If I Need Help Making Medical Choices

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

My Information

My Name: _____

My Date of Birth: _____

My Address: _____ City: _____

State: _____ Zip Code: _____

My Agent

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 medical choices for me if I cannot make these choices.

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 / mental health provider says that I cannot make my own choices.

If the doctor / mental health provider thinks I cannot make my own choices, they must explain why in writing.

What my agent can do:

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

- 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.

If there is anything I do not want my agent to do, I need to state it here:

I do not want my agent to_____

My 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, they must make choices that will help me the most.

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

My Signature:

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 BE 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: _____ Date: _____

Signature: _____

Address:_____

Second Witness
Name: _____ Date: _____

Signature: _____

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 their 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 their mark in our presence and requested the first of the undersigned to write their name, which they did, and we now subscribe our names as witnesses there to.

_____

Signature of Witness #1

_____

Signature of Witness #2