Advance Health Care Directive (AHCD)

CALIFORNIA

My first name:_____

My last name:_____

My date of birth:_____/_____/_____

My medical record number:_____

KP use: patient label

There are two versions of this document. This is the shorter one. You can view the two versions on **kp.org/lifecareplan** or ask your doctor for them. Choose the one you prefer.

Step 1 Choose a health care agent (decision maker). You can also choose an alternate agent if you want one.

This person is:

- 18 or older and knows your values and beliefs well;
- willing and able to do this for you;
- willing to honor **your** preferences even if they are different from their own;
- not your doctor or another health care professional who is caring for you.

I choose_____ relationship:_____

phone number:_____ email:_____,
as my health care agent to make health care decisions for me if I'm not able to make them for myself.

I choose_____ relationship:_____

phone number:_____ email:_____
as my alternate health care agent if my primary health care agent is not willing, able, or reasonably available to make health care decisions for me.

Step 2 Give guidance to my health care agent and care team. Choose ONE box only:

If I have an illness that is not curable and will result in my death in a short time,

OR I become unconscious, and my doctors do not think I will improve,

OR the likely risks and burdens of treatment would outweigh the expected benefits...

☐ I want to be kept alive as long as possible within the limits of generally accepted health care standards.

☐ I do not want my life to be prolonged. I would stop treatments to keep me alive or not start them.

☐ I am not sure which statements I most agree with. I trust my health care agent to do what is best for me.

Is there anything else your care team should know about you or your medical preferences?

_____

_____

_____

Step 3 Sign the form below. Ask either TWO witnesses (Option 1) OR a notary public (Option 2) to also sign.

My name (please print): _____

My signature: _____ Date: _____

My first name:_____

My last name:_____

My medical record number:_____

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Option 1 I choose TWO WITNESSES.

ALL WITNESSES MUST READ AND ACCEPT ALL THESE REQUIREMENTS.

- I declare under penalty of perjury under the laws of California that:
- I am at least 18 years old;
- I am not a person appointed as agent by this Advance Health Care Directive;
- only one of the witnesses can be family related;
- 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;
- the individual signed or acknowledged this Advance Health Care Directive in my presence;
- the individual appears to be of sound mind and under no duress, fraud, or undue influence
- 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

WITNESS NUMBER ONE:

Print name:_____ Signature:_____

Address:_____

Date:_____

WITNESS NUMBER TWO:

Print Name:_____ Signature:_____

Address:_____

Date:_____

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

Print Name:_____ Signature: _____

FOR CALIFORNIA SKILLED NURSING FACILITY RESIDENTS ONLY

Give this form to your nursing home director ONLY if you live in a nursing home. California law requires nursing home residents to have the nursing home ombudsman as an additional witness of Advance Health Care Directive (AHCD).

STATEMENT OF THE 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."

Signature of ombudsman:_____ Date:_____

Print name:_____

My first name:_____

My last name:_____

My medical record number:_____

KP use: patient label

Option 2 I choose a NOTARY PUBLIC instead of two witnesses.

State of California, County of: _____

A notary public or other office completing this certific te verifies onl the identity of the individual who signed the document to which this certific te is attached, and not the truthfulness, accuracy, or validity of that document.

On _____ before me, _____

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 that 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 of Notary Public) (Seal)

Next Steps

- ☐ **Keep the original**.
- ☐ **Give copies to your health care agent(s)**.
- ☐ **Bring a copy to your next Kaiser Permanente appointment** OR
- ☐ **Send in a copy by mail to:** Kaiser Permanente Central Scanning, 1011 S. East Street, Anaheim, CA 92805, **OR email a copy to:** SCALCentralized-Scanning-Center@kp.org
- ☐ **Talk to your health care agent(s)** about your values, beliefs, and your health care preferences. Use your AHCD to guide the conversation and make sure they can do this role. **Be sure to let your loved ones, family, and close friends** know who you have chosen to be your health care agent(s), 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.

You can cancel or change ANY of your choices in your AHCD at any time. As things change in your life or with your health, you can change your agent(s) and preferences by completing a new document or telling your doctor in person.

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