

Advance Health Care Directive



For California



Rooted and growing in Aging Services

Information and Assistance for Older Adults, Caregivers, and Persons with Disabilities

1-800-510-2020

Advance Health Care Directives

Introduction

California law gives everyone 18 years and older the right to make health care decisions, including what medical care or treatment to accept, reject, or discontinue. It provides individuals the ability to insure that their health care wishes are known and considered if they become unable to make these decisions themselves. If you do not want to receive certain types of treatment or you wish to name someone to make these medical decisions for you, you have the right to make this known to your doctor, hospital staff, and other health care providers. This document will ensure that these wishes will be respected.

Frequently Asked Questions about Advance Directives

What is an Advance Health Care Directive?

An Advance Health Care Directive is the best way to make sure that your health care wishes are known and considered if for any reason you are unable to speak for yourself. It is a document which states your choices about medical treatment or names someone to make decisions about your medical treatment if you are unable to do so yourself. It is called an "advance" directive because it is signed in advance to let your doctor and other health care providers know your wishes concerning medical treatment.

By completing a form called an "Advance Health Care Directive" California law allows you to do either or both of two things:

First, you may appoint another person to be your health care "agent." This person (who may also be known as your "attorney-in-fact") will have legal authority to make decisions about your medical care if you become unable to make these decisions for yourself.

Second, you may write down your health care wishes in the Advance Health Care Directive form—for example, a desire not to receive treatment that only prolongs the dying process if you are terminally ill. Your doctor and your agent must follow your lawful instructions.

Who can fill out an Advance Health Care Directive?

Any competent adult who is at least 18 years old and can make his or her own medical decisions can fill out an advance health care directive.

Do I have to have an Advance Health Care Directive?

No, it is entirely up to you whether you want to prepare any documents. But if questions arise about the kind of medical treatment that you want or do not want, advance health care directives may help solve these important issues. Your doctor or any health care provider cannot require you to have an advance health care directive in order to receive care nor prohibit you from having an advance health care directive. Under California law, no health care provider or insurer can charge different fees or rates depending on whether or not you have executed an advance health care directive.

What will happen if I do not prepare an Advance Health Care Directive?

You will receive medical care even if you do not have an advance health care directive. However, there is a greater chance that you will receive more treatment or more procedures than you may want. If you cannot speak for yourself and have not made an advance directive, your doctor or other health care providers will generally look to your family or friends for decisions about your care. But if your doctor or health care facility is unsure or if your family members cannot agree, they may ask the court to appoint a conservator to make those decisions for you.

Whom should I talk to about my Advance Health Care Directive?

Before writing down your instructions, you should talk to those people closest to you and who are concerned about your care. Discuss them with your family, your doctor, your friends, your lawyer, and/or clergy. These are the people who will be involved in your care if you are unable to make your own decisions.

When do Advanced Health Care Directives go into effect?

An advance health care directive takes effect when you are no longer able to make your own health care decisions. As long as you are able to give informed consent, your health care providers will rely on you and not your advance health care directive.

How will health care providers know if I have an Advance Health Care Directive?

All hospital, nursing homes, home health agencies, HMOs and other health care facilities that accept federal funds must ask if you have an advance health care directive, and if so, they must see that it is made part of your medical records.

Can I change my mind after I write an Advance Health Care Directive?

Yes, at any time, you can cancel or change any advance health care directive that you have written. To cancel your directive, simply destroy the original document and tell your family, friends, doctor, and anyone else with a copy that it is no longer valid. To change your advance health care directive, write and date a new one. Give copies of your revised document to all appropriate parties, including your doctor.

You should complete a new form if you want to name a different person as your agent or make other changes. However, if you need only to update the address or telephone numbers of your agent or alternate agent(s), you may write in the new information and initial and date the change. Of course, you should make copies or otherwise ensure that those who need this new contact information will have it.

You should make a list of the people and institutions to whom you give a copy of the form so you will know whom to contact if you revoke your advance health care directive, update contact information, or make a new one.

PLEASE NOTE: If you have multiple, valid planning documents with conflicting instructions, the **later in time** will legally prevail.

Do I need a lawyer to help me make an Advance Health Care Directive?

No. You do not need a lawyer to assist you in completing an advance health care directive. The only exception applies to individuals who have been involuntarily committed to a mental health facility who wish to appoint their conservator as their agent.

Will my California Advance Health Care Directive be honored in another state?

An advance health care directive that meets the requirements of California law may or may not be honored in another state, but most states will recognize an advance health care directive that is executed legally in another state, **excluding any term in your directive that is illegal under that state's law**. If you spend a lot of time in another state, you may want to consult a doctor, lawyer, or medical society in that state to find out about the laws there.

What should I do with my Advance Health Care Directive?

You should keep it in a safe place where your family members can get to it. Do **NOT** keep the original in your safe deposit box. Give a copy of your advance health care directive to as many people that you are comfortable with, such as your spouse, family members, doctor, lawyer, clergyperson, and the hospital or residential facility where you are residing. You can also keep a small card in your wallet or purse that alerts others that you have an advance health care directive and who should be contacted.

In addition, you should fill out a list of those you have given a copy of your advance health care directive. This will ensure that you communicate any changes you make to your directive to everyone who has a copy. Make sure you include the name, address, telephone, and fax numbers for each person or facility you have listed.

Frequently Asked Questions about Living Wills

Is an Advance Health Care Directive different from a "living will"?

The Advance Health Care Directive is now the legally recognized format for a living will in California. It replaces the Natural Death Act Declaration. The Advance Health Care Directive allows you to do more than the traditional living will, which only states your desire not to receive life-sustaining treatment if you are terminally ill or permanently unconscious. An advance health care directive allows you to state your wishes about refusing or accepting life-sustaining treatment in any situation.

Unlike a living will, an advance health care directive also can make clear your desires about your health care in any situation in which you are unable to make your own decisions, not only when you are in a coma or, are terminally ill. A living will only states whether or not you want life-sustaining treatments or procedures administered to you if you are in a terminal condition or a permanent unconscious state.

You do not need a separate living will if you have already stated your wishes about life-sustaining treatment in an advance health care directive. There is a section that allows you to make a living will statement that reflects your end of life decisions.

When does a living will go into effect?

A living will goes into effect when:

- 1) Your doctor has a copy of it;
- 2) Your doctor has concluded that you are no longer able to make your own health care decisions; and
- 3) Your doctor has determined that you are in a terminal condition or a permanent unconscious state.

What are “life-sustaining” treatments?

These are treatments or procedures that are not expected to cure your terminal condition or make you better. Examples are mechanical respirators, kidney dialysis, and cardiopulmonary resuscitation (CPR).

What is a “terminal condition”?

A terminal condition is an incurable condition for which medical treatments will only prolong the dying process. If these treatments are not administered, death will occur in a relatively short period of time.

What is a “permanent unconscious state”?

A permanent unconscious state means that a patient is in a permanent coma caused by illness, injury or disease. The patient is unaware of himself, his surroundings and environment and to a reasonable degree of medical certainty, there can be no recovery.

Is a Living Will the same as a Do Not Resuscitate (DNR) order?

No. A living will covers almost all types of life-sustaining treatments and procedures. A DNR order covers only two types of threatening situations: cardiac arrest and respiratory arrest. If your heart stops beating or you stop breathing, your health care providers are not to try to revive you by any means. A DNR order is prepared by your doctor at your direction and is placed in your medical records.

Will I receive medication for pain?

Unless you state otherwise in your living will, medication for pain will be provided where appropriate to make you comfortable and will not be discontinued.

Frequently Asked Questions about Durable Power of Attorneys for Health Care

What is a Durable Power of Attorney for Health Care (PAHC)?

A PAHC is a legal document which allows you (“the principal”) to appoint another person (“the agent”) to make medical decisions for you if you should become temporarily or permanently unable to make those decisions yourself.

Who can I select to be my agent?

You can appoint almost any adult to be your agent. You should select a person(s) knowledgeable about your wishes, values, religious beliefs, in whom you trust, have confidence in and who knows how you feel about health care. You should discuss the matter with the person(s) you have chosen and make sure they understand and agree to accept the responsibility.

You can select a family member or a close friend. If you select your spouse and then divorce, the appointment of your spouse as your agent is revoked.

The following people **CANNOT** be appointed as your agent:

- 1) Your supervising health care provider;
- 2) An employee of any health care institution where you are receiving care;
- 3) An operator or employee of a community care facility for the elderly where you are receiving care.

However, the above employees may be appointed as your agent if he/she is either:

- 1) Related to you by blood, marriage, or adoption;
- 2) Employed by the same health care institution, community care facility, or residential care facility for the elderly that employs you.

When does the PAHC take effect?

The PAHC only becomes applicable when you are temporarily or permanently unable to make your own health care decisions and your agent consents to start making those decisions. Your agent can begin making decisions on your behalf as soon as your doctors have decided that you are no longer able to make them. As long as you are able to make treatment decisions, you have the right to do so.

What decisions can my agent make?

Unless you limit his/her authority in your Advance Health Care Directive, your agent will be able to make almost every treatment decision in accordance with accepted medical practice that you could make if you were able to do so. If your wishes are not known or cannot be determined, your agent has the duty to act in your best interest. These decisions may include authorizing, refusing or withdrawing treatment, even if it could lead to your death.

Are there any decisions my agent cannot make?

California law prohibits your agent from committing you to a mental health treatment facility or authorizing convulsive treatment therapy, psychosurgery, sterilization, and abortion.

What happens if I regain the capacity to make my own decisions?

If your doctor determines that you have regained the capacity to make or to communicate health care decisions, your agent's authority will end and your consent will then be required for treatment. If your doctor later determines that you no longer have the capacity to make or to communicate health care decisions, then your agent's authority will be restored.

Can there be more than one agent?

It is recommended that you name only one person as your health care agent. If two or more people are given equal authority and they disagree about a health care decision, one of the important purposes of the Advance Health Care Directive—to identify clearly who has authority to speak for you—will be defeated. If you are afraid of offending people close to you by choosing one over another to be your agent, ask them to decide among themselves who will be the agent, and list the others as alternate agents. While you are not required to do so, you may designate alternatives who may act for you if your primary agent is unavailable, unable or unwilling to act. Your alternatives have the same decision-making authority as your primary agent.

Can my agent resign?

Yes. Your agent and your alternatives can resign at any time by giving written notice to you, your doctor, or the hospital or nursing home where you receive care.

Can my agent be legally or financially liable for decisions made on my behalf?

No. Your health care agent or your alternate agents cannot be held liable for treatment decisions made in good faith on your behalf.

Will my health care agent be responsible for my medical bills?

No, not unless that person would otherwise be responsible for your debts. The advance health care directive deals only with medical decision making and has no effect on financial responsibility for your health care. Please note, however, that unless you have made other arrangements, your agent may be responsible for costs related to the disposition of your body after you die. Consult an attorney regarding how your financial affairs should best be handled.

Does an Advance Health Care Directive have to be signed and witnessed?

Yes, you must sign and date the document. If you are unable to sign, you can have someone sign the directive in your presence and at your direction. Then it must be notarized or witnessed by two qualified adults.

The only people who **CANNOT** witness your signature of the directive are:

- 1) Your treating health care provider or an employee of your treating health care provider;
- 2) The person(s) you appointed as your agent or alternate agent;
- 3) An operator or an employee of a community care facility;
- 4) An operator or an employee of a residential care facility for the elderly.

At least one witness must not be related to you by blood, marriage, or adoption, or be entitled to any part of your estate upon your death. Also, if you are a resident of a skilled nursing facility, at least one of the witnesses must be a patient advocate or ombudsman designated by the California Department of Aging.

Can anyone force me to sign an Advance Health Care Directive?

No. The law specifically says that no one can require you to complete an advance health care directive before admitting you to a hospital or other health care facility and no one can deny you health insurance because you choose not to complete an advance health care directive.

Can I register my Advance Health Care Directive with the California state government?

Yes. California law allows you to register, amend or revoke the information in your advance health care directive with the California Secretary of State. By registering your directive, health care providers and other authorized individuals may be able to obtain needed information regarding your directive. This could be important if you or your family members are unable to provide this information. For example, suppose you are out-of-town and are admitted in an unconscious state to an emergency room. If you have registered your directive with the California Secretary of State, you are likely to have in your wallet or purse a card indicating that you have registered your directive. By following the instructions on this card, emergency room personnel will be able to obtain information regarding your directive from the California Secretary of State.

You may call the Advance Health Care Directive Registry at (916) 653-3984 or online at <http://www.ss.ca.gov/ahcdr/index.htm> to obtain the Registration of Written Advance Health Care Directive form. The current fee is \$10.00 to register a new advance directive and another \$10.00 each time to file a new or amended one. There is no fee to make changes to the registration form or to revoke the registration. You do **NOT** have to register your Advance Health Care Directive for it to be valid.

Important Numbers

County of Orange Office on Aging: Information on Orange County resources
Information and Assistance: 1-800-510-2020 or 714-480-6450
www.officeonaging.ocgov.com

Council on Aging Ombudsman Program
714-479-0107
www.coasc.org

Advance Health Care Directive Registry
916-653-3984
www.ss.ca.gov/ahcdr/index.htm

Organizations that provide assistance in preparing advance health care directives:

California Health Decisions
714-347-7921
www.cahd.org

Legal Aid Society of Orange County
714-571-5200
www.legal-aid.com

California Advance Health Care Directive

(California Probate Code Section 4701)

Explanation of this Document

You have the right to give instructions about your own health care. You also have the right to name someone else to make health care decisions for you. This form lets you do either or both of these things. It also lets you express your wishes regarding donation of organs and the designation of your primary physician. If you use this form, you may complete or modify all or any part of it. You are free to use a different form.

Part 1 of this form is a power of attorney for health care. Part 1 lets you name another individual as an agent to make health care decisions for you if you become incapable of making your own decisions or if you want someone else to make those decisions for you now even though you are still capable. You may also name an alternate agent to act for you if your first choice is not willing, able, or reasonably available to make decisions for you. Your agent may not be an operator or employee of a community care facility or residential care facility where you are receiving care, or your supervising health care provider or employee of the health care institution where you are receiving care, unless your agent is related to you or is a coworker.

Unless the form you sign limits the authority of your agent, your agent may make all health care decisions for you. This form has a place for you to limit the authority of your agent. You need not limit the authority of your agent if you wish to rely on your agent for all health care decisions that may have to be made. If you choose not to limit the authority of your agent, your agent will have the right to:

- a) consent or refuse consent to any care, treatment, service, procedure to maintain, diagnose, or otherwise affect a physical or mental condition.
- b) select or discharge health care providers and institutions.
- c) approve or disapprove diagnostic tests, surgical procedures, and programs of medication.
- d) direct the provision, withholding, or withdrawal of artificial nutrition and hydration and all other forms of health care, including cardiopulmonary resuscitation.
- e) make anatomical gifts, authorize an autopsy, and direct disposition of remains.

Part 2 of this form lets you give specific instructions about any aspect of your health care, whether or not you appoint an agent. Choices are provided for you to express your wishes regarding the provision, withholding, or withdrawal of treatment to keep you alive, as well as the provision of pain relief. Space is also provided for you to add to the choices you have made or for you to write out any additional wishes. If you are satisfied to allow your agent to determine what is best for you in making end-of-life decisions, you need not fill out Part 2 of this form.

****PLEASE NOTE:** "End of Life Decisions" or Other Wishes expressed in Part 2 of this form **do not** guarantee any rights under California's **End of Life Option Act (AB X2-15)** for individuals with terminal illness who wish to request an aid-in-dying drug. For more information on this option, please visit: <http://www.cdph.ca.gov/Pages/EndofLifeOptionAct.aspx>

Part 3 of this form lets you express an intention to donate your bodily organs and tissues following your death.

Part 4 of this form lets you designate a physician to have primary responsibility for your health care.

After completing this form, sign and date the form at the end. The form must be signed by two qualified witnesses or acknowledged before a notary public. Give a copy of the signed and completed form to your physician, to any other health care providers you may have, to any health care institution at which you are receiving care and to any health care agents you have named. You should talk to the person you have named as agent to make sure that he or she understands your wishes and is willing to take the responsibility.

You have the right to revoke this advance health care directive or replace this form at any time.

PART 1
POWER OF ATTORNEY FOR HEALTH CARE

DESIGNATION OF AGENT

I designate the following individual as my agent to make health care decisions for me:

(name of individual you choose as agent)

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

(home phone) (work phone)

Designation of Alternate Agents (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 choose as first alternate agent)

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

(home phone) (work phone)

If I revoke the authority of my agent and first alternate agent or if neither is willing, able, or reasonably available to make a health care decision for me, I designate as my second alternate agent:

(name of individual you choose as second alternate agent)

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

(home phone) (work phone)

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:

(Add additional sheets if needed.)

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.

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.

AGENT'S POST-DEATH 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:

(Add additional sheets if needed.)

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.

PART 2 **INSTRUCTIONS FOR HEALTH CARE**

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

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, 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.

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:

(Add additional sheets if needed.)

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)

Upon my death (mark applicable box):

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

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

(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

I understand that tissue banks work with both nonprofit and for-profit tissue processors and distributors. It is possible that donated skin may be used for cosmetic or reconstructive surgery purposes. It is possible that donated tissue may be used for transplants outside of the United States. (Circle Yes or No for each statement)

1. My donated skin may be used for cosmetic surgery purposes.
Yes No
 2. My donated tissue may be used for applications outside of the United States.
Yes No
 3. My donated tissue may be used by for-profit tissue processors and distributors.
Yes No

PART 4
PRIMARY PHYSICIAN (OPTIONAL)

I designate the following physician as my primary physician:

(name of physician)

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

(phone)

OPTIONAL: If the physician I have designated above is not willing, able, or reasonably available to act as my primary physician, I designate the following physician as my primary physician:

(name of physician)

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

(phone)

PART 5
Signature of Principal

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

SIGNATURE: Sign and date the form here:

(date)

(sign your name)

(print your name)

(address)

(city)

(state)

(zip code)

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 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

(date)

(print name)

(address)

(city)

(state)

(zip code)

(signature of witness)

Second witness

(date)

(print name)

(address)

(city)

(state)

(zip code)

(signature of witness)

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)

PART 6
SPECIAL WITNESS REQUIREMENT

The following statement is required only if you are a patient in a skilled nursing facility--a health care facility that provides the following basic services: skilled nursing care and supportive care to patients whose primary need is for availability of skilled nursing care on an extended basis. The patient advocate or ombudsman must sign the following statement:

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 name)

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

(signature of witness) (date)

NOTARY PUBLIC ACKNOWLEDGMENT

*YOU MAY USE THIS CERTIFICATE OF ACKNOWLEDGMENT BEFORE A NOTARY PUBLIC
INSTEAD OF THE STATEMENT OF WITNESSES.*

State of California

County of _____

On (date) _____ before me, (*here insert name and title of the officer*)

personally appeared (*name(s) of signer(s)*) _____,

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(s), 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 of notary public)

Notary Seal

Some Others Questions to Answer And Share and Discuss with Your Family and Friends

Your personal needs and concerns

- What are your biggest worries about the future?
- Who needs to be considered when making future plans? (i.e., spouse, children, grandchildren, friends)
- What thing(s) remain to be done or resolved?
- What aspects of your life are most important to you at this stage of life:
Being near family, returning to your homeland, making beautiful art or music, re-connecting with people, communing with nature, mastering a skill, bequeathing your fortune, practicing your religion?

Housing

- How important is it for you to remain in your current home?
- Where or with whom would you want to live if you could no longer manage alone?
- What are other acceptable options?

Financial and legal matters

Do you have or do your loved ones know how to find:

- A trusted attorney?
- A financial plan or list of assets and liabilities?
- A will, trust, or power of attorney?
- Life or long-term care insurance?

If you should need long-term residential care, who will pay? Be aware that Medicare does not cover long term care, however Medi-Cal does pay.

Health

- Do you have a doctor and/or medical plan that you trust?
- Do you fear suffering from a particular disability (dementia, blindness, paralysis)? If so, would family or friends be able to help?
- Are you able to drive without being a danger to yourself and others? If not, how will you get around?
- If you should need in-home care, who will be financially responsible?

Death and funeral

- What, if anything, frightens you about dying?
- What are your beliefs about the end of life?
- What do you wish to become of your body: burial, cremation, and donation?
- How can your descendants best honor you in death?

Community resources

- What resources are available in the community?
- Do you know how to find them?

Information and Assistance for Older Adults

1-800-510-2020

1-714-480-6450

WALLET CARDS FOR THE CALIFORNIA ADVANCE HEALTH CARE DIRECTIVE



ATTN: CALIFORNIA HEALTH CARE PROVIDERS

I have created the following Advance Directives:
(check one or both)

- California Instructions for Health Care
 Power of Attorney for Health Care

Please contact _____
at _____ (phone #)
for more information.

(date) _____ (signature) _____



ATTN: CALIFORNIA HEALTH CARE PROVIDERS

I have created the following Advance Directives:
(check one or both)

- California Instructions for Health Care
 Power of Attorney for Health Care

Please contact _____
at _____ (phone #)
for more information.

(date) _____ (signature) _____



ATTN: CALIFORNIA HEALTH CARE PROVIDERS

I have created the following Advance Directives:
(check one or both)

- California Instructions for Health Care
 Power of Attorney for Health Care

Please contact _____
at _____ (phone #)
for more information.

(date) _____ (signature) _____



ATTN: CALIFORNIA HEALTH CARE PROVIDERS

I have created the following Advance Directives:
(check one or both)

- California Instructions for Health Care
 Power of Attorney for Health Care

Please contact _____
at _____ (phone #)
for more information.

(date) _____ (signature) _____

Complete and cut out the cards above. Place one in your wallet with your driver's license or health insurance card. Keep the others in easy-to-find places, such as your car's glove compartment, a spare wallet or purse, or your refrigerator.



Office on Aging
1300 S. Grand Avenue, Bldg B
Santa Ana, CA 92705
www.officeonaging.ocgov.com

The materials or product were a result of a project funded by a contract with the California Department of Aging