Advance Directive for Health Care

Inmate Name: _____ **Date:** _____

CDC Number: _____ **Date of Birth:** ___/___/____ **Institution:** _____

What is an Advance Directive for Health Care?

Advance directive is a general term used for documents that traditionally include:

1. A "Durable Power of Attorney for Health Care" which allows you to choose someone to make medical decisions for you when you are unable to make them yourself. This person is called your "Agent" or "Proxy."
2. A "Living Will" which allows you to state your goals or desires for the type(s) of health care you want or do not want. Also called "Instructions for Health Care Form."

(For more information see Inmate Fact Sheet/Instructions regarding CDCR Form 7421 Advance Directive for Health Care)

What are the parts of this form?

Part 1: Selecting someone to speak for you. Who do you want to make decisions for you if you are unable to make your own decisions? You may choose up to three people, or may choose not to select anyone at this time.

Part 2: What type of health care do you want if you are very sick and unable to tell your wishes to the doctors and nurses? This usually refers to what are called "End-of-Life" decisions. If you have a condition that is so serious that you are dying, do you want your doctors and nurses to do everything possible to prolong your life or do you only want treatments to keep you comfortable?

Part 3: This allows you to choose whether or not you are willing to donate organs or other tissues.

Part 4: Before you sign the Advance Directive, a medical staff person must document that you have been fully informed and understand this form. After you sign and date the form, two people need to witness that you willingly signed the form and filled it out according to your wishes (in rare circumstances the form can be notarized instead of using two witnesses).

After completing the form what should I do? A copy will be placed in your Unit Health Record. Keep a copy for yourself and give a copy of the Advance Directive for Health Care to any health care agents you have named. You should talk to the person you have named as an agent to make sure that he or she understands your wishes and is willing to take the responsibility.

How long is the form valid? It does not have an expiration date but you have the right to cancel this advance health care directive or replace this form at any time. Also, a copy of this form is as good as the original (if you wish to change or cancel, tell your medical provider).

PART 1: Power of Attorney for Health Care

Optional: **Naming of Primary Agent:** I choose the following person as the person to make health care decisions for me in the event that I am unable to make them myself. This person is called by agent.

I understand that this designation may be revoked by me anytime by verbal or written instruction.

_____
(Name of person you choose as primary agent)

_____
(Address) (City) (State) (Zip Code)

_____
(Home and/or Cell Phone Number) (Work phone or a phone number of someone who can always reach agent)

Optional: **Naming of First Alternate Agent:** If the person named above is not willing, able, or reasonably available to make health care decisions for me, I revoke their authority and choose the following person instead to act as my agent.

I understand that this designation may be revoked by me anytime by verbal or written instruction.

_____
(Name of person you choose as first alternate agent)

_____
(Address) (City) (State) (Zip Code)

_____
(Home and/or Cell Phone Number) (Work phone or a phone number of someone who can always reach agent)

Optional: **Naming of Second Alternate Agent:** If the two persons named above are not willing, able, or reasonably available to make health care decisions for me, I revoke their authority and choose the following person instead to act as my agent.

I understand that this designation may be revoked by me anytime by verbal or written instruction.

_____
(Name of person you choose as second alternate agent)

_____
(Address) (City) (State) (Zip Code)

_____
(Home and/or Cell Phone Number) (Work phone or a phone number of someone who can always reach agent)

Agent's Authority: The person I choose to make health care decisions for me (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:

_____

When does my agent's authority become effective? My agent's authority becomes effective when my primary physician determines that I am unable to make my own health care decisions.

If I check this box ☐, I indicate that I want my agent's authority to be effective immediately* (* Please see CDCR Form 7421 Inmate Fact Sheet/Patient Instructions for details).

What is my agent obligated to do? My agent shall make health care decisions for me in accordance with this power of attorney for health care, any instructions or wishes I write in 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 interests. In determining my best interest, my agent shall consider my personal values to the extent known to my agent.

After I die, what authority does my agent have? My agent is authorized to make anatomical gifts, authorize an autopsy, and direct disposition of my remains, except as I state on this form:

_____

_____

(Add additional sheets if needed)

PART 2: Instructions for Health Care (Optional – but strongly recommended)

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

End-of-Life Decisions: If I am suffering from a terminal condition from which death is expected in a matter of months, or if I am suffering from an irreversible condition that leaves me unable to make decisions and life-support treatments are needed to keep me alive, then I choose the following statement as closest to my wishes (initial A or B if you agree):

_____ A. If I am at the end of my life as described above then I request that all treatments other than those needed to keep me comfortable be discontinued or not started and that my doctor allows me to die as peacefully as possible.

_____ B. If I am at the end of my life as described above, then I request that my life be prolonged as long as possible within the limits of generally accepted health care standards.

_____ 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)

Relief from Pain: In all cases 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)

Specific Health Care Instructions: (Examples: will you accept blood transfusions, feeding by a tube in your stomach, kidney dialysis, mechanical ventilation):

_____

_____

(Add additional sheets if needed)

PART 3: Donation of Organs at Death (Optional)

Upon my death (if you wish to donate organs, check the box that applies to your wish):

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

☐ (b) I give the **following organs, tissues,** or **parts only**. (List organs, tissues, or parts you want to donate). _____

☐ (c) I choose not to donate.

My gift is for the following purposes (cross out any of the following you do **not** want):

(1) Transplant
(2) Therapy
(3) Research
(4) Education

PART 4: Verification of Understanding, Signature, Witnesses

Verification of Effective Communication
(To be completed by medical staff)

I have met with the patient-inmate and communicated the purpose of this Advance Directive and discussed the decisions he/she is making regarding his/her future health care and he/she:

☐ Has no identified effective communication assistance need and appears to understand.

☐ Has the following effective communication need: _____
(i.e., Developmental or Learning Disability, Physical, or Mental Disability impacting communication - hearing, vision, speech).

This need was met by:
- ☐ Providing preferred method of communication in explaining this form
- ☐ Speaking slowly, using simple language, and having the patient explain in own words his or her understanding of this form.
- ☐ Other accommodations – specify: _____.

_____	_____	_____
Staff Printed Name	Staff Signature	Date

Signature of Patient-Inmate: Sign and date form here:		
(Print your Name)	(Institution)	
(City)	(State)	(Current Housing)
(Signature)	(Date)	

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 an 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."

- One witness may be a family member if available, but at least one witness must be someone who is not related to the patient-inmate. (witness 2)
- Correctional Staff, other CDCR employees or medical staff not directly involved with the care of this patient may act as witnesses to the patient's signature.
- As above, your agent may not be a witness.

Witness 1 Signature:	**Full Printed Name:**
Title:	**Date:**

"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."

Witness 2 Signature:	**Full Printed Name:**
Title:	**Date:**

Notary: In unusual circumstances a notary may be used to verify the signature of the patient-inmate. If so, please see page 7.

Notary – Not required if two witnesses have signed document

In unusual circumstances, such as two witnesses are not available, a notary may be used to verify the patient-inmate's signature on this document.

Notary Public – State of California

County of _____

On _____ before me, _____
(Insert Name of Notary Public)

personally appeared _____,
(Insert the Name of Principal)

Personally known to me (or proved to me on the basis of satisfactory evidence) to be the person whose name is subscribed to the within instrument and acknowledged that he/she executed the same in his/her authorized capacity and that by his/her signature on the instrument the person upon behalf of which the person acted, executed the instrument.

WITNESS my hand and official seal.

NOTARY SEAL _____
(Signature of Notary)

Statement of Patient Advocate or Ombudsman

If the patient-inmate is currently residing in a Skilled Nursing Facility, the following must be completed by a patient advocate or ombudsman (This does **not** apply to OHU, CTC, Hospice, or GACH).

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 witness as required by Section 4675 of the Probate Code.

(Date)	(Signature)
(Address)	(Printed Name)