Durable Health Care Power of Attorney

(Plain Language Durable Power of Attorney for Health Care, adapted from the ACLU Disability Rights Program, adapted from CA Probate Code § 4701)

Help Making Medical Choices

My name is _____

My birthday is _____

My address 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 _____

Their phone number is: _____

Their address 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.

Backup agent's name: _____

Their phone number is: _____

Their address 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:

(Select everything you want the agent to be able to do for you.)

☐ 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.

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 or 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.

I know that I can stop or change this agreement at any time.

My signature: _____

Today's date is: _____

THIS DOCUMENT MUST SIGNED BY TWO WITNESSES.

Certain individuals cannot serve as witnesses, as 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 Health Care 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 Health Care 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 Health Care, 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 _____

Address: _____

City/State: _____

Signature: _____

Date: _____

Second Witness

Name _____

Address: _____

City/State: _____

Signature: _____

Date: _____

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.

Signature: _____

Date: _____

IF THE PERSON MAKING THIS POWER OF ATTORNEY IS UNABLE TO WRITE, BOTH WITNESSES MUST SIGN THE FOLLOWING DECLARATION:

_____, 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 #1: _____

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 _____

Address: _____

City/State: _____

Signature: _____

Date: _____