খরচে আপনার নিজের ভাষায় সাহায্য পাওয়ার অধিকার আপনার আছে। আপনার যদি আপনার আবেদন বা Kaiser Permanente-এর মাধ্যমে পাওয়া কভারেজ নিয়ে কোনো প্রশ্ন থাকে বা এটি যদি কোনো নোটিস হয় যার ফলে আপনার একটি নির্ধারিত দিনের মধ্যে কোনো পদক্ষেপ গ্রহণ করার প্রয়োজন হয়, তাহলে দোভাষীর সাথে কথা বলতে আপনার রাজ্য বা অঞ্চলের জন্য প্রদত্ত নম্বরটিতে ফোন করুন।

California.....	1-800-464-4000
Colorado.....	1-800-632-9700
District of Columbia.....	1-800-777-7902
Georgia.....	1-888-865-5813
Hawaii.....	1-800-966-5955
Maryland.....	1-800-777-7902
Oregon.....	1-800-813-2000
Virginia.....	1-800-777-7902
Washington.....	1-800-813-2000
TTY.....	711

Kaiser Foundation Health Plan, Inc., in Northern and Southern California and Hawaii • Kaiser Foundation Health Plan of Colorado • Kaiser Foundation Health Plan of Georgia, Inc., Nine Piedmont Center, 3495 Piedmont Road NE, Atlanta, GA 30305, 404-364-7000 • Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc., in Maryland, Virginia, and Washington, D.C., 2101 E. Jefferson St., Rockville, MD 20852 • Kaiser Foundation Health Plan of the Northwest, 500 NE Multnomah St., Suite 100, Portland, OR 97232

Have questions? Call us at 1-800-494-5314. • Go to buykp.org/apply. • Or contact your agent or broker.

Cebuano (Bisaya): Anaa moy katungod nga mangayo og tabang sa inyo pinulongan ug kini walay bayad. Kung naa mo pangutana bahin sa inyo aplikasyon o coverage sa Kaiser Permanente, o kung kaning pahibalo nanginahanglan sa inyo paglihok sa dili pa usa ka piho nga petsa, palihug lang pagtawag sa mga numero sa telepono nga gihatag sa imong estado ("state") o rehiyon ("region") para makigstorya sa usa ka interpreter.

中文 (Chinese): 您有權免費以您的語言獲得幫助。如果您對您的Kaiser Permanente申請或承保有任何疑問，或者如果本通知要求您在具體日期之前採取措施，請致電您所在的州或地區的電話，與口譯員進行溝通。

Chuuk (Chukese): Mei wor omw pwuung omw kopwe angei aninis non foosun fonuomw (Chuukese), ese kamo. Ika mei wor omw kapas eis usun omw apilikeison me/ika policy fan nemenien Kaiser Permanente, are ika ei esinesin a erenuk pwe kopwe fori pwan ekoch foror, ka tongeni omw kopwe kori ewe nampa mei kawor faniten omw state ika fonu (asan) iwe eman chon chiakku epwe anisuk non kapasen fonuomw.

Français (French): Une assistance gratuite dans votre langue est à votre disposition. Si vous avez des questions à propos de votre demande d'inscription ou de la couverture par Kaiser Permanente, ou si cet avis vous demande de prendre des mesures à une date précise, appelez le numéro indiqué pour votre Etat ou votre région pour parler à un interprète.

Deutsch (German): Sie haben das Recht, kostenlose Hilfe in Ihrer Sprache zu erhalten. Falls Sie Fragen bezüglich Ihres Antrags oder Ihres Krankenversicherungsschutzes durch Kaiser Permanente haben oder falls Sie aufgrund dieser Benachrichtigung bis zu bestimmten Stichtagen handeln müssen, rufen Sie die für Ihren Bundesstaat oder Ihre Region aufgeführte Nummer an, um mit einem Dolmetscher zu sprechen.

ગુજરાતી (Gujarati): તમને કોઈ પણ ખર્ચ વગર તમારી ભાષામાં મદદ મેળવવાનો અધિકાર છે. જો તમને Kaiser Permanente મારફતે તમારી અરજી અથવા કવરેજ વિશે પ્રશ્નો હોય, અથવા જો આ નોટિસ હોય જેમાં તમને કોઈ ચોક્કસ તારીખથી પગલાં લેવાની જરૂર હોય, તો દુભાષિયા સાથે વાત કરવા તમારા સ્ટેટ અથવા રીજીયન માટે પૂરા પાડવામાં આવેલ નંબર પર ફોન કરો.

Kreyòl Ayisyen (Haitian Creole): Ou gen dwa pou jwenn èd nan lang ou gratis. Si ou gen nenpòt kesyon sou aplikasyon ou an oswa asirans ou ak Kaiser Permanente, oswa si nan avni sa a gen bagay ou sipoze fè sa a avan yon sèten dat, rele nimewo nou mete pou Eta ouwa rejyon ou a pou w ka pale ak yon entèprèt.

‘ōlelo Hawai‘i (Hawaiian): He pono a ua loa‘a no kekahi kōkua me kāu ‘ōlelo inā makemake a he manuahi no ho‘i. Inā he mau nīnau kāu e pili ana i kāu palapala noi ‘inikua ola kino a i ‘ole i kōkua ma‘ō ka polokalamu kōkua ola kino Kaiser Permanente, a i ‘ole inā ke ha‘i nei paha kēia leka nei iā‘oe e hana koke aku i kēia ma mua o kekahi lā i waiho ‘ia, e kelepona aku i ka helu i loa‘a ma kēia leka nei no kāu moku‘āina a i ‘ole pana‘āina no ka wala‘au ‘ana me kekahi kanaka unuhi ‘ōlelo.

हिन्दी (Hindi): आपको बिना किसी कीमत चुकाए आपकी भाषा में सहायता पाने का अधिकार है। यदि आप आपके आवेदन पत्र के विषय में या Kaiser Permanente के कवरेज के विषय में कुछ पूछना चाहते हैं या यदि यह एक नोटिस है जिसके कारण आपको किसी विशेष तिथि तक कारवाई करनी पड़ेगी तो आपके राज्य या क्षेत्र के लिए दिए गए नंबर पर फोन करके किसी दुभाषिये से बात करें।

Hmoob (Hmong): Koj muaj cai kom tau txais kev pab uas hais koj hom lus yam tsis tau them nqi. Yog koj muaj lus nug txog koj daim ntawv thov los yog cov kev pab them nyiaj tim Kaiser Permanente, los yog tias daim ntawv no yog ib tsab ntawv ceebtoom uas yuav kom koj ua ib yam dabtsi raws li hnuv tau teev tseg, hu rau tus nab npawb xovtooj uas tau muab rau koj lub xeev lossis cheeb tsam kom tau tham nrog tus kws txhais lus.

Igbo (Igbo): ! nwere ikike inweta enyemaka n'asụsụ gi na akwughị ugwo ọ bụla. Ọ bụrụ na i nwere ajụjụ gbasara akwụkwọ anamachọihe gi ma ọ bụ mkpuchi si na Kaiser Permanente, ma ọ bụ ọ bụrụ na nke bụ ọkwa a chọrọ ka i mee ihe tupu otu ụbọchị, kpọọ nomba enyere maka steeti ma ọ bụ mpaghara gi iji kwukọrịta okwu n'etiti onye ọkọwa okwu.

Iloko (Ilocano): Adda ti karbenganyo a dumawat iti tulong iti pagsasaoyo nga awan ti bayadanyo. No addaankayo kadagiti saludsod maipanggep ti aplikasionyo wenno coverage babaen ti Kaiser Permanente, wenno no daytoy ket maysa a pakdaar a kalikagumanna a rumbeng nga aramidenyo ti addang iti espesipiko a petsa, tawagan ti numero nga inpaay para ti estado wenno rehion tapno makipatang ti maysa mangipatarus iti pagsasao.

Italiano (Italian): Hai il diritto di ricevere assistenza nella tua lingua gratuitamente. In caso di domande riguardanti la tua richiesta o la copertura attraverso Kaiser Permanente, o se occorre intervenire entro una data specifica secondo quanto indicato in questa comunicazione, chiama il numero fornito per il tuo stato o la tua regione per parlare con un interprete.

日本語 (Japanese): あなたは、費用負担なしでご使用の言語で支援を受ける権利を保持しています。お申し込みまたはKaiser Permanenteの担保範囲に関してご質問があるか、または本通知により、あなたが特定の日付までに行動を起こすよう依頼されている場合、お住まいの州または地域に対して提供された電話番号に電話して、通訳とお話ください。

ខ្មែរ (Khmer): អ្នកមានសិទ្ធិទទួលបានជំនួយជាភាសារបស់អ្នកដោយឥតគិតថ្លៃ។ បើសិនអ្នកមានសំណួរណាមួយអំពីពាក្យស្នើសុំឬការធានារ៉ាប់រងតាមរយៈ Kaiser Permanente ឬប្រសិនបើជាលិខិតជូនដំណឹងដែលតម្រូវឲ្យអ្នកចាត់វិធានការត្រឹមកាលបរិច្ឆេទជាក់លាក់ សូមទូរស័ព្ទទៅលេខដែលបានផ្តល់ជូនសម្រាប់រដ្ឋឬតំបន់របស់អ្នកដើម្បីនិយាយទៅកាន់អ្នកបកប្រែ។

한국어 (Korean): 귀하에게는 한국어 통역서비스를 무료로 받으실 수 있는 권리가 있습니다. Kaiser Permanente를 통한 귀하의 보험 신청서나 보험 보장 범위에 관해 질문이 있을 경우 또는 이 통지서의 요구대로 어느 날짜까지 조치를 취해야만 하는 경우, 귀하의 주 및 지역의 제공된 전화번호로 연락해 통역사와 통화하십시오.

ລາວ (Laotian): ທ່ານມີສິດທີ່ຈະໄດ້ຮັບການຊ່ວຍເຫຼືອໃນພາສາຂອງທ່ານໂດຍບໍ່ເສັຽຄ່າ. ຖ້າວ່າ ທ່ານມີຄໍາຖາມກ່ຽວກັບການສະໝັກຂອງທ່ານ ຫຼື ການຄຸມຄອງຜ່ານ Kaiser Permanente, ຫຼື ຖ້າອັນນີ້ເປັນແຈ້ງການທີ່ຮຽກຮ້ອງໃຫ້ທ່ານດໍາເນີນການພາຍໃນວັນທີທີ່ເຈາະຈົງໃດໜຶ່ງ, ໃຫ້ໂທຕາມໝາຍເລກທີ່ໃຫ້ໄວ້ສໍາລັບລັດ ຫຼື ເຂດຂອງທ່ານ ເພື່ອຂໍລິມັດຖານພາສາ.

Kajin Majōl (Marshallese): Ewōr jimwe eo aṃ in bōk jipañ ilo kajin eo aṃ ejjelōk wōṇāān. Ñe ewōr aṃ kajitōk kōn peba in aplaiki eo aṃ ak insurance eo aṃ jān Kaiser Permanente, ak ñe enaan in kōjelā in ej aikuj bwe kwōn ṃakūtūt ṃokta jān juon raan eo eṃōj an kallikkar, kaḷok nōṃba eo ej leḷok ñan state eo aṃ ak jikūṃ bwe kwōn maroñ kōnono ippān juon ri-ukōt.

Naabeehó (Navajo): T'áá ni nizaad bee níká i'doolwoł doo bik'é asíníłáágóó éí bee náhaz'á. Kaiser Permanente áká aná'álwo' ná bik'é azláadoo yíníkeedgo naaltsoos hadinílaa, éí bína'idíłkíd doogo, éí doodago díí naaltsoos haa'ída yoolkáálgo hait'áoda í'dííłíł níłniigo éí nitsaa hahoodzojį éí doodago t'áá aadi nahós'a'di ata' dahalne'ígíí bich'į' hólne'go bee bíł ahíł hódíłníh.

नेपाली (Nepali): तपाईंसँग कुनै शुल्क नदिइ आफ्नो भाषामा सहायता पाउने अधिकार छ । तपाईंसँग आफ्नो आवेदन बारे वा Kaiser Permanente मार्फत कवरज बारेमा कुनै प्रश्नहरू भए, वा यो नोटिस अनुसार तपाईंले कुनै निर्धारित मितिमा कुनै कार्यवाही गर्नु पर्ने आवश्यकता भएमा, दोभाषेसंग कुराकानी गर्न तपाईंको राज्य वा क्षेत्रका लागि दिइएको नम्बरमा कल गर्नुहोस् ।

Afaan Oromoo (Oromo): Baasii malee afaan keetiin gargaarsa argachuudhaaf mirga qabda. Waa'ee iyyata keetii yookaan tajaajila Kaiser Permanente hammatu ilaalchisee gaaffii yoo qabaatte, yookaan yoo kun beeksisa guyyaa murtaa'e irratti tarkaanfii akka ati fudhattu gaafatu ta'e, lakkoofsa bilbilaa naannoo yookaan goodina keetiif kenname bilbiluudhaan turjumaana haasofsiisi.

فارسی (Persian): شما حق دارید که بدون هیچ هزینه ای به زبان خود کمک دریافت کنید. اگر درباره درخواست یا پوشش خود در Kaiser Permanente سوالی داشته یا بر اساس این اعلامیه باید تا تاریخ مشخصی اقدامی بعمل آورید، برای صحبت با یک مترجم شفاهی با شماره تلفن ارائه شده برای ایالت یا منطقه خود تماس بگیرید.

lokaiahn Pohnpei (Pohnpeian): Komw anehki pwung en rapahki sounkawehwe en omw palien lokaia ni sohte isaihs. Ma mie iren owmi kalelapak ohng aplikeisin de iren audepe kan ohng Kaiser Permanente, de ma pakair wet me anahne komwi en mwekid ohng rahn me kileledi, ah komw anahne koahl nempe me sansalehr ohng owmi palien wehi pwe komwi en lokaiaieng owmi tungoal soun kawehwe.

Português (Portuguese): Você tem o direito de obter ajuda em seu idioma sem nenhum custo. Se você tiver dúvidas sobre sua solicitação ou cobertura por meio da Kaiser Permanente, ou se este aviso exigir que você tome alguma medida até uma data específica, ligue para o número fornecido para seu estado ou região para falar com um intérprete.

ਪੰਜਾਬੀ (Punjabi): ਤੁਹਾਨੂੰ ਬਿਨਾਂ ਕਿਸੇ ਸੁਲਕ ਤੇ ਆਪਣੀ ਭਾਸ਼ਾ ਵਿਚ ਮਦਦ ਪਾਉਣ ਦਾ ਹੱਕ ਹੈ। ਜੇਕਰ ਤੁਹਾਡੇ ਆਪਣੀ ਅਰਜ਼ੀ ਜਾਂ Kaiser Permanente ਰਾਹੀਂ ਕਵਰੇਜ ਬਾਰੇ ਸਵਾਲ ਹਨ, ਜਾਂ ਇਸ ਨੋਟਿਸ ਵਜੋਂ ਤੁਹਾਨੂੰ ਕਿਸੇ ਨਿਸ਼ਚਿਤ ਮਿਤੀ ਤੱਕ ਕਾਰਵਾਈ ਕਰਨ ਦੀ ਲੋੜ ਪਵੇ, ਤਾਂ ਦੁਬਾਰੀਏ ਨਾਲ ਗੱਲ ਕਰਨ ਲਈ ਆਪਣੇ ਰਾਜ ਜਾਂ ਇਲਾਕੇ ਲਈ ਮੁਹੱਈਆ ਕਰਵਾਏ ਗਏ ਨੰਬਰ ਤੇ ਫ਼ੋਨ ਕਰੋ।

Română (Romanian): Aveți dreptul de a solicita ajutor care să vă fie oferit în mod gratuit în limba dumneavoastră. Dacă aveți întrebări legate de solicitarea dumneavoastră sau de acoperirea oferită de Kaiser Permanente sau dacă acest aviz vă solicită să luați măsuri până la o anumită dată, sunați la numărul de telefon furnizat pentru statul sau regiunea dumneavoastră pentru a sta de vorbă cu un interpret.

Русский (Russian): У вас есть право получить бесплатную помощь на своем языке. Если у вас имеются вопросы относительно вашего заявления или медицинского страхования в Kaiser Permanente, либо если такое уведомление требует от вас каких-либо действий к определенной дате, позвоните по номеру телефона для своего штата или региона, чтобы поговорить с переводчиком.

Faa-Samoa (Samoan): E iai lou 'aia e maua se fesoasoani i lou gagana e aunoa ma le totogi. Afai e iai ni fesili e uiga i lou tusi apalai po o puipuiga e ala mai Kaiser Permanente, po o lenei tusi e manaomia ona e gaoioi i se taimi atofaina, vili le numera ua fuafuaina mo lou setete po o oganuu e fesoota'i i se faaliliu.

Español (Spanish): Usted tiene derecho a obtener ayuda en su idioma sin costo alguno. Si tiene preguntas acerca de su solicitud o cobertura a través de Kaiser Permanente, o si este es un aviso que requiere que usted tome alguna medida antes de una fecha determinada, llame al número de teléfono que se proporciona para su estado o región para hablar con un intérprete.

Tagalog (Tagalog): Mayroon kang karapatang humingi ng tulong sa iyong wika nang walang bayad. Kung mayroon kang mga katanungan tungkol sa iyong aplikasyon o coverage sa pamamagitan ng Kaiser Permanente, o kung ito ay abisong nangangailangan ng iyong aksyon sa tiyak na petsa, tumawag sa numerong ibinigay para sa iyong estado o rehiyon para makipag-usap sa isang interpreter.

ไทย (Thai): ท่านมีสิทธิที่จะได้รับความช่วยเหลือในภาษาของท่านโดยไม่เสียค่าใช้จ่าย หากท่านมีคำถามเกี่ยวกับการสมัครของท่าน หรือความคุ้มครองผ่าน Kaiser Permanente หรือหากนี่คือหนังสือที่ต้องการให้ท่านดำเนินการภายในวันที่ที่กำหนดไว้ โปรดติดต่อหมายเลขที่ให้ไว้สำหรับรัฐหรือเขตพื้นที่ของท่านเพื่อคุยกับล่าม

Lea Faka-Tonga (Tongan): 'Oku 'ia ho totonu ke ke ma'u ha fakatonulea ta'etotongi. Kapau 'oku 'i ai ha'o fehu'i ki ho tohi kole na'e fakafonu ki he malu'i 'inisiua 'a e Kaiser Permanente, pea kapau ko e tohina 'oku fiema'u keke fai ha me'a ki ai pe ko ha 'aho na'e tuku pau atu ke fai ia, taa ki he fika kuo 'oatu ki ho siteiti pe ko e vahefonua 'oku ke 'i ai ke talanoa mo ha tokotaha tene fakatonu lea atu kiate koe.

Українська (Ukrainian): У Вас є право на отримання допомоги безкоштовно на Вашій рідній мові. Якщо Ви маєте питання стосовно Вашого звернення чи страхового покриття в Kaiser Permanente, чи якщо відповідно до такого повідомлення Вам треба буде здійснити певну дію до конкретної дати, подзвоніть по номеру, що відповідає Вашій країні чи регіону, щоб поговорити з перекладачем.

اردو (Urdu): آپ کو کوئی بھی قیمت ادا کئے بغیر اپنی زبان میں مدد حاصل کرنے کا حق ہے۔ اگر آپ کے ذہن میں اپنی درخواست یا Kaiser Permanente کے ذریعہ کوریج کے متعلق کوئی بھی سوالات ہیں، یا اگر اس نوٹس کی وجہ سے آپ کو کسی مخصوص تاریخ تک عمل انجام دینے کی ضرورت ہوگی تو، کسی مترجم سے بات چیت کرنے کے لئے آپ کی ریاست یا علاقہ کے لئے فراہم کئے گئے نمبر پر کال کریں۔

Tiếng Việt (Vietnamese): Quý vị có quyền được nhận trợ giúp miễn phí bằng ngôn ngữ của mình. Nếu quý vị có các câu hỏi về mẫu đơn hoặc mức bảo hiểm của mình thông qua Kaiser Permanente, hoặc đây là thông báo yêu cầu quý vị thực hiện vào một ngày cụ thể, hãy gọi đến số điện thoại được cung cấp cho bang hoặc khu vực của quý vị để trò chuyện với phiên dịch viên.

Yorùbá (Yoruba): O ní ètò láti rí ìrànṣẹ́ gba nípa èdè rẹ láisan owó. Bí o bá ní ibèèrè nípa iwé tí o kọ tàbí ìṣedéédé nípaṣẹ́ Kaiser Permanente, tàbí ifitonilétí yíì jẹ èyí o nílò láti ìgbésẹ́ kan ní ojò kan patọ́, pé nọmbà tí a pèsè fún ipínlẹ̀ tàbí agbègbè rẹ láti bá ònǵbifọ́ kan sọrọ́.

LIFE CARE **planning**

my values, my choices, my care

Need additional assistance?
kp.org/lifecareplan

kp.org



Instructions

- 1-A** Learn more about [our approach to Life Care Planning](#).
- 1-B** Please remember to write these items on every page:
- Your name.
 - Your medical record number, which is found on your blue Kaiser insurance card.
- 2-A** What are the qualities you should look for in agent? Learn [how to choose an agent](#).
- 2-B** Learn more about [what is an agent and their responsibilities](#).
- 2-C** Some people don't have anyone in mind to be their agent. Learn about [Life Care Planning without an agent](#).
- 2-D** An alternate agent would be needed if your primary agent is not available. [Learn more about agents](#).
- 3-A** Video: [What I might consider when choosing my agent](#).
- 3-B** This space may be used for any instructions related to agents and their powers. If you have a family member who has beliefs about these topics that are significantly different from yours, you may decide to exclude this person from being involved in decision-making, even informally.
- 4-A** In a serious medical situation, where the outcome is uncertain, your agent may look to this section for guidance. You'll be doing your agent a favor by providing rich detail here.
- 4-B** For further guidance, read [your values are at the center of your life care plan](#).
- 4-C** [Situations where values matter](#).
- 5-A** Should you ever be in a similar situation, it would be valuable for your agent to know your opinions about life sustaining treatment.
- 5-B** Video: Get more details about this [brain injury scenario](#).
- 5-C** Video: Learn more accepting life [sustaining treatments for a specific time period](#), in this scenario.
- 6-A** CPR can save lives, but it's not as effective most people think. [Read a discussion about CPR](#).
- 7-A** Sometimes, our values inform not only what we want, but of what we don't want. If you have some thoughts about how you would ideally like to die, please add them here.

LIFE CARE planning

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7-B

If you are part of a faith community, please add in details of how we may contact them.

7-C

Be aware that if you're interested in whole body donation, this is typically arranged well in advance and requires forms and documentation.

7-D

If you're interested in organ donation, please be sure your agent is aware of this. Your agent would be responsible for arranging this at the time of death.

8-A

Learn more about [making this document legally valid](#).

9-A

It must be signed by two adult witnesses: Any person over the age of 18, a spouse, other family member, or health care provider.

10-A

Learn more about [sharing your values](#) with your agent.

10-B

If you have a scheduled appointment, you may hand deliver a copy to your doctor or you may visit Membership Services.

10-C

If you'd like to let your doctor know you've completed your Advance Health Care Directive and who you've chosen as your agent, you may send a secure message on kp.org using this handy email template.

10-D

Read more: [With whom should you share your Life Care Plan?](#)