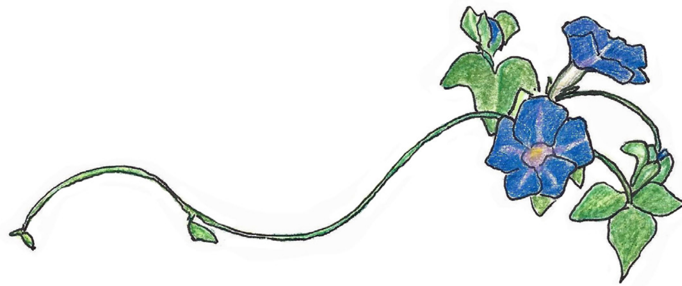
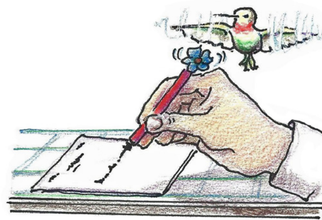
Making a **Plan** Thinking **Ahead**

MY Way • MY Choice • MY Plan



Part II: Forms

Notes



Making a Plan – Thinking Ahead includes a Workbook and Forms produced by collaboration between the Behavioral Health Division, County of Sonoma (BHD), the Community Network for Appropriate Technologies, the Coalition for Compassionate Care of CA (CCCC), and Goodwill Redwood Empire. It is adapted from the original *Thinking Ahead – My Way, My Choice, My Life at the End* created in 2007 by CCCC and Coalition partners. Please see **Making a Plan –Thinking Ahead** Workbook for more background and credits.

Illustrations by Gloria Potter, Community Network Journey Project

v. 11/18

ADVANCE HEALTH CARE DIRECTIVE

Form A

Advance Health Care Directive for:

____

(print your name and date)

My Health Care Advocate (Health Care Agent) is:

____

(Print name of person here)

____

Street Address City State Zip

____

Home Phone Cell Phone Email

My alternate 1 is: Name___________________________________Phone________________

My alternate 2 is: Name___________________________________Phone________________

My Health Care Advocate will make decisions for me only if I cannot make my own decisions, unless I say otherwise.

Additional instructions are attached: ❑ Yes ❑ No

If yes, please say here what is attached: ____

(Even if you don't name a Health Care Agent, it is important to complete the other sections of the Advance Directive so that health care providers know what is important to you. Draw a line through the "My Health Care Advocate" section, initial that line and then complete the remainder of this document.)

My Choices for Serious Illness or Life's End

My quality of life means:

- ❑ Being awake and thinking for myself
- ❑ Being able to communicate with loved ones and friends
- ❑ Being free from constant and severe pain, even if it clouds my thinking and makes me sleepy.
- ❑ Not being connected to machines for many days
- ❑ Having as much choice as possible
- ❑ Having palliative (supportive) care as a part of my care
- ❑ ____

If I am terminally ill, my life support treatment decision is:

- ❑ I want life support treatment only if my doctor thinks it could help.
- ❑ I do not want any life support treatment.
- ❑ I want my Health Care Agent/Advocate to decide for me.
- ❑ I want life support treatment for as long as possible.

When I die I want to donate my body, organs or other parts.

❑ Yes ❑ No

If yes, please clarify ____

Copies of this form are valid and should be used to share with others. You should keep the original.

Signing Your Advance Health Care Directive

- ➪ Signing your Advance Directive must be done properly according to the law. TWO WITNESSES MUST SEE YOU SIGN THE FORM. See below for other things you must require of your witnesses.
- ➪ If you do not have two qualified witnesses you need to take your form to a Notary Public who can verify your identification and notarize your signature so it is legally recognized.
- ➪ If you are a nursing home resident, California law requires that you must have the nursing home ombudsman as a witness of your Advance Directive along with one other witness.

YOUR SIGNATURE:

____

Sign Your Name Date

____

Print Your Name

____

Address City State/Zip Code

If you have witnesses, make sure they are qualified and that they are together when they see you sign the form. Then have them complete the following.

Witness One and Witness Two Promise by signing that:
(Print YOUR name here) ______________________________ signed this form while I watched, was thinking clearly and was not forced to sign it.

Witness One and Witness Two also promise by signing that:

- ❑ I know the person or the person could prove to me who they are.
- ❑ I am 18 years or older and I do not work where this person lives.
- ❑ I am not this person's health care provider and I do not work for this person's health care provider.

Witness Two also promises that:
I am not related to this person by blood, marriage or adoption and that I will not get any of their money or property after this person dies.

Witness One:

____
Sign Your Name Date

____
Print Your Name

____
Address City State/Zip Code

Witness Two:

____
Sign Your Name Date

____
Print Your Name

____
Address City State/Zip Code

If you have the signatures of witnesses, your Advance Directive is complete. **Share your Advance Directive with people close to you who know you and care about you. Also share it with your doctors, nurses, social workers and others who you want to know about your wishes for care should you be unable to direct your own care.**

If you do not have witnesses take your completed form to a person who is a notary public who can verify your identification and notarize your signature to complete your advance directive. The Notary will complete a Certificate of Acknowledgement that you must keep as a part of your Advance Health Care Directive. If needed, a form to do that is on page 7.

If you are in a nursing home, the nursing home ombudsman (Witness One) must witness you signing your Advance Directive along with one other witness who must meet all the witnessing requirements on page 5 where they will sign as Witness Two. A form for the Ombudsman is on page 8 following the Notary page.

The Advance Health Care Directive, Part II Form B is in compliance with CA Probate Code, Sections 4657, 4659(c), 4670-4675, 4700-4701AHCD Part 3 thru Part 6; 4766; and Welf. & Inst. Code Sections 5005, 5327. Prepared by the Community Network Journey Project (www.caringcommunity.org) in collaboration with the Coalition for Compassionate Care of CA (http://coalitionccc.org/). 10/16

Certificate of Acknowledgement of Notary Public

(*NOT required if your document is signed by two witnesses*)

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 this ____________________before me____,
(date) (insert name and title of officer)

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.

Notary Signature: _______________________________ **(Seal)**

Title or Type of Attached Document:_____________________________________

Number of pages:___________________________Date:_____________________

Capacity(ies) Claimed by Signer(s):
__Individual __Conservator __Other_____________________________

Statement of Patient Advocate or Ombudsman

(*Required ONLY if you live in a California skilled nursing facility.*)

The following statement is required only if you are a patient in a skilled nursing facility--a health care facility that provides the following basic services: skilled nursing care and supportive care to patients whose primary need is for availability of skilled nursing care on an extended basis. The patient advocate or ombudsman must sign the following statement:

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 a witness as required by Section 4675 of the Probate Code.

____
(print your name)

____
(sign your name) (date)

____
(address) (city) (state) (ZIP code)

PERSONAL REQUESTS

These are my personal requests for what I would like to have happen if I can't speak for myself or if I were to die. I understand that this is NOT a Will.

Your Name: ______________________________________**Date:**____________________

(1) Where I want to be

This is my choice about where I want to be when seriously ill or at the end of life:

❑ At my home ❑ With loved ones ❑ Hospital

❑ With people who know and care about me

❑ Other place (where) ____

❑ I trust those who know me best to make the best choice for me.

(2) How I want to be cared for in serious illness or at life's end

❑ Have my loved ones and friends near.

❑ Have my pet(s) with me.

❑ Have care that helps me feel comfortable.

❑ Be awake and aware as long as pain and suffering isn't too great.

❑ Have my favorite things around me, including: ______________________________

❑ Have my favorite music playing, including: _________________________________

❑ Have my religious, cultural or spiritual practices respected.

❑ Have palliative (supportive) care

Other ways I want to be cared for: ____

____

Other things important to me: ____

____

I would not want: ____

____

(3) What I want done with my belongings <u>if I am seriously ill and/or unable to look after my own things</u>:

a. For my most important possessions: *(May include information about items such as keys, phone, wallet, car, valuables, plants, collectables, books, music, etc., that need to be protected.*)

____
____
____
____

b. For my pets: If I cannot care for my pets, this is what is important to me. *(May include information about type and color of animal, pet name, vet info, feeding etc.)* _______________

____
____
____
____

c. My belongings: They can safely be stored here if need be (please give details)

____
____
____
____

d. Other things important to know: ____

____
____
____
____

(4) Where I want my things to go when I die.

Sometimes people donate personal items to organizations or give them to friends and family members. Think about where you want your things to go and write it down.

Money: ____

Clothing: ____

Furniture: ____

Jewelry and other valuables: ____

____

Pet(s): ____

Other: ____

____

____

(5) Gifts I want to give when I die.

You may want to give special gifts to friends, family members and others who have been important to you. **If you would like to do that, write what you want to give and to whom:**

Item: ____

To: _____________________________________Phone: __________________

Item: ____

To: _____________________________________Phone: __________________

Item: ____

To: _____________________________________Phone: __________________

❑ See Additional Information attached

(5a) For the rest of my important possessions, I would like this done:

- ❑ **Check here if same as 3a above.**

____
____
____
____

(5b) For my pets, I would like this done:

- ❑ **Check here if same as 3b above.**

____
____
____
____

(5c) If need be, my belongings can be safely stored here until people who are helping me can take care of my things. Please give details.

- ❑ **Check here if same as 3b above.**

____
____
____
____

(6) My body

You may have religious, cultural or family traditions that could help you decide what happens to your body after you die. **Think about what you want and write it down.**

❑ I want to be buried. Where: ____

❑ I want to be cremated. I want my ashes to go: ____________________________

❑ I do not want: ____

(7) Do you have a burial trust fund to pay for cost of cremation and/or burial when you die?

❑ Yes ❑ No If yes, give details:____________________________________

Would you like more information about a burial trust fund? ❑ Yes ❑ No
(*Information about creating a burial trust fund can also be found at www.cfb.ca.gov/consumer/pre_need.shtml.*)

(8) Being remembered

Having a time to remember is a way people pay their respects and celebrate the life of someone who has died. How would you like to be remembered? **Think about what you want and write it down.**

I want a funeral or memorial service ❑ Yes ❑ No If yes:

❑ At my place of worship ___________________________________
❑ At a funeral home _______________________________________
❑ Other place ____
❑ I do not want ____

I want people to remember me by doing this: ____
____
____
____

____
Sign Your Name **Date**

____
Street Address **City** **State** **Zip Code**

____
Home Phone **Cell Phone** **Email**

____

If there are other things important to know about your wishes, please clarify those things here OR draw a line through here if not needed.

____

____

____

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