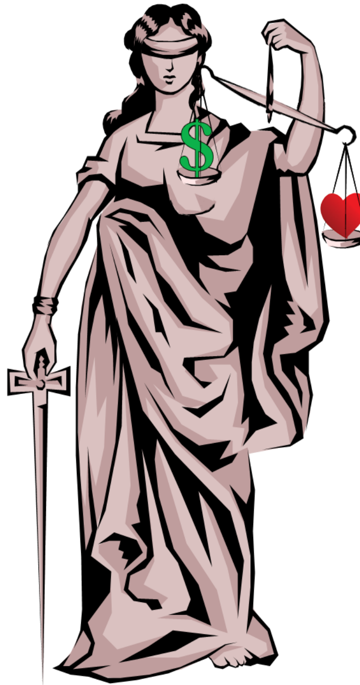
CALIFORNIA ADVANCE HEALTH CARE DIRECTIVE

Living Will



This Legal Document is brought to you compliments of:

LA LAW CENTER, LLP

Center for Life Care Planning

Joseph McHugh, Esq.

Alexandra Woodward, Esq.

We are dedicated to ensuring everyone protects themselves in case of incapacity. This is a simple form to make sure you have a health directive according to California Law. This information shall ***not*** be considered formal legal advice or the formation of an attorney-client relationship.

If you need legal services or help finding the best care for your loved one and assistance in determining the resources to pay for that care call us:

OFFICE: 818-241-4238

TOLL FREE: 877-537-8283

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CALIFORNIA ADVANCE HEALTH CARE DIRECTIVE

My name is ________________________

PART 1
POWER OF ATTORNEY FOR HEALTH CARE

The following people have the authority to make Health Care Decisions for me if I can not. They have they right to review my medical records to find out what my heal problem is, or how to treat it. They can authorize test, medicine, or surgery.

(1.1) NAMING OF AGENT: I designate the following individual as my agent to make health care decisions for me:

____

(name of individual you chose as agent)

____

(address of agent)

____

(home phone)

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

____

(name of individual you chose as first alternate agent)

____

(address of agent)

____

(home phone)

OPTIONAL: If I revoke my agent's authority or if my agent is not willing, able, or reasonably available to make a health care decision for me, I designate as my second alternate agent:

____

(name of individual you chose as first alternate agent)

____

(address of agent)

____

(home phone)

(1.2) 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, except as I state here:

____

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____
(Add additional sheets if needed.)

(1.3) 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 health care decisions unless I mark the following box.

If I mark this box [__], my agent's authority to make health care decisions for me takes effect immediately.

I expressly authorize my agent to make decisions for me even if I am competent to make decisions.

All medical providers shall discuss all medical decisions with my healthcare agent even if I am competent to make medical decisions. No medical decision shall be made until the medical provider, and my agent have discussed the options and I have made an informed medical decision with the assistance of my agent.

(1.4) AGENT'S OBLIGATION: My agent shall make health care decisions for me in accordance with this power of attorney for health care, any instructions I give in Part 2 of this form, and my other wishes to the extent known to my agent. To the extent my wishes are unknown, my agent shall make health care decisions for me in accordance with what my agent determines to be in my best interest. In determining my best interest, my agent shall consider my personal values to the extent known to my agent.

(1.5) 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 or in Part 3 of this form:

_____I want to be cremated, and I want my ashes ______________________________________

____I want to be buried____

____

____
(Add additional sheets if needed.)

(1.6) NOMINATION OF CONSERVATOR: If a conservator of my person needs to be appointed for me by a court, I nominate the agent designated in this form. If that agent is not willing, able, or reasonably available to act as conservator, I nominate the alternate agents whom I have named, in the order designated.

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PART 2
INSTRUCTIONS FOR HEALTH CARE

If you fill out this part of the form, you may strike any wording you do not want.

(2.1) END-OF-LIFE DECISIONS: I direct that my health care providers and others involved in my care provide, withhold, or withdraw treatment in accordance with the choice I have marked below:

______ (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,

In the event that I have a respiratory or cardiac arrest, I do not want CPR or other advanced resuscitation methods / procedures, or life support equipment utilized in the following instances:

It has been determined, using a cerebral blood flow study and an EEG, or other advanced medical testing procedure, that I have suffered brain death;

It has been determined through appropriate testing, and is the opinion of at least three independent physicians, that I have suffered irreversible brain damage, recovery is not possible, and I am in a persistent vegetative state;

I have been diagnosed with a terminal medical condition and am within a few days or weeks of death.

Resuscitation methods or procedures that are NOT to be utilized in these instances include:

CPR (cardiopulmonary resuscitation)
Intubation (breathing tube)
Emergency resuscitation medications

Life sustaining treatment and equipment that is NOT to be used includes:

Food and/or fluids supplied artificially though the use of a tube through the nose to the stomach, through the skin to the stomach, or total parenteral nutrition;
Antibiotics
Kidney dialysis
Major surgery

OR

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

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(2.3)RELIEF FROM PAIN: Except as I state in the following space, I direct that treatment for alleviation of pain or discomfort be provided at all times, even if it hastens my death:

In the event that I am unable to act as my own decision-maker I want all personal care and comfort measures provided including adequate pain control. If during this time I must spend a large amount of time in bed I want a pressure relief/negative mattress used as a comfort measure.

(2.3) 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:

____

____

____

(Add additional sheets if needed.)

PART 3
DONATION OF ORGANS AT DEATH
(OPTIONAL)

(3.1) Upon my death (mark applicable box):

_____ (a) I give any needed organs, tissues, or parts, OR

_____ (b) I give the following organs, tissues, or parts only.

____

____

(c) My gift is for the following purposes (strike any of the following you do not want):

(1) Transplant
(2) Therapy
(3) Research
(4) Education

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PART 4
PRIMARY PHYSICIAN
(OPTIONAL)

(4.1) I designate the following physician as my primary physician:

____
(name of physician)

____
(address)

____
(phone)

* * * * * * * * * * * * * * * * * *

PART 5

(5.1) EFFECT OF COPY: A copy of this form has the same effect as the original.

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

____________________ ____
(date) (sign your name)

____
(print your name)

____
(street address)

____
(city, state zip)

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CERTIFICATE OF ACKNOWLEDGEMENT OF NOTARY PUBLIC

State of California)

County of ___________________________)

On ______________ before me, ____ (here insert name and title of the officer), personally appeared ____________________________, 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)

(5.3) 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 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 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

____

(print name)

____

(address)

____

(city, state zip)

____

(signature of witness)

____

(date)

Second witness

____

(print name)

____

(address)

____

(city, state zip)

____

(signature of witness)

____

(date)

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(5.4) 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 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.

_____________________________________ _____________________________________
(signature of witness) (signature of witness)

DECLARATION OF OMBUDSMAN PROGRAM REPRESENTATIVE

I declare under penalty of perjury under the laws of California that I am an 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.

Dated:________________ _____________________________________
(signature of Ombudsman)

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