ADVANCE HEALTH CARE DIRECTIVE

By this document, I, _____, intend to create an advance health care directive under California Probate Code Section 4600 and following. This advance directive shall not be affected by my subsequent incapacity.

Part 1

POWER OF ATTORNEY FOR HEALTH CARE

1.1. DESIGNATION OF HEALTH CARE AGENT. I do hereby designate and appoint _____ as my agent to make health care decisions for me as authorized in this document. For the purposes of this document, "health care decision" means any decision regarding any care, treatment, service, or procedure to maintain, diagnose, or otherwise affect my physical or mental condition.

1.2. ALTERNATE AGENT. If _____ is not reasonably available, able or willing, or becomes ineligible to act as my agent to make health care decisions for me, or if I revoke her appointment or authority to act as my agent to make health care decisions for me, then I designate the following persons, in the order of priority designated below, to serve as my agent to make health care decisions for me as authorized in this document:

First Alternate Agent: _____;

Second Alternate Agent: _____;

Third Alternate Agent: _____.

1.3. GENERAL STATEMENT OF AUTHORITY GRANTED. Subject to any limitations in this document, I hereby grant to my agent full power and authority (a) to make

health care decisions for me to the same extent that I could make such decisions for myself if I had the capacity to do so, including, without limitation, decisions to provide, withhold or withdraw artificial nutrition and hydration and all other forms of health care to keep me alive, including cardiopulmonary resuscitation; and (b) to make personal care decisions for me to the same extent that I could make those decisions for myself if I had the capacity to do so, including, without limitation, determining where I will live, providing me meals, hiring household employees, providing transportation, handling mail, and arranging recreation and entertainment for me.

1.4. PERIOD DURING WHICH AGENT'S AUTHORITY IS EFFECTIVE.

[CHECK THE APPROPRIATE BOX]

☐ OPTION 1: My agent's authority to make health care decisions for me shall take effect immediately upon execution of this document.

☐ OPTION 2: This Directive is effective when my primary physician determines that I am unable to make my own health care decisions. My agent's authority ceases to be effective when my primary physician determines that I am again able to make my own health care decisions.

☐ OPTION 3: This Directive is effective immediately upon its execution if my spouse is the agent. If anyone other than my spouse is acting as my agent, then this Directive is effective when my primary physician determines that I am unable to make my own health care decisions. My agent's authority ceases to be effective when my primary physician determines that I am again able to make my own health care decisions.

1.5. 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.

1.6. ANATOMICAL GIFTS. Upon my death, my agent shall have the power and authority to make a disposition of a part or parts of my body under the Uniform Anatomical Gift Act, as follows:

[CHECK THE APPROPRIATE BOX]

☐ OPTION 1: My agent may donate any needed organs, tissues, or parts to anyone in need, in my agent's sole and absolute discretion.

☐ OPTION 2: My agent may donate any needed organs, tissues, or parts only to any individual related to me by blood or marriage.

☐ OPTION 3: My agent may donate any needed organs, tissues, or parts, as follows: _____ _____ _____ _____.

1.7. DISPOSITION OF REMAINS.

[CHECK THE APPROPRIATE BOX]

☐ OPTION 1: I do not want to be cremated. Subject to the foregoing directive, my agent shall have the power and authority to direct the disposition of my remains according to my agent's discretion

☐ OPTION 2: I desire that my remains be cremated and I direct my agent to take all steps necessary to ensure that my wishes are carried out in this regard. Subject to the foregoing, my agent shall have the power and authority to direct the disposition of my remains according to my agent's discretion.

☐ OPTION 3: I desire that my remains be cremated and that my ashes be disposed of as follows: _____ _____ _____ _____.

I direct my agent to take all steps necessary to ensure that my wishes are carried out in this regard. Subject to the foregoing, my agent shall have the power and authority to direct the disposition of my remains according to my agent's discretion.

1.8. ARRANGEMENTS FOR FUNERAL OR MEMORIAL SERVICE. My agent shall have the power and authority to arrange for my funeral or other memorial service.

1.9. AUTHORIZATION OF AUTOPSY.

[CHECK THE APPROPRIATE BOX]

☐ OPTION 1: My agent shall have the power and authority to authorize an autopsy.

☐ OPTION 2: My agent shall <u>not</u> have the power or authority to authorize an autopsy.

Part 2

INSTRUCTIONS FOR HEALTH CARE

2.1. END-OF-LIFE DECISIONS.

[CHECK THE APPROPRIATE BOX]

☐ OPTION 1: I recognize that modern medical technology has made possible the artificial prolongation of my life beyond natural limits. I do not wish to artificially prolong the process of my dying if continued health care will not improve my prognosis for recovery or otherwise enable me to live a productive and/or enjoyable life and my death is likely to occur within several months, or if I require life support as the result of an irreversible condition, even if that life support might prolong my life for a sustained period. Therefore, I do not want efforts made to prolong my life and I do not want life-sustaining treatment to be provided or continued (1) if I am in an irreversible coma or persistent vegetative state; or (2) if I am terminally ill and the use of life-sustaining procedures would serve only to artificially delay the moment of my death; or (3) under any other circumstances in which the burdens of the treatment outweigh the expected benefits. By "an irreversible coma," I mean a coma from which the treating physicians have reasonably concluded I will never regain consciousness. In making decisions about life-sustaining treatment under provision (3) above, I want my agent to consider the relief of suffering and quality of remaining life as well as the extent of the possible prolongation of my life. At the same time that I

am signing this advance health care directive, I am entering my initials in the space immediately below this provision to show that I have read this provision and that it reflects my desires.

_____

☐ OPTION 2: I want to live as long as possible, while maintaining a high quality and productive life; therefore, I want to receive all medical treatment that will prolong and sustain my life within the limits of generally accepted health care standards. Initially, I want such treatment provided to me regardless of my prognosis. I recognize that modern medical technology has made possible the artificial prolongation of my life beyond natural limits. I do wish to artificially prolong the process of my dying if continued health care will improve my prognosis for recovery and otherwise enable me to live and maintain a productive and/or enjoyable life. However, if I require life support as the result of an irreversible condition and I am considered to be brain dead, or if my death is imminent, I do not wish to artificially prolong the process of my dying. Therefore, I do not want efforts made to prolong my life and I do not want life-sustaining treatment to be provided or continued, if, **after a period of _____ months following the initial prognosis**: (1) I am in an irreversible coma or persistent vegetative state; or (2) if I am terminally ill and the use of life-sustaining procedures would serve only to artificially delay the moment of my death; or (3) under any other circumstances in which the burdens of the treatment outweigh the expected benefits. By "an irreversible coma," I mean a coma from which the treating physicians have reasonably concluded I will never regain consciousness. In making decisions about life-sustaining treatment under provision (3) above, I want my agent to consider the relief of suffering and quality of remaining life as well as the extent of the possible prolongation of my life. Notwithstanding the foregoing, I do not want to be starved to death; therefore, I do not want food or artificial nutrition or hydration to be withdrawn or withheld. At the same time that I am signing this advance health care directive, I am entering my initials in the space immediately below this provision to show that I have read this provision and that it reflects my desires.

_____

☐ OPTION 3: I want to live as long as possible; therefore, I want to receive all medical treatment that will prolong and sustain my life within the limits of generally accepted health care standards. I want such treatment provided to me regardless of my chances of recovery, my condition, or the cost of such treatment. At the same time that I am signing this advance health care directive, I am entering my initials in the space immediately below this provision to show that I have read this provision and that it reflects my desires.

_____

☐ OPTION 4: I have discussed with my agent and alternate agents my wishes regarding end-of-life decisions. My agent shall have sole and absolute discretion to make decisions for me regarding life support if I am in an irreversible coma or persistent vegetative state; or if I am terminally ill and the use of life-sustaining procedures would serve only to artificially delay the moment of my death. At the same time that I am signing this advance health care directive, I am entering my initials in the space immediately below this provision to show that I have read this provision and that it reflects my desires.

_____

2.2. RELIEF FROM PAIN; PALLIATIVE CARE.

[CHECK THE APPROPRIATE BOX]

☐ OPTION 1: I direct that treatment for alleviation of pain or discomfort be provided at all times, even if it hastens my death. I wish to receive any other forms of palliative care that may ease my suffering.

☐ OPTION 2: I direct that treatment for alleviation of pain or discomfort be provided at all times and I wish to receive any other forms of palliative care that may ease my suffering, but not if such treatment may hasten my death.

2.3. OTHER WISHES:

_____
_____
_____
_____.

Part 3

INSTRUCTIONS FOR PERSONAL CARE

3.1. INDEPENDENT LIVING. I wish to live in my home for as long as that is reasonably possible without endangering my physical or mental health and safety and to receive whatever assistance from household employees or personal care givers may be necessary to permit me to do so; provided, however, that in the event my agent determines that appropriate household employees or personal care givers are not available without putting my financial position or physical or mental health or safety at risk, then I wish to live in the least restrictive

and most home-like setting deemed appropriate by my agent. I further request that I live as near as possible to my primary residence in order that I may visit with friends and neighbors to the degree my agent believes that I will benefit from such relationships. I wish to return home as soon as reasonably possible after any hospitalization or transfer to convalescent care. If my agent determines that I am no longer able to live in my home, I wish that my agent consider alternatives to convalescent care which will permit me as much privacy and autonomy as possible, including such options as placing me in an assisted living facility or board and care facility.

3.2. SOCIAL INTERACTION & OUTDOOR ACTIVITIES. I wish to be encouraged to maintain my social relationships and to engage in social interaction even if I am no longer able to recognize my family and friends or to fully participate in social activities. I wish to spend significant time outdoors. If I can no longer travel, I wish my agent to arrange for trips to local parks and other areas where I may be outdoors in a natural setting.

Part 4

MISCELLANEOUS MATTERS

4.1. HIPAA AND CMIA HEALTH INFORMATION RELEASE. I intend my agent, as my "personal representative" as that term is used in the Health Insurance Portability and Accountability Act, 42 U.S.C. Section 1320d, 45 C.F.R. Parts 160 and 164, and as my "patient's representative" as that term is used in the California Civil Code Section 56.10, to be treated as I would be with respect to my rights regarding the use and disclosure of my individually identifiable health information and other medical records. The authority of my agent with respect to the use and disclosure of such information and records shall control my agent's dealings with any physician or other health care provider who is providing health care services to

me at any time when my agent shall seek access to such information and/or records. Subject to any limitations in this document, my agent has the power and authority to do all of the following:

(a) Request, review, and receive from any physician or any other "covered entity" as defined under HIPAA, any information, verbal or written, regarding my physical or mental health, including, but not limited to, any medical and hospital records regarding any past, present or future physical or mental health conditions, including all information relating to the diagnosis and treatment of HIV/AIDS, sexually transmitted diseases, mental illness, and drug or alcohol abuse;
(b) Execute on my behalf any releases or other documents that may be required in order to obtain such information, including, but not limited to, a Valid Authorization under the California Confidentiality of Medical Information Act and the Health Insurance Portability and Accountability Act; and

(c) Consent to the disclosure of such requested information.

4.2. SIGNING DOCUMENTS, WAIVERS, AND RELEASES. When necessary to implement the health care decisions that my agent is authorized by this document to make, my agent has the power and authority to execute on my behalf all of the following:

(a) Documents titled or purporting to be a "Refusal to Permit Treatment" and "Leaving Hospital Against Medical Advice" and;

(b) Any necessary waiver or release from liability required by a hospital or physician.

4.3. PRIOR DESIGNATIONS REVOKED. I revoke any prior advance health care directive and any prior durable power of attorney for health care.

4.4. USE OF COPIES PERMITTED. Persons dealing with my agent may rely fully on a photocopy of this document as though the photocopy was an original.

DATE AND SIGNATURE OF PRINCIPAL

I sign my name to this Advance Health Care Directive on _____.

_____
Signature

_____
Print Name

ACKNOWLEDGMENT

A notary public or other officer completing this certificate verifies only the identity of the individual who signed the document to which this certificate is attached, and not the truthfulness, accuracy, or validity of that document.

State of California
County of _____

On _____, before me, _____,
Notary Public, 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)

ATTESTATION OF WTINESSES

I declare under penalty of perjury under the laws of California (1) that I am an adult; (2) 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; (3) that the individual signed or acknowledged this advance directive in my presence; (4) that the individual appears to be of sound mind and under no duress, fraud, or undue influence; (5) that I am not a person appointed as agent by this advance directive; and (6) 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.

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.

Dated: _____, 2020 _____
Signature

_____
Print Name

Dated: _____, 2020 _____
Signature

_____
Print Name

***This Advance Health Care Directive must either be: (1) acknowlged in the presence of a notary and notarized (using the attached notarial acknowledgment form or other appropriate acknowledgement form provided by the notary); <u>OR, ALTERNATIVELY</u>, (2) properly witnessed by two individuals using the "Attestation of Witnesses" form attached herto.**

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DISCLAIMER: Use of the Advance Health Care Directive (AHCD) Form does not in any way create an attorney-client relationship with Velasco Law Group, APC (VLG) or constitute a solicitation by VLG for its services. The AHCD form is not complete without the individual user making a personal selection of the various health care options offered in those sections where a choice must be made and then checking the appropriate box. The AHCD is only valid when properly notarized or witnessed, as indicated on the form. VLG cannot take responsibility for forms that are incomplete or are otherwise not completed correctly by the user, or for forms that have not been property notarized or witnessed. VLG also emphasizes that the AHCD is not intended to be a substitute for a comprehensive estate plan that includes, the creation of revocable living trusts, wills, powers of attorney and other important documents. VLG strongly recommends that each individual user of this form engage a highly qualified attorney who specializes in estate planning and trust law to review the user's current family and financial situation and make recommendations for a complete estate plan.

Advance Health Care Directive

Explanation

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 your personal care, donation of organs, and the designation of your primary physician. If you use this form, you may 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 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 a 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 co-worker).

Unless the form you sign limits the authority of your agent, your agent may make all health care decisions for you and all decisions regarding your personal care. You do not need to limit the authority of your agent if you wish to rely on your agent for all health care decisions and personal 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, or procedure to maintain, diagnose, or otherwise affect a physical or mental condition.

(b) Select or disapprove 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.

(f) Make personal care decisions, including determining where you will live, providing meals, hiring household employees, providing transportation, handling mail, and arranging recreation and entertainment for you.

Part 2 of this form lets you give specific instructions about any aspect of your health care, including the provision, withholding, or withdrawal of treatment to keep you alive, as well as the provision of pain relief. You may make other choices and should not sign this form until you are satisfied that the instructions in Part 2 express your wishes and not the wishes of any other person. If you are satisfied to allow your agent to determine what is best for you in making end-of-life decisions and other health care decisions, you need not include Part 2 of this form.

Part 3 of this form lets you give specific instructions about any aspect of your personal care. You may make other choices and should not sign this form until you are satisfied that the instructions in Part 3 express your wishes and not the wishes of any other person. If you are satisfied to allow your agent to determine what personal care is best for you, you need not include Part 3 of this form.

Part 4 of this form contains miscellaneous provisions regarding your advance directive.

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.