Hillside Memorial Park and Mortuary

Advance Health Care Directive

HILLSIDE
MEMORIAL PARK AND MORTUARY

Advance Health Care Directive

This booklet lets you name another individual as an agent to make health care decisions for you if you are unable to make them for yourself. It lets you say exactly how you wish to be treated. Use this booklet to inform your family, friends and physicians on the specific care you wish to receive, giving them peace of mind knowing they understand your needs and are giving you the proper care. If you have any questions about this form or how to complete it, you should consult an attorney.

Is This Form Right For You?

This form is for anyone 18 or older; married, single, parents, adult children and friends. It is a powerful tool that allows you to specify the treatment needs you have if you are unable to speak for yourself. You can use this form to designate a trusted "health care agent" to make decisions and communicate your wishes.

Why Is An Advance Health Care Directive Important?

It's important to plan ahead and make your care preferences clear whether you're young or old, healthy or sick. An Advance Health Care Directive is something you can do now to ensure your quality of life in the future, as well as protect your family and friends from the emotional burden of having to make difficult decisions without knowing your wishes.

Filling Out The Advance Health Care Directive

This booklet lets you name an individual as agent to make health care decisions on your behalf 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 are also allowed to select an alternate agent to act for you if your first choice is not willing, able or reasonably available to make decisions for you.

This booklet also lets you give specific instructions about any aspect of your health care, whether or not you designate an agent. Space is provided for you to express your wishes regarding your medical and emotional wishes should you become seriously ill and unable to communicate your needs.

Give a completed and signed copy of this form to any health care providers you may have as well as your designated health care agent, family, friends and loved ones.

You have the right to revoke this advance health care directive or replace this form at any time.

Who I Want To Make Decisions On My Behalf

If I am no longer able to make my own health care decisions, this form names the person I choose to make these choices for me. This person will be my Healthcare Agent and will make my health care choices if my doctors find I am no longer able to make health care decisions on my own.

Your health care agent may ***not*** be an operator or employee of a community care facility or a residential care facility where you are receiving care, your supervising health care provider, or an employee of the health care institution where you are receiving care, unless your agent is related to you or is a co-worker.

Your agent will have the right to:

- Consent or refuse consent to any care, treatment services, or procedure to maintain, diagnose, or otherwise affect a physical or mental condition. This includes medical care choices such as tests, medicine or surgery for the purposes of diagnosis and care to keep you alive.
- Choose or discharge health care providers and institutions.
- Agree or disagree with providing, witholding, or withdrawl of artificial feeding and fluids and all other forms of health care, including cardiopulmonary resuscitation (CPR).
- Move you to another state to get the care you need or to carry out your wishes.
- After your death make anatomical gifts (donation or ogans/tissues), authorize an autopsy, and make decisions about what will be done with your body; subject to restrictions you indicate in this directive.

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

Name of individual you choose as agent: _____

Relationship: _____

Address: _____

_____

Telephone numbers: (Indicate home, work, cell) _____

ALTERNATE AGENT (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 alternate agent: _____

Relationship: _____

Address: _____

_____

Telephone numbers: (Indicate home, work, cell) _____

SECOND ALTERNATE AGENT (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: _____

Relationship: _____

Address: _____

_____

Telephone numbers: (Indicate home, work, cell) _____

AGENT'S AUTHORITY: My agent is authorized to 1) 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, 2) to choose a particular physician or health care facility 3) to receive or consent to the release of medical information and records, except as I state here:

_____

_____

_____

_____

The Kind Of Medical Treatment I Want Or Do Not Want

Please list your specific wishes for the type of medical treatment you want or do not want to receive. For example, you may list specific instructions for pain management, food or fluids, and life-support treatment. If you wish to limit the meaning of life-support treatment, please include your specific wishes. Life-support treatment may include cardiopulmonary resuscitation (CPR), artificial nutrition or fluids, respirator or ventilator, dialysis, etc.

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

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

END-OF-LIFE DECISIONS: I direct my health care providers and others involved in my case to provide, withhold, or withdraw treatment in accordance with the choice I have marked below:

☐ **Choice Not To Prolong**
I do not want my life to be prolonged if the likely risks and burdens of treatment would outweigh the expected benefits, or if I become unconscious and, to a realistic degree of medical certainty, I will not regain consciousness, or if I have an incurable and irreversible condition that will result in my death in a relatively short time.
OR

☐ **Choice To Prolong**
I want my life to be prolonged as long as possible within the limits of generally accepted medical treatment standards.

Life-Support Treatment

If I am likely to die within a short period of time and life-support treatment will only delay my death (choose one of the following):

☐ I want to have life-support treatment.

☐ I do not want life-support treatment. If it has been started, I want it stopped.

☐ I want to have life-support treatment if my doctor believes it could help. But I want my doctor to stop giving me life-support treatment if it is not helping my health condition or symptoms.

If I am in a coma and am not expected to wake up or recover, and I have brain damage and life-support treatment will only delay my death (choose one of the following):

☐ I want to have life-support treatment.

☐ I do not want life-support treatment. If it has been started, I want it stopped.

☐ I want to have life-support treatment if my doctor believes it could help. But I want my doctor to stop giving me life-support treatment if it is not helping my health condition or symptoms.

If I have permanent and severe brain damage and am not expected to get better, and life-support treatment would only delay my death (choose one of the following):

☐ I want to have life-support treatment.

☐ I do not want life-support treatment. If it has been started, I want it stopped.

☐ I want to have life-support treatment if my doctor believes it could help. But I want my doctor to stop giving me life-support treatment if it is not helping my health condition or symptoms.

OTHER WISHES: If you have different or more specific instructions other than those marked above, such as what you consider reasonable quality of life, treatments you consider unacceptable, write them in space provided below:

Donation of Organs at Death

Upon my death (mark applicable box):

- ☐ I give any needed organs, tissues or parts.
- ☐ I give the following organs, tissues or parts only: _____
- ☐ I do not wish to donate organs, tissues or parts.

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

Transplant Therapy Research Education

My Comfort

Please list your wishes for your care in terms of medication and pain management, cleanliness and hygiene, etc. For example, use this section to discuss personal care such as shaving, nail clipping, hair brushing, etc.

My Treatment and Emotional Needs

Please list your specific wishes for your treatment in terms of your emotional needs. Use this section to discuss the people you wish to be by your side and the type of interaction you want to have. For example, you may list having people talk to you and hold your hand or have pictures placed by your bedside.

What I Want My Loved Ones To Know

Please list what you want your family and friends to know when you are not able to express yourself. Use this section to discuss your feelings and thoughts towards your family, friends and your own passing. For example, you may list your fears or acceptance towards your death or how you wish your family and friends to remember you after you pass.

Funeral & Burial Information

After my death I would like to be interred or cremated. (Circle one)

My body or remains should be placed in the following location: _____

I have pre-planned my cemetery and mortuary with: _____

Address: _____ Phone: _____

These documents are located at: _____

Signature of Advance Health Care Directive

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

(5.2) SIGNATURE: Sign name: _____ Date: _____

Print Name: _____

Address: _____

(5.3) 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 health care directive in my presence, (3) that the individual appears to be of sound mind and under no duress, (4) that I am not a person appointed as 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.

FIRST WITNESS

Print Name: _____

Address: _____

Signature of Witness: _____ Date: _____

SECOND WITNESS

Print Name: _____

Address: _____

Signature of Witness: _____ Date: _____

(5.4) ADDITIONAL STATEMENT OF WITNESSES: At least one of the above witnesses must also 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 on his or her death under a will now existing or by operation of law.

Signature of Witness: _____

Signature of Witness: _____

Special Witness Requirement if in a Skilled Nursing Facility

(6.1) 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 Probate Code:

Print Name: _____ Signature: _____

Address: _____ Date: _____

ACKNOWLEDGEMENT

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 Los Angeles)

On _____, before me, _____,
Date Insert Name and Title of Officer

personally appeared _____, who proved to me on the basis of
Name(s) of Signers

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.

_____ [Seal]
Signature of Notary Public

HILLSIDE

MEMORIAL PARK AND MORTUARY

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