

ADVANCE HEALTH CARE DIRECTIVE CALIFORNIA POWER OF ATTORNEY FOR HEALTH CARE (Appointing an Agent to Make Health Care Decisions)

NOTE: COMPLETION OF THIS FORM IS ONLY THE FIRST STEP. YOU SHOULD DISCUSS YOUR WISHES IN DETAIL WITH YOUR DESIGNATED AGENT(S).

My name is: _____

My address is: _____

In this document, I appoint one or more agents to make health care decisions for me. **My agent's authority shall begin immediately, even though I currently have the mental capacity to make my own health care decisions.**

The following persons cannot be selected as your agent or alternate agent:

- Your primary physician.
- The operator of a community care facility or residential care facility where you receive care.
- An employee of the health care institution, community care facility or residential care facility where you receive care (unless you are related to that person, the person is your registered domestic partner, or you and the person are employed by the same facility or institution).

AGENT

Name: _____

Address: _____

Home Phone: _____ Work Phone: _____

1ST ALTERNATE AGENT (If Agent is unavailable or unwilling to serve.)

Name: _____

Address: _____

Home Phone: _____ Work Phone: _____

2ND ALTERNATE AGENT (If Agent and 1ST Alternate Agent are unavailable or unwilling to serve.)

Name: _____

Address: _____

Home Phone: _____ Work Phone: _____

California Probate Code, my agent has the same rights to request, receive, examine, copy and consent to the disclosure of my medical or other health care information as I would have.

The above authority applies to any individually identifiable health or medical information, health care information or other medical records governed by HIPAA, CMIA or Section 4678 of the California Probate Code.

PERSONAL CARE DECISIONS

I authorize my agent to make decisions regarding my personal care, including decisions regarding where I will live, hiring household employees, furnishing transportation and meals, handling my mail and arranging recreation and entertainment on my behalf. If I initial here _____, I do not want my agent to have the authority provided by the preceding sentence.

DISAGREEMENT WITH OTHER AGENTS

In case of disagreement between my agent and an agent under any financial or other power of attorney of mine regarding payment for my health and/or personal care or regarding any other matters addressed under this power of attorney for health care, the decision of my agent under this power of attorney for health care shall control. If I initial here _____, I do not want my agent to have the authority provided by the preceding sentence.

REVOCAION OF PREVIOUS DOCUMENTS

I revoke any previously-executed Power of Attorney for Health Care, Individual Health Care Instruction or Natural Death Act Declaration.

SIGNATURE OF PRINCIPAL (PERSON APPOINTING THE AGENT)

Date: _____

Signature: _____

(If principal is not physically able to sign, he or she can instruct another person to sign the principal's name, if signature is done in the principal's presence.)

WITNESSES

This document must either be notarized or signed by two adult witnesses. If the principal (the person appointing the agent) currently resides in a nursing facility, this document also must be witnessed by a patient advocate or ombudsman designated by the California Department of Aging. If the two-witness method is chosen, the patient advocate or ombudsman may serve as one of the two witnesses, or may serve as a third witness. If the notarization method is chosen, the patient advocate or ombudsman serves as a separate witness.

Certain individuals cannot serve as witnesses. Those rules are set forth in the following witness statements.

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 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 agent by this advance 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.

First Witness: _____
 Name (printed) Signature

Date: _____ Address: _____

Second Witness: _____
 Name (printed) Signature

Date: _____ Address: _____

ONE OF THE PRECEDING WITNESSES ALSO MUST 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.

Date: _____ Signature: _____

DECLARATION OF PATIENT ADVOCATE OR OMBUDSMAN
 (Required if person appointing the agent currently resides in a nursing facility)
 I declare under penalty of perjury under the laws of California that I am a patient advocate or ombudsman designated by the California Department of Aging and that I am serving as a witness as required by Section 4675 of the California Probate Code.

Date: _____ Signature: _____

CERTIFICATE OF ACKNOWLEDGMENT OF NOTARY PUBLIC (Not required if two-witness method is followed)

State of California, County of _____

On this _____ day of _____, _____, before me, the undersigned, a Notary Public in and for said State, personally appeared _____, who proved to me on the basis of satisfactory evidence to be the person whose name is subscribed to the within instrument and acknowledged to me that he/she executed it.

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)

NOTE: USE OF THIS FORM IS NOT APPROPRIATE FOR EVERY PERSON OR EVERY SITUATION. FOR MORE INFORMATION ABOUT POWERS OF ATTORNEY FOR HEALTH CARE, CONSULT WITH AN ATTORNEY.