Saint Agnes Medical Center

Fresno, California

ADVANCE HEALTH CARE DIRECTIVE

106500-597 (5/05)

Guidelines for Signers

What is an Advance Health Care Directive?
An "Advance Health Care Directive" is a document you can use to appoint another person, such as a family member or friend, to make health care decisions for you if you become unable to make the decisions on your own. The person may make all decisions about your health care, subject to any restrictions on that person's authority you specify and several restrictions imposed by law.

Why Complete an Advance Health Care Directive?

An Advance Health Care Directive will be helpful even if you have executed a "Living Will" or a "Declaration to Physician" since it applies to all health care decisions and allows you to appoint a person to carry out your wishes if you become incapable of making your own decisions. The other primary reasons for completing an Advance Health Care Directive are to avoid court proceedings, possible delays in receiving needed medical care, and emotional and financial stress on family and friends. These benefits are available because an Advance Health Care Directive can be executed by simply completing the attached form, without going to court. It may be advisable to execute an Advance Health Care Directive before surgery or other medical care. Persons with chronic conditions that may "flare up" and leave them unable to make decisions might also consider executing an Advance Health Care Directive. Persons with no close relatives living nearby may want to identify a close friend to make medical decisions for them in the event they become unable to make such decisions for themselves. As a practical matter, many people may want to keep an Advance Health Care Directive in effect at all time. Just as they maintain insurance to protect their interests in the event of unforeseen occurrences.

Who Can Complete an Advance Health Care Directive?
Any adult who has the ability to understand the nature and consequences of the proposed Advance Health Care Directive and to make and communicate a health care decision may execute an Advance Health Care Directive.

Can a Person Appointed in an Advance Health Care Directive Manage My Financial Affairs?

An Advance Health Care Directive authorizes only health care decisions, arrangements for medical services, and personal decisions. If you want to appoint a person to handle your other legal or financial affairs, you should consult with an attorney about completing a General Power of Attorney for Finances for such matters or use alternative methods for taking care of these matters.

How Do I complete an Advance Health Care Directive?

Simply fill out the attached form, in which you will name your health care agent and state any limits imposed by you on his or her authority. Limits imposed by law are already stated on the form. Read the guidelines and instructions carefully before completing it. It must be witnessed or notarized.

Who will make health care decisions for me if I am unable to do so?

You may appoint a health care agent to carry out your wishes.

If I am unable to make health care decisions for myself, how can I give instructions about my future health care?

By giving health care instructions in writing in advance to the person(s) you would want involved in making these decisions.

Attention Person Completing This document

This is an important document. Before completing this document, you should know these important facts:

This document gives the person you designate as your agent the power to make health care decisions for you when you are unable to do so. Your agent must act consistently with your desires as stated in this document or otherwise made known.

Except as you otherwise specify in this document, this document gives your agent the power to consent to your doctor giving treatment or stopping treatment necessary to keep you alive.

Whether or not you have this document, you have the right to make medical and other health care decisions for yourself so long as you can give informed consent with respect to the particular decision. In addition, no treatment may be given to you over your objection, and health care necessary to keep you alive may not be stopped or withheld if you object at the time.

This document gives your agent authority to consent, to refuse to consent, or to withdraw consent to any care, treatment, service, or procedure to maintain, diagnose, or treat a physical or mental condition. This power is subject to any statement of your desires and any limitations that you include in this document. You may state in this document any types of treatment that you do not desire. In addition, a court can take away the power of your agent to make health care decisions for you if your agent; 1) authorizes anything that is illegal, 2) acts against your known desires, or 3) where your desires are not known does anything that is clearly against your best interests.

This power will exist for an indefinite period of time unless you limit its duration in this document.

You have the right to revoke the authority of your agent by notifying your agent or your treating doctor, hospital, or other health care provider orally or in writing of the revocation.

Your agent has the right to examine your medical records and to consent to their disclosure unless you limit this right in this document.

Unless you otherwise specify in this document, this document gives your agent the power after you die to: 1) authorize an autopsy, 2) donate your body or parts there of for transplant, therapeutic, educational or scientific purposes, and 3) direct the disposition of your remains.

Your agent may need this document immediately in case of an emergency that requires a decision concerning your health care. Either keep this document where it is immediately available to your agent and alternate agents or give each of them a completed copy of this document. You may also want to give your doctor a completed copy of this document.

If there is anything in this document that you do not understand, you should ask a resource such as a lawyer or your health care provider to explain it to you.

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This form is intended to help you give instructions about your future health care. You may also name a health care agent to make decisions for you. To be valid, this form must be signed, dated and **witnessed or notarized**. You are free to use a different form if you desire.

1. YOUR NAME: _____

(Print your full name if you intend to use this form)

2. MY WISHES REGARDING HEALTH CARE AGENT.

☐ By initialing this box I wish to name a health care agent at this time (Complete Section 3)

OR

☐ By initialing this box I do not wish to appoint a health care agent at this time (Proceed to Section 6)

3. APPOINTMENT OF HEALTH CARE AGENT.

I hereby name as my agent to make health care decisions for me:

Name: _____

(Print agent's name)

Address: _____

Home Phone: _____ Work Phone: _____

Other: (cell phone, pager or other): _____

If my agent is not reasonably available able or willing to make health care decisions for me or if I revoke the appointment of my agent, I name the following person(s) to do so:

Optional - First Alternate Agent:

Name: _____

(Print agent's name)

Address: _____

Home Phone: _____ Work Phone: _____

Other: (cell phone, pager or other): _____

If my first alternate is not reasonably available, not able or unwilling to make health care decisions for me or if I revoke the appointment of my first alternate agent, I name the following person(s) to do so:

Optional - Second Alternate Agent:

Name: _____
(Print agent's name)

Address: _____

Home Phone: _____ Work Phone: _____

Other: (cell phone, pager or other): _____

4. **AGENT'S AUTHORITY**. My agent is authorized to make all health care 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, unless I state anything to the contrary here:

_____

_____

_____

5. **WHEN AGENT'S AUTHORITY BECOMES EFFECTIVE**

☐ By initialing this box, my agent's authority becomes effective when my primary physician determines that I am unable to make my own health care decisions.

OR

☐ By initialing this box, I desire my agent's authority to make health care decisions for me to be effective **now** **(even though I am able to make health care decisions for myself).**

6. **HEALTH CARE INSTRUCTIONS**

You have the right to give instructions about your health care. By providing written health care instructions your desires are more clearly available to your primary physician and others providing health care services. You may wish to make statements about your desires concerning life-support treatment or life-sustaining treatment used to keep you alive. Such treatments may include; cardiopulmonary resuscitation; artificial nutrition and hydration (tube feeding); medical devices to help you breath; blood transfusions and other medical procedures.

The following instructions apply if I have initialed in the box before the instruction:

☐ **Choice not to prolong life.** 1) If I have an incurable and irreversible condition that will result in my death within a relatively short time, or 2) if I become unconscious and my primary physician indicates I will not regain consciousness, or 3) the likely risks and burdens of treatment would outweigh the expected benefits, then I do not want my life to be prolonged by medical means. I request that all treatments other than those needed to keep me comfortable be discontinued or withheld

☐ **Choice to prolong life.** Even if I am suffering from a terminal or irreversible condition, I want my life to be prolonged as long as possible within the limits of generally accepted health care standards by using all available and effective life support treatments.

☐ **Other Wishes.** I desire my physician(s) and my health care agent if I have appointed one to do the following:

_____

_____

_____

Attach additional pages if you have more instructions.

7. **REVOCATION OF ADVANCE DIRECTIVES.** I revoke any prior Advance Health Care Directive. I understand I may revoke all or part of this Advance Health Care Directive at any time by informing my treating health care provider personally or in writing.

8. **SIGNATURE.** Sign and date this form here.

Signature: _____ Date: _____

(Sign your name)

Date of Birth:_____

9. **STATEMENT OF WITNESSES**

This Advance Health Care Directive will not be valid unless it is either; 1) signed by two qualified adult witnesses who are present when you sign or acknowledge your signature or 2) acknowledged before a notary public in California. If you use witnesses rather than a notary public, the law prohibits using the following as witnesses: 1) the persons you have appointed as your agent or alternate agent(s), 2) your health care provider or an employee of your health care provider, or 3) an operator or employee of an operator of a community care facility or residential care facility for the elderly. Additionally, at least one of the witnesses cannot be related to you by blood, marriage or adoption, or be named in your will, or by operation of law be entitled to any portion of your estate upon your death.

Special Rules for Skilled Nursing Facility Residents

If you are a patient in a skilled nursing facility, you must have a patient advocate or ombudsman sign as a witness and sign the Statement of Patient Advocate or Ombudsman. You must also have a second qualified witness sign below or have this document acknowledged before a notary public.

Statement of Patient Advocate or Ombudsman

I declare under penalty of perjury under the laws of California that I am a patient advocate or ombudsman as designated by the State Department of Aging and that I am serving as a witness as required by Section 4675 of the Probate Code.

Print your Name _____ Date _____

Sign your Name _____

Address _____

City, State, Zip _____

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 Health Care 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 Health Care Directive, and 5) I am not the individual's health care provider nor an employee of that health care provider, nor an operator or employee of an operator of a community care facility or a residential care facility for the elderly.

First Witness: _____
(Print name) (Signature) (Date)

Address: _____
(City) (State)

Second Witness: _____
(Print name) (Signature) (Date)

Address: _____
(City) (State)

AT LEAST ONE OF THE ABOVE WITNESSES MUST ALSO SIGN THE FOLLOWING:

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/her death under a will now existing or by operation of law.

Date: _____ Signature _____

Statement and Seal of 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 within this instrument and acknowledged that he/she executed it. I declare under penalty of perjury that the person whose name is subscribed to this instrument appears to be of sound mind and under no duress, fraud, or undue influence.

Witness my hand and official seal.

NOTARY SEAL _____
(signature of notary)