Advance Health Care Directive
LIFE CARE **planning**

my values, my choices, my care

REMEMBER

1. **Have this document witnessed or notarized**
2. **Sign and date**
3. **Return a copy to KP**

kp.org/lifecareplan

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Name*: _____
Medical Record Number*: _____
Form fields marked with an asterisk (*) are required.

Introduction

What's an Advance Health Care Directive?

An Advance Health Care Directive is a legal document that allows you to:

- Choose someone to make health care decisions on your behalf (your "health care agent").
- Provide guidance about your health care wishes if you're unable to make your own health care decisions.

All sections of this document are optional. You may fill out as much of the document as you choose. However, it is required that it is signed and dated by you and witnessed or notarized. You can update any of your preferences in your Advance Health Care Directive at any time by completing a new document. You have the right to cancel or replace this Advance Health Care Directive at any time with a new one. A new Advance Health Care Directive will replace any you have completed in the past, if they differ.

This document provides guidance to both your health care agent and health care team. An Advance Health Care Directive does not tell emergency personnel what treatments you want during a medical emergency.

Why is an Advance Health Care Directive important?

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

The Advance Health Care Directive gives you the opportunity to have a say in your medical care. Your documented wishes will serve as a guide for your health care agent and medical team.

People with serious illness or nearing the end of their life may also benefit from a conversation with their health care team to discuss the need for additional documents that can guide care.

Who can complete an Advance Health Care Directive?

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

Other references

Life Care Planning:
my values, my choices, my care

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Document type: Advance Directive **Description: Advance Directive Signed On**

What's in this document?

The Kaiser Permanente Advance Health Care Directive contains 5 parts to complete, including how to make it legally valid:

Part 1: Choosing My Health Care Agent

Allows you to name someone to make health care decisions on your behalf.

Part 2: My Values and Beliefs

Gives you an opportunity to reflect on and share your values, beliefs, and preferences for your medical care. 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 your health care.

Part 4: Information for End of Life

Provides an opportunity for you to communicate any after-death wishes you may have, such as organ donation, funeral wishes, or any cultural or religious end-of-life ceremonies.

Part 5: Making It Legal

Allows you to make your Advance Health Care Directive legally valid in the State of California.

Next Steps

Includes a checklist to review to guide you on how to share your preferences and this document with others.

This Advanced Health Care Directive belongs to:

Full legal name: _____

Preferred name: _____

Medical record number: _____

Mailing address: _____

City: _____ State: _____ Zip code: _____

Home phone: _____ Cell phone: _____

Work phone: _____ Email: _____

Name*: _____
Medical Record Number*: _____

Part 1

Choosing your Health Care Agent also means sharing your values and beliefs with them and telling them what medical care you would want if you're unable to make decisions for yourself.

Choosing My Health Care Agent

This section allows you to name someone you trust to make health care decisions for you immediately or in the event that your doctor determines you're unable to make your own health care decisions.

Your designated health care agent will speak on your behalf to make health care decisions for you based on the preferences you've shared with them or what they believe to be in your best interest, considering what they know about your personal values and beliefs.

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 your friends and loved ones know who you have chosen to be your agent and why.

Sometimes, a spouse or family member may be the best choice, or sometimes a close friend is the best choice. You know best.

A good health care agent is someone who:

- Is willing to perform this role and can be reasonably available,
- Knows your values and beliefs well,
- Is willing to honor and represent your preferences even if these are different from their own,
- Won't be afraid to ask questions and speak on your behalf, even if doing so goes against convention or the wishes of other loved ones,
- Is comfortable making decisions under stress, and
- Will continue to check in with you about your preferences over time.

You can also choose to give your health care agent the authority to make decisions for you immediately by stating so in this Advance Health Care Directive.

If there is a dissolution, annulment, or termination of a marriage or domestic partnership with the person you've named as your health care agent, your health care agent designation will be revoked unless you complete the form again and name that person as your health care agent.

Your health care agent can't be an operator or employee of a community care facility or a residential care facility where you're receiving care, or your supervising health care provider or employee of the place where you're receiving care, unless that person is related to you or is a co-worker.

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

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Talk with your **Agent** about the kinds of responsibilities they might have to take on in this role. Use this directive and the questions in Part 1 to guide your conversation.

When my health care agent's authority becomes effective:

Unless I limit my agent's authority, they can make the following decisions for me:

- Agree with or say no to any care, treatment, service, or procedure to maintain, diagnose, or otherwise affect a physical or mental condition,
- Select or discharge health care providers and decide where I will receive care,
- Approve or refuse diagnostic tests, surgical procedures, and programs of medication,
- Make decisions to provide, not provide, or stop all forms of life support treatments to keep me alive, and
- Arrange for and make decisions about the care of my body after death (including autopsy, organ donation, and what happens to my remains).

If I wish to limit my health care agent's authority, I will specify below what health care decisions **I DO NOT** want my agent to make. I may also name people who **I DO NOT** want to be involved in making health care decisions for me.

I do not want my health care agent to...

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 my own health care decisions, or **if I initial here_____, I want my health care agent to be able to make health care decisions for me immediately.**

My primary (main) health care agent:

Name: _____ Relationship: _____

Mailing address: _____

City: _____ State: _____ Zip code: _____

Phone: _____ Email: _____

Name*: _____
Medical Record Number*: _____

This section is recommended but optional. If you do not wish to select alternate health care agents, go to the next page.

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:

Name: _____ Relationship: _____

Mailing address: _____

City: _____ State: _____ Zip code: _____

Phone: _____ Email: _____

Second alternate health care agent:

Name: _____ Relationship: _____

Mailing address: _____

City: _____ State: _____ Zip code: _____

Phone: _____ Email: _____

Name*: _____
Medical Record Number*: _____

Part 2

Completing the **My Values and Beliefs** section allows you to state what's most important in your life. Take your time with these questions, as they will help you think through Parts 2 and 3 of this document.

Think about what you value most. What does quality of life mean to you? What do you want your decision maker to know is important to you?

My Values and Beliefs

This section allows for a reflection on what living well means to you if you're unable to make your own health care decisions. It serves as a foundation for the rest of this document.

It's important to understand and reflect on what matters most to you so you can make decisions about your health care that match who you are and what is important to you. It's also important for your health care agent to understand your values and what matters most to you.

Please review and respond to the following questions:

I want to guide my health care agent by sharing what is most important to me.

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

1. For my life, it's most important for me to:

- ☐ Be physically active
- ☐ Be socially active
- ☐ Be able to live on my own
- ☐ Work and/or volunteer
- ☐ Spend time with friends and family
- ☐ Make my own decisions
- ☐ Engage with the community
- ☐ Participate in my hobbies and/or passions
- ☐ Engage in spirituality and/or religion
- ☐ Other

Here is WHY these abilities are critical for me to live my life well.

These abilities are important to me because...

Name*: _____
Medical Record Number*: _____

2. I feel that my life would no longer be worth living if I have a serious injury or illness that can't be cured and I'm in the following situation(s) for the rest of my life: (check all that apply)

- ☐ I am unable to recognize my friends and family.
- ☐ I am unable to understand or communicate with others in a meaningful way.
- ☐ I am unable to think clearly or make my own decisions.
- ☐ I am unable to feed, bathe, or take care of myself.
- ☐ I am unable to stay alive without being hooked up to machines.
- ☐ I'm not sure.

Here are additional thoughts I want to share about question 2 above:

Only answer if this statement is relevant to you.

How does my faith/spirituality, culture, and belief system influence my health care? How critical is that to me?

It is important to me that...

Name*: _____
Medical Record Number*: _____

Choosing My Health Care Preferences

This section, along with **Part 2: My Values and Beliefs**, describes my preferences to guide my doctors and health care agent to make medical decisions for me if I'm unable to make my own health care decisions **AND I have an illness or injury** so that my organs are failing to keep me healthy and allow recovery.

Part 3

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

I ask that my health care agent represent my health care preferences as detailed below.

I recognize that decisions will be made in partnership with my doctors and care team, and that my doctors and care team will consider both my values and beliefs and my health care preferences below.

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 health care agent and doctors.

When you have a serious illness or injury so that your organs begin to fail, treatments *may* include medical procedures, devices/machines, or medications to artificially support the organ(s); this is often referred to as life-sustaining treatments.

If do not want CPR or other life-sustaining treatments now, please discuss with your doctor. You may benefit from completing a Physician Orders for Life Sustaining Treatment (POLST) form.

Definitions:

- **Cardiopulmonary resuscitation (CPR):** An attempt to restart the heart if your heart and breathing stop.
- **Ventilator:** A machine that breathes for you when your lungs aren't working. A tube is inserted either through your mouth or an incision in your neck into your airway. The tube connects to the machine.
- **Feeding tube (artificial nutrition):** A plastic tube put inside your nose or into your stomach through a small incision. This plastic tube gives you food and water.
- **Dialysis machine:** A machine that removes toxins from your blood if your kidneys aren't working.
- **Blood transfusions:** The process of transferring blood or blood products into your body through a narrow tube placed within a vein in your arm.
- **Choosing NOT to have these treatments means allowing a natural death to occur.** This means that if your heart stops beating or if you stop breathing, no medical procedure to restart breathing or heart functioning will occur.

Name*: _____
Medical Record Number*: _____

Consider the following scenario: My health care agent is being asked to make medical decisions for me because **I have a serious medical event or illness that I won't recover from, I am unable to recover the abilities that are important to me, I am unable to make my own health care decisions,** and life-sustaining treatments are needed because my organs are failing.

Choose **one** option from the following:

A. Consider the following as you choose your health care preferences:

___ **I DO NOT want any life-sustaining treatments.** I do not want to start, and/or I would want to STOP life-sustaining treatments that have been previously started. I would prefer to die naturally with a focus on my comfort.

___ **I want a limited trial of life-sustaining treatments, but I do not want to stay on the treatments** if they are not helping me recover and there is little hope of me getting better.

___ **I would want life-sustaining treatments to start or to continue,** even if that means that I may remain on these treatments for the rest of my life.

___ **I would want my health care agent to make the decision about the use of life-sustaining treatments** for me based on my values and beliefs.

My preferences for a trial period and life-sustaining treatments are... because my goal is…

Only answer if this is relevant to you.

If I have additional preferences related to specific conditions (for example, advanced dementia, end stage cancer), I will write them here or attach another page to this form. I will do this to make clear what I want or don't want and under what conditions.

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Name*: _____
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Information for End of Life

This optional section allows you to record your preferences for in what setting you would like to die, 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 **Information for End of Life** 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 know what is most important to you. Take some time to reflect on these questions and, if it helps, you can refer back to **Part 1: My Values and Beliefs.**

Remember: This section is optional. If you're struggling or don't have all the answers, document what you know and move forward.

Choose **one** option and use the space below to describe more.

1. **If I am at the end of life and have choices available for where I could die, I choose to be:**

- ☐ At home
- ☐ Not at home
- ☐ I am not sure
- ☐ Other

My preference for where I would like to die is...

2. **If I am at the end of life, it's important for me to have the following around me (such as rituals, spiritual support, people, music, food, pets, etc.):**

My preference are…

Name*: _____
Medical Record Number*: _____

You and your loved ones are responsible for making the arrangements described in this section.

3. After I die, these are my preferences for how I want my body to be treated (funeral, memorial, burial, etc.), including any religious or spiritual wishes I may have:

My preferences are…

Choose **one** option for organ donation.

4. Upon my death, I want to donate my organs, tissues, and 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 parts for purposes of donation.

Choose **as many** options as apply.

I want to donate my organs for the following purposes:

❑ Transplant ❑ Research

❑ Therapy ❑ Education

If I want to restrict my donation of organ, tissue, or parts in any way, I will state my restrictions below:

I would like to restrict…

❑ No

❑ I'm not sure

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

Name*: _____
Medical Record Number*: _____

Part 5

Making This Document Legally Valid ensures that all the work and thinking you put into this AHCD will be valid.

Remember, you can update your preferences in your AHCD at any time.

Making This Document Legally Valid

This section makes your Advance Health Care Directive (AHCD), legally valid in the State of California. For this document to be legally valid, you must sign and date it or acknowledge your signature in front of two witnesses, OR it must be acknowledged before a Notary Public.

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

- At least 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 can NOT sign** as witnesses.
- The operator or employee of the place you're receiving care and/or **your health care provider, or an employee of your health care provider, can NOT sign** as a witness.
- When you are with your witnesses, sign or acknowledge your signature.
- Note that this means your witnesses must sign and date on the same date or a later date than you.
- Witnesses will sign on page 13.

OR

Notary Public

- Do **NOT** sign this document unless you are with a Notary Public.
- Notary Public will sign on page 14.

Your signature here

Keep going! For this document to be legally valid in the State of California, it also must be 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.

Name*: _____
Medical Record Number*: _____

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 (AHCD) 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 AHCD 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 appointed as an agent by this AHCD, and (5) That I am not the individual's health care provider, an employee of the individual's health care provider, the operator or employee of a community care facility or a residential care facility where the individual is receiving care (note, however, that (5) is not prohibited if I am related to the individual or a a co-worker of the individual).

Witness Number One signature. 1

Remember that your health care agent cannot be a witness.

Witness number one:

Name*

Address*

Signature* Date*

Witness Number Two signature. 2

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 AHCD 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* _____

Document type: Advance Directive **Description: Advance Directive Signed On**

Name*: _____
Medical Record Number*: _____

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 to witness this document and make it legally valid in the State of 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, _____
(date*) (Insert name and title of the officer*)

appeared (name(s) of signer(s*) _____

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)

Next Steps

Now that you have completed your Advance Health Care Directive (AHCD), use this checklist to ensure you receive the kind of care that's right for you.

Give copies of your AHCD

- ❑ **To your** health care agent,
- ❑ **To your doctor by uploading at kp.org OR bring to your local Kaiser Permanente Health Education Department,** and
- ❑ **Keep** a copy for yourself.

Discuss your AHCD

- ❑ **Talk to your health care agent** about your values and 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 friends and loved ones 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 you experience any of the **"5 D's":**

- ❑ **Decade:** Start of a new decade of your life.
- ❑ **Death:** Death of a loved one.
- ❑ **Divorce:** Divorce or other major family change.
- ❑ **Diagnosis:** Diagnosis of a serious health condition.
- ❑ **Decline:** Significant decline or deterioration of an existing health condition, especially if you're unable to live on your own.

Remember: You can cancel or replace this AHCD at any time. As things change in your life or with your health, you can change who your health care agent is and your medical and other preferences.

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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 medical professional. If you have persistent health problems, or if you have additional questions, please consult with your doctor. If you have questions or need more information about your medication, please speak to your pharmacist.

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