



compassion & choices

of Northern California

Support. Educate. Advocate. Choice & Care at the End of Life.

Advance Directive: Planning for Important Healthcare Decisions

(Abridged version for Northern California Chapter)

Congratulations on taking the first step in protecting your right to freedom and choice at the end of life. These documents will help ensure that you continue to make your own healthcare decisions. They offer not only personal autonomy – they also give you and your loved ones peace of mind, knowing that your wishes are firm and clear.

HOW TO USE THESE MATERIALS

1. You may want to photocopy these forms before you start so you will have a clean copy if you need to start over.
2. You may want to talk with your family, friends, and physicians about your decision to complete an Advance Directive. Be sure the person you appoint to make decisions on your behalf understands your wishes.

What is an Advance Directive for Healthcare?

Advance Directive is a generic term used for documents that traditionally include a living will and the appointment of a health care agent.

These documents allow you to provide instructions relating to your future healthcare, such as when you wish to receive medical treatment or when you wish to refuse life-sustaining medical treatments.

The living will portion of an Advance Directive is a place for you to specify what kinds of treatment and care you would or would not want if you were unable to speak for yourself. The durable power of attorney for healthcare allows you to appoint someone to act on your behalf. That person will be called your healthcare agent.

Witness

California law requires that you sign your Advance Directive in the presence of two witnesses or a notary public. Your witness can NOT be: your appointed agent, related by blood, marriage or adoption, entitled to any portion of your estate, or an employee of a residential care facility.

You can change or cancel your Advance Directive at any time.

Agent

The person you appoint to serve as your health care agent cannot be: your health care provider or an employee of a residential care facility. It CAN be a family member or close friend.

When you complete your Advance Directive, provide copies to your agents, close family and friends, health care providers, and possibly, clergy. Keep your documents in an accessible place and let others know where they are.

California Advance Directive

Power of Attorney for Healthcare

(1) DESIGNATION OF AGENT: I designate the following individual as my agent to make healthcare decisions for me:

(Name of individual you choose as agent)

(address) (city) (state) (zip code)

(home phone) (work phone)

OPTIONAL: ALTERNATIVE AGENT. If I revoke my agent's authority or if my agent is not willing, able, or reasonably available to make a healthcare decision for me, I designate as my first alternate agent:

(Name of individual you choose as first alternate agent)

(address) (city) (state) (zip code)

(home phone) (work phone)

(2) AGENT'S AUTHORITY: My agent is authorized to make all healthcare decisions for me, including decisions to provide, withhold, or withdraw artificial nutrition and hydration, and all other forms of health care to keep me alive, except as I state here:

(3) WHEN AGENT'S AUTHORITY BECOMES EFFECTIVE: My agent's authority becomes effective when my primary physician determines that I am unable to make my own healthcare decisions unless I check the following box . If I check this box, my agent's authority to make healthcare decisions for me takes effect immediately.

(4) AGENT'S OBLIGATION: My agent shall make healthcare decisions for me in accordance with this power of attorney for healthcare. To the extent my wishes are unknown, my agent shall make healthcare decisions for me in accordance with my best interest, i.e., my personal values.

(5) AGENT'S POSTDEATH AUTHORITY: My agent is authorized to make anatomical gifts, authorize an autopsy, and direct disposition of my remains, except as I state here:

(6) END-OF-LIFE DECISIONS: I direct that my healthcare providers and others involved in my care provide, withhold, or withdraw treatment in accordance with the choice I have marked below: (Initial **only one** paragraph.)

_____ **(a)** Choice NOT To Prolong Life; I do not want my life to be prolonged if **(1)** I have an incurable and irreversible condition that will result in my death within a relatively short time, **(2)** I become unconscious and, to a reasonable degree of medical certainty, I will not regain consciousness, or **(3)** the likely risks and burdens of treatment would outweigh the expected benefits,

OR

_____ **(b)** Choice To Prolong Life; I want my life to be prolonged as long as possible within the limits of generally accepted healthcare standards.

(7) RELIEF FROM PAIN: I direct that treatment for alleviation of pain or discomfort should be provided at all times even if it hastens my death.

(8) OTHER WISHES: (If you do not agree with any of the optional choices above and wish to write your own, or if you wish to add to the instructions you have given above, you may do so here.) I direct that:

(9) THE DEMENTIA PROVISION: If I remain conscious but have a progressive illness that will be fatal and the illness is in an advanced stage, and I am consistently and permanently unable to communicate, swallow food and water safely, care for myself and recognize my family and other people, and it is very unlikely that my condition will substantially improve, I would like my wishes regarding specific life-sustaining treatments, as indicated herein to be followed.

If I am unable to feed myself while in this condition, I do / do not **(circle one)** want to be fed.

(10) SIGNATURE: Sign and date the form here:

(date) (sign your name)

(address)

(print your name)

(city) (state) (zip code)

(11) WITNESSES: This Advance Directive will not be valid for making healthcare decisions unless it is either: signed by two qualified adult witnesses who are personally known to you and who are present when you sign; **OR** acknowledged before a notary public.

ALTERNATIVE NO. 1: Statement of Witnesses.

I declare under penalty of perjury under the laws of California (1) that the individual who signed or acknowledged this Advance Directive is personally known to me, or that the individual's identity was proven to me by convincing evidence, (2) that the individual signed 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 an agent by this Advance Directive.

First Witness:

(date) (signature of witness)

(address) (printed name of witness)

(city) (state) (zip code)

Second Witness:

(date) (signature of witness)

(address) (printed name of witness)

(city) (state) (zip code)

ALTERNATIVE NO. 2: Notary Public, State of California.

County of _____ On _____

Before me, _____

(insert name of notary public)

personally appeared _____,

(insert name of principal)

personally known to me (or proved to me on the basis of satisfactory evidence) to be the person whose name is subscribed to the within instrument and acknowledged that he/she executed the same in his/her authorized capacity and that by his/her signature on the instrument the person upon behalf of which the person acted, executed the instrument.

WITNESS my hand and official seal.

NOTARY SEAL _____

(signature of notary)

Need Help?

We'll be here when you need us! Providing Advance Directive documents is just one of the many services we offer. Compassion & Choices members receive free counseling and guidance on how to complete and how to use Advance Directives.

Those who join at the Benefactor level can get a wallet-sized CD of their Advance Directives, which they can carry with them at all times. Emergency personnel will find this CD. It will speak for you when you can't speak for yourself.

Your dues and donations assure the continuation of our programs and services. Our Client Support Program offers free support for individuals and families as they contemplate life's end. Our education program provides literature and speakers in communities across the nation. And our advocacy team defends your right to a peaceful death on legal and legislative fronts.

Through our national team of volunteers and top-notch legal talent, we stand ready to deliver advocacy services by telephone, at the bedside, and even in the courtroom, if necessary.

Please join us in our effort to ensure care, choice, dignity and control at life's end.

Yes! I want to join Compassion & Choices Northern California:

Individual (\$45) - Couple/Dual (\$60) - Benefactor (\$100)

Individual Life (\$450) - Couple/Dual Life (\$600)

I choose not to join now, but please accept my enclosed donation of

\$50, \$100, \$150, or \$ _____ (check payable to Compassion & Choices NCA)

Credit card number: _____ Expiration: _____ Visa or Mastercard _____

Name: _____

Address: _____ City, State, Zip _____

Daytime phone: _____ Evening phone: _____ Email: _____

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