If I Need Help Making Medical Choices

(*Plain Language Durable Power of Attorney for Health Care, adapted from CA Probate Code § 4701*)

My name is ______________________________________.

My address is ____.

My birthday is _______________________________________.

My agents

If I cannot make health choices for myself, I want someone to make choices for me.

The person who will make these choices for me is called my **agent**.
My agents cannot be my doctor or someone who works in the hospital or a group home where I live.

My agent will only make choices for me if I cannot say what I want.

My agent's name is: ____.

My agent's address is: ____.

My agent's phone number is: _______________________________.

If I need help and my agent is away or cannot help me, another person can help me. This person is a **back-up agent**.

My back-up agent's name is: ____________________________________.

Their address is: ____.

Their phone number is: ______________________________.

When my agent can help me

My agent can make choices for me if my doctor says that I cannot make my own choices.

If the doctor thinks I cannot make my own choices, he or she must explain why in writing.

What my agent can do:

My agent can make choices for me if I cannot make my own choices.

My agent can choose what medicine I will get.

My agent can see the notes doctors and nurses write about me.

My agent can choose when I should stay in the hospital.

I agree that my agent can do all of these things.

Your signature: ____

When my agent is making choices for me, my agent must do what I want.

I will talk to my agent about what is important to me.

If my agent does not know what I want, he or she must make choices that will help me the most.

If my agent does not know what I want, he or she can talk to other people who love me and care about me.

I know that I have to sign this form with two people who are **witnesses.** My witnesses will sign on the next page.

My signature: ____________________________________.

Today's date is: ____.

THIS DOCUMENT MUST SIGNED BY TWO WITNESSES.

WITNESSES: **Certain individuals cannot serve as witnesses. Those rules are set forth in the following witness statements:**

I DECLARE UNDER PENALTY OF PERJURY UNDER THE LAWS OF CALIFORNIA

(1) That the individual who signed or acknowledged this Power of Attorney for Healthcare 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 Power of Attorney for Healthcare 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 Power of Attorney for Healthcare, 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

Name ________________________ Signature____________________

Date:__________________________ Address _____________________

Second Witness

Name ________________________ Signature____________________

Date:__________________________ Address _____________________

ONE OF THE PRECEDING WITNESSES ALSO MUST 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 operations of law.

Date: ________________

Signature:________________________________

Only if the person making this power of attorney is unable to write, both witnesses must complete this section:

______________________________, being unable to write, made his/her mark in our presence and requested the first of the undersigned to write his/her name, which he/she did, and we now subscribe our names as witnesses thereto.

____
Signature of Witness #1

____
Signature of Witness #2

Only if the person making this power of attorney lives in a nursing home, this section must be completed by 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:

Name _______________________ Signature: ________________________

Date:_________________ Address: ______________________________

City: __________________________ State: _______________________