CALIFORNIA
Advance Directive
Planning for Important Healthcare Decisions

Caring Connections
1700 Diagonal Road, Suite 625, Alexandria, VA 22314
www.caringinfo.org
800/658-8898

Caring Connections, a program of the National Hospice and Palliative Care Organization (NHPCO), is a national consumer engagement initiative to improve care at the end of life, supported by a grant from The Robert Wood Johnson Foundation.

Caring Connections tracks and monitors all state and federal legislation and significant court cases related to end-of-life care to ensure that our advance directives are up to date.

It's About How You LIVE

It's About How You LIVE is a national community engagement campaign encouraging individuals to make informed decisions about end-of-life care and services. The campaign encourages people to:

Learn about options for end-of-life services and care
Implement plans to ensure wishes are honored
Voice decisions to family, friends and health care providers
Engage in personal or community efforts to improve end-of-life care

Please call the HelpLine at 800/658-8898 to learn more about the LIVE campaign, obtain free resources, or join the effort to improve community, state and national end-of-life care.

If you would like to make a contribution to help support our work, please visit www.nationalhospicefoundation.org/donate. Contributions to national hospice programs can also be made through the Combined Health Charities or the Combined Federal Campaign by choosing #0544.

Support for this program is provided by a grant from The Robert Wood Johnson Foundation, Princeton, New Jersey.

Your Advance Care Planning Packet

Using These Materials

BEFORE YOU BEGIN

1. Check to be sure that you have the materials for each state in which you could receive health care.

2. These materials include:
   - Instructions for preparing your advance directive.
   - Your state-specific advance directive forms, which are the pages with the gray instruction bar on the left side.

PREPARING TO COMPLETE YOUR ADVANCE DIRECTIVE

3. Read the HIPAA Privacy Rule Summary on page 4.

4. Read all the instructions, on pages 7 through 10, as they will give you specific information about the requirements in your state.

5. Refer to the Glossary of Terms About End-of-Life Decision-making if any of the terms are unclear, located in Appendix A.

ACTION STEPS

6. You may want to photocopy these forms before you start so you will have a clean copy if you need to start over.

7. When you begin to fill out the forms, refer to the gray instruction bars - they will guide you through the process.

8. Talk with your family, friends, and physicians about your advance directive. Be sure the person you appoint to make decisions on your behalf understands your wishes.

9. Once the form is completed and signed, photocopy the form and give it to the person you have appointed to make decisions on your behalf, your family, friends, health care providers and/or faith leaders so that the form is available in the event of an emergency.

If you have questions or need guidance in preparing your advance directive or about what you should do with it after you have completed it, please refer to the list of state-specific contacts for Legal Assistance for Questions Pertaining to Health Care Advance Directives located in Appendix B.

Summary of the HIPAA Privacy Rule

HIPAA is a federal law that gives you rights over your health information and sets rules and limits on who can look at and receive your health information.

Your Rights

You have the right to:

- Ask to see and get a copy of your health records.
- Have corrections added to your health information.
- Receive a notice that tells you how your health information may be used and shared.
- Decide if you want to give your permission before your health information can be used or shared for certain purposes, such as marketing.
- Get a report on when and why your health information was shared for certain purposes.
- If you believe your rights are being denied or your health information isn't being protected, you can
  - File a complaint with your provider or health insurer
  - File a complaint with the U.S. Government

You also have the right to ask your provider or health insurer questions about your rights. You also can learn more about your rights, including how to file a complaint from the Web site at www.hhs.gov/ocr/hipaa/ or by calling 1-866-627-7748.

Who Must Follow this Law?

- Doctors, nurses, pharmacies, hospitals, clinics, nursing homes, and many other health care providers.
- Health insurance companies, HMOs, most employer group health plans.
- Certain government programs that pay for health care, such as Medicare and Medicaid.

What Information is Protected?

- Information your doctors, nurses, and other health care providers put in your medical record.
- Conversations your doctor has about your care or treatment with nurses and others.
- Information about you in your health insurer's computer system.
- Billing information about you by your clinic / health care provider.
- Most other health information about you held by those who must follow this law.

Summary of the HIPAA Privacy Rule (continued)

Providers and health insurers who are required to follow this law must keep your information private by:

- Teaching the people who work for them how your information may and may not be used and shared.
- Taking appropriate and reasonable steps to keep your health information secure.

To make sure that your information is protected in a way that does not interfere with your health care, your information can be used and shared:

- For your treatment and care coordination.
- To pay doctors and hospitals for your health care and help run their businesses.
- With your family, relatives, friends or others you identify who are involved with your health care or your health care bills, unless you object.
- To make sure doctors give good care and nursing homes are clean and safe.
- To protect the public's health, such as by reporting when the flu is in your area.
- To make required reports to the police, such as reporting gunshot wounds.

Your health information cannot be used or shared without your written permission unless this law allows it. For example, without your authorization, your provider generally cannot:

- Give your information to your employer.
- Use or share your information for marketing or advertising purposes.
- Share private notes about your mental health counseling sessions.

INTRODUCTION TO YOUR CALIFORNIA ADVANCE DIRECTIVE

This packet contains a legal document, the California Advance Health Care Directive, that protects your right to refuse medical treatment you do not want, or to request treatment you do want, in the event you lose the ability to make decisions yourself.

1. Part 1, **Power of Attorney for Health Care**, lets you name someone to make decisions about your medical care—including decisions about life support—if you can no longer speak for yourself or immediately if you designate this on the document. The Power of Attorney for Health Care is especially useful because it appoints someone to speak for you any time you can not or do not choose to make your own medical decisions, not only at the end of life.

2. Part 2, **Instructions for Health Care**, functions as your state's living will. It lets you state your wishes about medical care in the event that you can no longer speak for yourself.

Although you have the option to complete only one part of this document, Caring Connections suggests that you complete Part 1 and Part 2 to best ensure that you receive the medical care you want when you can no longer speak for yourself.

3. Part 3, **Donation of Organs at Death** this is an optional section that allows you to record your wishes regarding organ donation.

4. Part 4, **Primary Physician**, this is an optional section that allows you to designate your primary physician.

Note: This document will be legally binding only if the person completing it is a competent adult who is 18 years of age or older.

INTRODUCTION TO YOUR CALIFORNIA ADVANCE HEALTH CARE DIRECTIVE

How do I make my advance health care directive legal?

In order to make your Advance Health Care Directive legally binding you have two options:

1. Sign your document in the presence of two witnesses, who must also sign the document to show that they personally know you (or you provided convincing evidence of identity) and believe you to be of sound mind and under no duress, fraud or undue influence.

Neither of your witnesses can be:

- the person you appointed as your agent,
- your health care provider, or an employee of your health care provider.
- the operator or employee of a community facility,
- the operator or employee of a residential care facility for the elderly.

In addition, only one of your witnesses may be:

- related to you by blood or marriage or adoption,
- entitled to any part of your estate either under your last will and testament or by operation of law.

OR

2. Sign your document in the presence of a notary public.

If you are a resident in a skilled nursing facility, one of the witnesses must be a patient advocate or ombudsman designated by the State Department of Aging.

Are there any important facts that I should know?

A copy of your California Advance Health Care Directive has the same effect as the original.

COMPLETING PART 1: POWER OF ATTORNEY FOR HEALTH CARE

Whom should I appoint as my agent?

A health care agent is the person you appoint to make decisions about your medical care if you become unable to make these decisions yourself. Your agent can be a family member or a close friend whom you trust to make serious decisions. The person you name as your agent should clearly understand your wishes and be willing to accept the responsibility of making medical decisions for you. The person you appoint as your agent **cannot be**:

1. your supervising health care provider or an employee of the health care institution where you are receiving care; or
2. an operator or employee of a community care facility or residential care facility at which you are receiving care.

Unless:

1. the employee is related to you by blood, marriage, adoption or is your registered domestic partner; or
2. the employee is your co-worker employed by the same health care institution, community care facility, or residential care facility for the elderly where you are a patient.

You can appoint a second and third person as your alternate agents. An alternate agent will step in if the person you name as agent is unable, unwilling or unavailable to act for you.

Should I add personal instructions to my Power of Attorney?

You can use the space provided under paragraph (2) to limit your agent's authority. Unless the form you sign limits the authority of your agent, your agent may make almost all health care decisions for you including:

a) consenting or refusing consent to any care, treatment, service or procedure to maintain, diagnose or otherwise affect a physical or mental condition;
b) selecting or discharging healthcare providers and institutions;
c) approving or disapproving diagnostic tests, surgical procedures, programs of medications and orders not to resuscitate; and
d) directing the provision, withholding and withdrawal of artificial nutrition and hydration and all other forms of health care.

Your agent is not authorized to consent to:

- commitment to or placement in a mental health treatment facility,
- convulsive treatment,
- psychosurgery,
- abortion,
- sterilization

COMPLETING PART 1: POWER OF ATTORNEY FOR HEALTH CARE (CONTINUED)

One of the strongest reasons for naming a health care agent is to have someone who can respond flexibly as your medical condition changes and can deal with situations that you did not foresee.

We urge you to talk with your health care agent about your future medical care and describe what you consider to be an acceptable "quality of life". If you want to record your wishes about specific treatments or conditions, you can use Part 2 of this document, Instructions for Health Care.

What if I change my mind?

If you wish to cancel your Durable Power of Attorney for Health-Care Decisions you may do so by a signed writing or by personally notifying your supervising health care provider, of your intent to revoke.

Are there any important facts I should know?

Paragraph (4) contains various statements about your agent's authority. Cross out and initial any portion of these statements that do not reflect your wishes. Paragraph (5) gives your agent the authority to make anatomical gifts, authorize an autopsy, and direct the disposition of your remains after your death.
Cross out and initial any portion of these statements that do not reflect your wishes. Paragraph (6) nominates your agent or alternate agents to be your court appointed guardian should one become necessary. If this is not your intention, cross out and initial this section.

COMPLETING PART 2: INSTRUCTIONS FOR HEALTH CARE

Can I add personal instructions to my Instructions for Health Care?

Yes. Paragraphs (7) and (8) allow you to include instructions about certain care and treatment. If there are any specific instructions that you would like to include that are not already listed on the document you may list them in paragraph (9). For example, you may want to include a sentence such as, " I especially do not want cardiopulmonary resuscitation, a respirator or antibiotics." If you have appointed an agent, it is a good idea to write a statement such as,
"Any questions about how to interpret or when to apply my Instructions for Health Care are to be decided by my agent."

What if I change my mind?

You may cancel your Instructions for Health Care at any time and in any manner that communicates your intent to do so.

It is important to learn about the kinds of life-sustaining treatment you might receive. Consult your doctor or order the Caring Connections booklet, "Advance Directives and End-of-Life Decisions."

If you have questions about filling out your advance directive, please consult the list of state-based resources located in Appendix B.

You Have Filled Out Your Advance Directive, Now What?

Your California Advance Health Care Directive is an important legal document. Keep the original signed document in a secure but accessible place. Do not put the original document in a safe deposit box or any other security box that would keep others from having access to it.

1. Give photocopies of the signed original to your agent and alternate agent(s), doctor(s), family, close friends, clergy and anyone else who might become involved in your health care. If you enter a nursing home or hospital, have photocopies of your document placed in your medical records.

2. Be sure to talk to your agent and alternate agent(s), doctor(s), clergy, family and friends about your wishes concerning medical treatment. Discuss your wishes with them often, particularly if your medical condition changes.

3. If you want to make changes to your document after it has been signed and witnessed, you should complete a new document.

4. Remember, you can always revoke one or both sections of your California Advance Health Care Directive.

5. Be aware that your California document will not be effective in the event of a medical emergency. Ambulance personnel are required to provide cardiopulmonary resuscitation (CPR) unless they are given a separate order that states otherwise. These orders, commonly called "non-hospital do-not-resuscitate orders," are designed for people whose poor health gives them little chance of benefiting from CPR. **Caring Connections does not distribute these forms.**

   These orders must be signed by your physician and instruct ambulance personnel not to attempt CPR if your heart or breathing should stop. Currently not all states have laws authorizing non-hospital do-not-resuscitate orders. **Caring Connections does not distribute these forms.** We suggest you speak to your physician.

   If you would like more information about this topic contact Caring Connections or consult the Caring Connections booklet "Cardiopulmonary Resuscitation, Do-Not-Resuscitate Orders and End-Of-Life Decisions."

CALIFORNIA ADVANCE HEALTH CARE DIRECTIVE - PAGE 1 OF 8

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 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 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 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 an employee of the health care institution where you are receiving care, unless your agent is related to you, is your registered domestic partner, or is a co-worker. Your supervising health care provider can never act as your agent.)

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, or 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; and
(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 the disposition of your 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 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.

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.

INSTRUCTIONS

PART 1: POWER OF ATTORNEY FOR HEALTH CARE

(1) DESIGNATION OF AGENT: I designate the following individual as my agent to make health care decisions for me:

PRINT THE NAME, HOME ADDRESS AND HOME AND WORK TELEPHONE NUMBERS OF YOUR PRIMARY AGENT

_ _
(Name of individual you choose as agent)

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

_ _
(home phone) (work phone)

PRINT THE NAME, HOME ADDRESS AND HOME AND WORK TELEPHONE NUMBERS OF YOUR FIRST ALTERNATE AGENT (OPTIONAL)

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)

PRINT THE NAME, HOME ADDRESS AND HOME AND WORK TELEPHONE NUMBERS OF YOUR SECOND ALTERNATE AGENT (OPTIONAL)

OPTIONAL: 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)

INSTRUCTIONS

ADD PERSONAL INSTRUCTIONS ONLY IF YOU WANT TO LIMIT THE POWER OF YOUR AGENT

(2) 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.)

INITIAL THE BOX IF YOU WISH YOUR AGENT'S AUTHORITY TO BECOME EFFECTIVE IMMEDIATELY

(3) 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.

CROSS OUT AND INITIAL ANY STATEMENTS IN PARAGRAPHS 4, 5, OR 6 THAT DO NOT REFLECT YOUR WISHES

(4) 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.

(5) AGENT'S POSTDEATH 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:

____

____

____

(6) 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

INITIAL THE PARAGRAPH THAT BEST REFLECTS YOUR WISHES REGARDING LIFE-SUPPORT MEASURES

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

(7) 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: (**Initial only one box**)

[ ] (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.

ADDITIONAL INSTRUCTIONS (IF ANY)

(8) RELIEF FROM PAIN: Except as I state in the following space, I direct that treatment for alleviation of pain or discomfort should be provided at all times even if it hastens my death:

____

____

____

(9) 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.)

ORGAN DONATION (OPTIONAL)

MARK THE BOX THAT AGREES WITH YOUR WISHES ABOUT ORGAN DONATION

PART 3: DONATION OF ORGANS AT DEATH
(OPTIONAL)

(10) Upon my death: (mark applicable box)

[ ] (a) I give any needed organs, tissues, or parts,

OR

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

[ ] (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

PART 4: PRIMARY PHYSICIAN
(OPTIONAL)

PRINT THE NAME, ADDRESS AND TELEPHONE NUMBER OF YOUR PRIMARY PHYSICIAN (OPTIONAL)

(11) I designate the following physician as my primary physician:

_ _
(name of physician)

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

_ _
(phone)

PRINT THE NAME, ADDRESS AND TELEPHONE NUMBER OF YOUR ALTERNATE PRIMARY PHYSICIAN (OPTIONAL)

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)

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

SIGN AND DATE THE DOCUMENT AND THEN PRINT YOUR NAME AND ADDRESS

(13) SIGNATURE: Sign and date the form here:

_____ _____
(date) (sign your name)

_____ _____
(address) (print your name)

_____
(city) (state)

WITNESSING PROCEDURE

(14) WITNESSES: This advance health care directive will not be valid for making health care decisions unless it is either:

(1) signed by two (2) qualified adult witnesses who are personally known to you and who are present when you sign or acknowledge your signature; or
(2) acknowledged before a notary public.

BOTH OF YOUR WITNESSES MUST AGREE WITH THIS STATEMENT

ALTERNATIVE NO. 1
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.

HAVE YOUR WITNESSES SIGN AND DATE THE DOCUMENT AND THEN PRINT THEIR NAME AND ADDRESS

First Witness:

_____ _____
(date) (signature of witness)

_____ _____
(address) (printed name of witness)

_____
(city) (state)

Second Witness:

_____ _____
(date) (signature of witness)

_____ _____
(address) (printed name of witness)

_____
(city) (state)

ONE OF YOUR WITNESSES MUST ALSO AGREE WITH THIS STATEMENT

ADDITIONAL WITNESS STATEMENT
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.

HAVE ONE OF YOUR WITNESSES ALSO SIGN AND DATE THIS SECTION AND PRINT THEIR NAME AND ADDRESS

_____ _____
(date) (signature of witness)

_____ _____
(address) (printed name of witness)

_____
(city) (state)

OR

A NOTARY PUBLIC SHOULD FILL OUT THIS SECTION OF YOUR DOCUMENT

ALTERNATIVE NO. 2: NOTARY PUBLIC

State of California)
) SS.
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)

THIS SECTION IS TO BE COMPLETED ONLY IF YOU ARE A RESIDENT IN A SKILLED NURSING FACILITY

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 witness as required by section 4675 of the Probate Code.

_____ _____

(date) (signature)

_____ _____

(address) (printed name)

_ _

(city) (state)

Courtesy of Caring Connections
1700 Diagonal Road, Suite 625, Alexandria, VA 22314
www.caringinfo.org, 800/658-8898

Appendix A

Glossary of Terms About End-of-life Decision Making

Advance directive - A general term that describes two kinds of legal documents, living wills and medical powers of attorney. These documents allow a person to give instructions about future medical care should he or she be unable to participate in medical decisions due to serious illness or incapacity. Each state regulates the use of advance directives differently.

Artificial nutrition and hydration – Artificial nutrition and hydration (or tube feeding) supplements or replaces ordinary eating and drinking by giving a chemically balanced mix of nutrients and fluids through a tube placed directly into the stomach, the upper intestine or a vein.

Assisted Suicide - Providing someone the means to commit suicide, such as a supply of drugs or a weapon, knowing the person will use these to end his or her life.

Best Interest - In the context of refusal of medical treatment or end-of-life court opinions, a standard for making health care decisions based on what others believe to be "best" for a patient by weighing the benefits and the burdens of continuing, withholding or withdrawing treatment.

Brain Death -The irreversible loss of all brain function. Most states legally define death to include brain death.

Capacity - In relation to end-of-life decision-making, a patient has medical decision making capacity if he or she has the ability to understand the medical problem and the risks and benefits of the available treatment options. The patient's ability to understand other unrelated concepts is not relevant. The term is frequently used interchangeably with competency but is not the same. Competency is a legal status imposed by the court.

Cardiopulmonary Resuscitation - Cardiopulmonary resuscitation (CPR) is a group of treatments used when someone's heart and/or breathing stops. CPR is used in an attempt to restart the heart and breathing. It may consist only of mouth-to-mouth breathing or it can include pressing on the chest to mimic the heart's function and cause blood to circulate. Electric shock and drugs also are used frequently to stimulate the heart.

Do-Not-Resuscitate (DNR) order - A DNR order is a physician's written order instructing health care providers not to attempt cardiopulmonary resuscitation (CPR) in case of cardiac or respiratory arrest. A person with a valid DNR order will not be given CPR under these circumstances. Although the DNR order is written at the request of a person or his or her family, it must be signed by a physician to be valid. A non-hospital DNR order is written for individuals who are at home and do not want to receive CPR.

***Emergency Medical Services (EMS*)**: A group of governmental and private agencies that provide emergency care, usually to persons outside of health care facilities; EMS personnel generally include paramedics, first responders and other ambulance crew.

Euthanasia - The term traditionally has been used to refer to the hastening of a suffering person's death or "mercy killing". Voluntary active euthanasia involves an intervention requested by a competent individual that is administered to that person to cause death, for example, if a physician gives a lethal injection with the patient's full informed consent. Involuntary or non-voluntary active euthanasia involves a physician engaging in an act to end a patient's life without that patient's full informed consent. See also Physician-hastened Death (sometimes referred to as Physician-assisted Suicide).

Guardian ad litem - Someone appointed by the court to represent the interests of a minor or incompetent person in a legal proceeding.

Healthcare Agent**:** The person named in an advance directive or as permitted under state law to make healthcare decisions on behalf of a person who is no longer able to make medical decisions.

Hospice care - A program model for delivering palliative care to individuals who are in the final stages of terminal illness. In addition to providing palliative care and personal support to the patient, hospice includes support for the patient's family while the patient is dying, as well as support to the family during their bereavement.

Incapacity - A lack of physical or mental abilities that results in a person's inability to manage his or her own personal care, property or finances; a lack of ability to understand one's actions when making a will or other legal document.

Incompetent – Referring to a person who is not able to manage his/her affairs due to mental deficiency (lack of I.Q., deterioration, illness or psychosis) or sometimes physical disability. Being incompetent can be the basis for appointment of a guardian or conservator.

Intubation- Refers to "endotracheal intubation" the insertion of a tube through the mouth or nose into the trachea (windpipe) to create and maintain an open airway to assist breathing.

Life-Sustaining Treatment - Treatments (medical procedures) that replace or support an essential bodily function (may also be called life support treatments). Life-sustaining treatments include cardiopulmonary resuscitation, mechanical ventilation, artificial nutrition and hydration, dialysis, and certain other treatments.

Living Will - A type of advance directive in which an individual documents his or her wishes about medical treatment should he or she be at the end of life and unable to communicate. It may also be called a "directive to physicians", "health care declaration," or "medical directive." The purpose of a living will is to guide family members and doctors in deciding how aggressively to use medical treatments to delay death.

Mechanical ventilation - Mechanical ventilation is used to support or replace the function of the lungs. A machine called a ventilator (or respirator) forces air into the lungs. The ventilator is attached to a tube inserted in the nose or mouth and down into the windpipe (or trachea). Mechanical ventilation often is used to assist a person through a short-term problem or for prolonged periods in which irreversible respiratory failure exists due to injuries to the upper spinal cord or a progressive neurological disease.

Medical power of attorney - A document that allows an individual to appoint someone else to make decisions about his or her medical care if he or she is unable to communicate. This type of advance directive may also be called a health care proxy, durable power of attorney for health care or appointment of a health care agent. The person appointed may be called a health care agent, surrogate, attorney-in-fact or proxy.

Palliative care - A comprehensive approach to treating serious illness that focuses on the physical, psychological, spiritual, and existential needs of the patient. Its goal is to achieve the best quality of life available to the patient by relieving suffering, by controlling pain and symptoms, and by enabling the patient to achieve maximum functional capacity. Respect for the patient's culture, beliefs, and values are an essential component. Palliative care is sometimes called "comfort care" or "hospice type care."

Power of Attorney – A legal document allowing one person to act in a legal matter on another's behalf pursuant to financial or real estate transactions.

Respiratory Arrest: The cessation of breathing - an event in which an individual stops breathing. If breathing is not restored, an individual's heart eventually will stop beating, resulting in cardiac arrest.

Surrogate Decision-Making - Surrogate decision-making laws allow an individual or group of individuals (usually family members) to make decisions about medical treatments for a patient who has lost decision-making capacity and did not prepare an advance directive. A majority of states have passed statutes that permit surrogate decision making for patients without advance directives.

Ventilator – A Ventilator, also known as a respirator, is a machine that pushes air into the lungs through a tube placed in the trachea (breathing tube). Ventilators are used when a person cannot breathe on his or her own or cannot breathe effectively enough to provide adequate oxygen to the cells of the body or rid the body of carbon dioxide.

Withholding or withdrawing treatment - Forgoing life-sustaining measures or discontinuing them after they have been used for a certain period of time.

Appendix B

Legal & End-of-Life Care Resources Pertaining to Health Care Advance Directives

LEGAL SERVICES

California seniors seeking legal advice can contact the Senior Legal Service Hotline from 9-12 and 1-4 Monday through Friday until 7 p.m.

General legal aid programs are available to individuals of all ages with low incomes.

Individuals can get legal information and advice about most issues, including:

- Medicare drug plan
- Health care planning
- Civil matters
- Advance Directives
- Living Wills
- Education programs and much more

- Must be 18 or older
- Free for individuals with low to moderate incomes

For more information call toll free:
1-800-222-1753 in California or 916-551-2140 in Sacramento

You can also visit the Senior Legal Services Hotline website for locations and phone numbers in your county, click on the following link:
http://www.seniorlegalhotline.org/6-offices.html

END-0F-LIFE SERVICES

Individuals can contact California Area Agencies on Aging (AAA) for other senior services, including, but not limited to:

- Home Healthcare
- Meals
- Adult Daycare
- community Services
- Volunteering
- Legal Assistance
- Information and referrals to other resources

To locate an AAA in your region please click on the following link:
http://www.aging.state.ca.us/html/local%20aaa/AAA_listing.html

OR

Call toll free: 1-800-510-2020