Law Office of Janet L. Brewer

A GUIDE TO

Life Care Planning

Advance Health Care Directive

REMEMBER

1. Have this document witnessed or notarized
2. Sign and date
3. Give a copy to your primary medical clinic

Law Office of Janet L. Brewer, 4 Main Street, Suite 20, Los Altos, CA 94022 | (650) 325-8276 | calprobate.com | staff@calprobate.com

Full name: _____
Medical Record #: _____

Introduction

This Advance Health Care Directive allows you to share your values, your choices, and your instructions about your health care. This form may be used to:

- Name someone you trust to make health care decisions for you (your "health care agent"), OR
- Provide written instructions about your health care, OR
- Both name a health care agent AND provide written instructions for health care.

Part 1 allows you to name a health care agent.

Part 2 gives you an opportunity to share your values and what is important to you.

Part 3 allows you to give written instructions about your health care.

Part 4 allows you to guide your agent's decision making by stating your hopes and wishes.

Part 5 allows you to make your Advance Health Care Directive legally valid in the State of California.

Part 6 prepares you to share your wishes and this document with others.

You are free to complete or modify all or any part of this form, or use a different form.

This Advance Health Care Directive will replace any Advance Health Care Directive you have completed in the past, to the extent that they differ. If you want to cancel or change your named agent, complete a new document or inform your health care provider in person.

Full name: _____

Medical Record number: _____ Date of birth: _____

Mailing address: _____

Home phone: _____ Cell phone: _____

Work phone: _____ Email: _____

Full name: _____
Medical Record #: _____

Part 1. My Health Care Agent

Selecting a health care agent:
Choose someone who knows you well, who you trust to honor your views and values, and who is able to make difficult decisions in stressful situations. Once you have selected your health care agent, take the time to discuss your views and treatment goals with that person and make sure they are willing to act as your decision maker.

If I am unable to communicate my wishes and health care decisions, or if my health care provider has determined that I am not able to make my own health care decisions, I choose the following person(s) to make my health care decisions.*

My health care agent must make health care decisions that are consistent with my instructions in this document, if any, and other wishes known by my agent. Otherwise, my agent must make health care decisions that he or she believes to be in my best interest, considering what he or she knows about my personal values.

This form does not give my health care agent the authority to make financial or other business decisions. My health care agent does not have the power to place me in a mental health treatment facility or consent to some types of mental health treatments.

My primary (main) health care agent is:

Full name: _____ Relationship to me: _____

Home phone: _____ Cell phone: _____

Work phone: _____ Email: _____

Mailing address: _____

*I understand that my health care agent cannot be my supervising health care provider or an operator of a community or residential care facility where I am receiving care. My agent also may not be an employee of a community care, residential care, or health care facility where I am receiving care, unless that person is my relative by blood, marriage, or adoption, is my registered domestic partner, or is my co-worker.

Need additional assistance?
Review the AHCD Instructions
starting on page 16.

Full name: _____
Medical Record #: _____

If I cancel my primary health care agent's authority, or if my primary agent is not willing, able, or reasonably available to make a health care decision for me, I name the individual below as my first alternate agent.

First alternate health care agent:

Full name: _____ Relationship to me: _____

Home phone: _____ Cell phone: _____

Work phone: _____ Email: _____

Mailing address: _____

If I cancel my agent's authority, primary or first alternate, or if neither is willing, able, or reasonably available to make a health care decision for me, I name the individual below as my second alternate agent.

Second alternate health care agent:

Full name: _____ Relationship to me: _____

Home phone: _____ Cell phone: _____

Work phone: _____ Email: _____

Mailing address: _____

Powers of my health care agent:

Unless I limit my agent's authority, my health care agent has all of the following powers:

A. Make choices for me about my health care. This includes decisions about tests, medicine, and surgery. It also includes decisions to provide, not provide, or stop all forms of health care to keep me alive, including artificial nutrition (food), hydration (water), and cardiopulmonary resuscitation.

B. Decide which physicians, health providers, and organizations provide my medical treatment.

C. Arrange for and make decisions about the care of my body after death (including autopsy and organ donation).

Full name: _____
Medical Record #: _____

Please provide any additional comments or restrictions to your agent's authority here. (For example, you may name people you would not want involved in medical decisions on your behalf. You may also specify decisions you would not want your agent to make.) Attach additional page(s) if necessary.

_____
_____
_____
_____
_____
_____
_____

Additional health care agent instructions:

Check the box or boxes below, if you want your agent to follow these instructions.

❑ I want my agent to continue as my health care agent even if a dissolution, annulment, or termination of our marriage or domestic partnership has been completed.

❑ I want my agent to immediately begin making health care decisions for me even if I am able to decide or speak for myself.

Need additional assistance?
Review the AHCD Instructions
starting on page 16.

Full name: _____
Medical Record #: _____

Part 2. My Values and Beliefs

I want my agent and loved ones to know what matters most to me, so that they can make decisions about my health care that match who I am and what is important to me.

To give you a sense of what matters most to me, I'd like to tell you some things about myself, such as how I enjoy spending my time, who I like to be with, and what I like to do. I'd also like to tell you about the circumstances that would make life no longer worthwhile for me.

1. If I were having a good day, I would be doing the following:

_____

_____

_____

2. What matters most to me is:

_____

_____

_____

3. Life would no longer be worth living if I were not able to:

_____

_____

_____

4. Religious or spiritual traditions:

I am of the _____ faith, and am a member of (faith/spiritual community) _____ in (city) _____, (phone #) _____. I would like my agent to notify them if I am seriously ill or dying. I would like to include in my funeral, if possible, the following (people, music, rituals, etc.):

_____

_____

_____

❑ I have no specific religious or spiritual traditions.

Full name: _____
Medical Record #: _____

Part 3. My Health Care Instructions

If you choose not to provide written instructions, your health care agent will make decisions based on your spoken directions. If your directions are unknown, your agent will make decisions based on what he or she believes is in your best interest, considering your values.

In the situation below, we ask you to consider a sudden unexpected event that leaves you unable to communicate for yourself.

I ask that my health care agent represent my choices as detailed below, and that my doctors and health care team honor them. If my health care agent or alternate agents are not available or are unable to make decisions on my behalf, this document represents my wishes.

1. Treatments to prolong life

Consider the following situation:

You have a sudden accident or stroke.

Doctors have determined you have a brain injury, leaving you unable to recognize yourself or your loved ones. The doctors have told your agent and/or family that you are not expected to recover these abilities. Life-sustaining treatments, such as a ventilator (i.e., breathing machine), or a feeding tube, are required to keep you alive. In this situation what would you want?

I would want to be kept comfortable and:

Choose One

- ☐ I would want to STOP life-sustaining treatment. I realize this would probably lead me to die sooner than if I were to continue treatment.
- ☐ I would want to continue life-sustaining treatments.

Please provide any additional instructions about life-sustaining treatments. For example, you may want to state a specific time period that you would want to be kept alive if there were no improvement to your health.

_____

_____

_____

_____

_____

_____

Full name: _____
Medical Record #: _____

2. CPR (Cardiopulmonary resuscitation)

CPR is an attempt to bring you back to life when your heart and breathing have stopped. It may include chest compressions (forceful pushing on the chest to make the heart contract), medicines, electrical shocks, and a breathing tube.

You have a choice about CPR. CPR can save lives. It is not as effective as most people think. CPR works best if done quickly, within a few minutes, on a healthy adult. When CPR is performed, it can result in broken ribs, punctured lungs, or brain damage from lack of oxygen.* If you would like additional information about CPR, please request the brochure called **CPR: Cardiopulmonary Resuscitation**

If you do not want CPR, please discuss with your physician other documents you may want to complete.

In the event that your heart and breathing stop, what would you want?

Choose One

❑ I always want CPR attempted.

❑ I never want CPR attempted, but rather want to permit a natural death.

❑ I want CPR attempted unless the doctor treating me determines any of the following:
- I have an incurable illness or injury and am dying; or
- I have no reasonable chance of survival if my heart or breathing stops; or
- I have little chance of survival if my heart or breathing stops and the process of resuscitation would cause significant suffering.

Need additional assistance?
Review the AHCD Instructions
starting on page 16.

*Research shows that if you are in a hospital and get CPR, you have a 22 percent chance of surviving and leaving the hospital alive. Saket Girotra, M.D., Brahmajee K. Nallamothu, M.D., M.P.H., John A. Spertus, M.D., M.P.H., et al. "Trends in Survival after In-Hospital Cardiac Arrest;" *New England Journal of Medicine* 367; 20 November 15, 2012.

Full name: _____
Medical Record #: _____

Part 4. My Hopes and Wishes (Optional)

1. **As I'm nearing my death, I want my loved ones to know I would appreciate having the following (prayers, rituals, music) and where I prefer to die:**

2. **Other wishes/instructions**:

3. **Organ donation** (If you have no preference, your agent may decide for you.):

   ❑ **Upon my death, I want to donate my eyes, tissues, and any organs. My specific wishes (if any) are:**

   ❑ **Upon my death, I only wish to donate the following organs, tissues, or body parts:**

   ❑ **I DO NOT want to donate my eyes, tissues, and/or organs.**

Full name: _____
Medical Record #: _____

Part 4. My Hopes and Wishes (Optional)

4 . If you wish to donate your body for research, arrangements must be made in advance:
Organization/Institution Name: _____ **Phone:** _____

Full name: _____
Medical Record #: _____

Part 5. Making This Document Legally Valid

To make your Advance Health Care Directive legally valid in California, it must be signed by two witnesses, OR acknowledged before a Notary Public. Follow the steps outlined below in the order in which they are listed:

1. Choose EITHER

Two Witnesses **OR** **Notary Public**

- One of your witnesses cannot be related to you (by blood, marriage, or adoption) and cannot be entitled to any part of your estate.
- Your primary and alternate agents cannot sign as witnesses.
- When you are with your witnesses, sign or acknowledge your signature.
- Witnesses will sign on page 11.
- You will sign on page 12.

- Do NOT sign this document unless you are with a Notary Public.
- Notary Public will sign on page 12. (Skip page 11.)
- You will sign on page 12.

Special Witness Requirement

If you are a patient in a skilled nursing facility, 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 an ombudsman as designated by the State Department of Aging and that I am serving as a witness as required by Section 4675 of the California Probate Code.

Signature: _____ Date: _____

Full name: _____
Medical Record #: _____

This form must be signed by two witnesses (only one of whom can be related to you), OR acknowledged before a Notary Public. If using a Notary Public, skip this page.

Statement of Witnesses

STATEMENT OF WITNESSES: I declare under penalty of perjury under the laws of California

- 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,
- that the individual signed or acknowledged this Advance Health Care Directive in my presence,
- that the individual appears to be of sound mind and under no duress, fraud, or undue influence,
- that I am not appointed as an agent by this Advance Health Care Directive, and
- 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, or an employee of an operator of a residential care facility for the elderly.

Witness Number One:

Print full name: _____

Address: _____

Signature: _____ Date: _____

Witness Number Two:

Print full name: _____

Address: _____

Signature: _____ Date: _____

ADDITIONAL STATEMENT OF WITNESS: At least one of the witnesses must meet the following requirements and 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 his or her death under a will now existing or by operation of law.

Print full name: _____ Signature: _____

Date: _____

Full name: _____
Medical Record #: _____

SIGNATURE

My name printed: _____

My Signature: _____ **Date:** _____

If you are physically unable to sign, any mark you make that you intend to be your signature is acceptable.

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.

Notary Public

State of California

County of _____

on _____ before me, _____,
Date Name and Title of Officer

personally appeared _____
Name of Signer

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.

Signature _____ (Seal)

Full name: _____
Medical Record #: _____

Part 6. Next Steps

Now that you have completed your Advance Health Care Directive, you should also take the following steps.

Discuss:

- ❑ Review your health care wishes with the person you have asked to be your agent (if you haven't already done so). Make sure he or she feels able to perform this important job for you in the future.
- ❑ Talk to the rest of your family and close friends who might be involved if you have a serious illness or injury. Make sure they know who your health care agent is, and what your wishes are.

Give copies:

- ❑ Give your health care agent a copy of your Advance Health Care Directive.
- ❑ Give a copy of your Advance Health Care Directive to your doctor.
- ❑ Make a copy for yourself and keep it where it can be easily found.

Take with you:

- ❑ If you go to a hospital or nursing home, take a copy of your Advance Health Care Directive and ask that it be placed in your medical record.
- ❑ Take a copy with you any time you will be away from home for an extended period of time.

Review regularly:

- ❑ Review your health care wishes whenever any of the "Five D's" occur:

  Decade—when you start each new decade of your life.

  Death—whenever you experience the death of a loved one.

  Divorce—when you experience a divorce or other major family change.

  Diagnosis—when you are diagnosed with a serious health condition.

  Decline—when you experience a significant decline or deterioration of an existing health condition, especially when you are unable to live on your own.

Changing your Advance Health Care Directive:

If your wishes or health care agent change, please notify your provider or fill out a new Advance Health Care Directive. Tell your agent, your family, and anyone else who has a copy, and provide a copy to your doctor.

Full name: _____
Medical Record #: _____

Copies of this document have been given to:

- Primary (Main) Health Care Agent

  Full name: _____

  Telephone: _____

- Alternate Health Care Agent #1

  Full name: _____

  Telephone: _____

- Alternate Health Care Agent #2

  Full name: _____

  Telephone: _____

- Health Care Provider/Clinic

  Name: _____

  Telephone: _____

- Others:

  Name: _____

  Telephone: _____

Return a copy of your completed Advance Health Care Directive to your doctor.

Need additional assistance? Keep reading for instructions and guidance

Advance Health Care Directives Instructions

What is an Advance Health Care Directive?

The Advance Health Care Directives (AHCD) is a legal document that provides your health care team with guidance about what to do in the event you are not able to make health care decision for yourself.

The AHCD allows you to:

- Choose a health care agent (decision maker) to make health care decisions on your behalf if you are unable to do so AND/OR
- Express your values, beliefs, and health care preferences

The AHCD provides guidance to both your health care agent (decision maker) and health care team in developing a treatment plan for you. **It does NOT tell emergency personnel what treatments you want during a medical emergency.**

You can update ANY of your preferences in your AHCD at any time by completing a new document. This new AHCD will replace any AHCD you have completed in the past.

Why is an AHCD Important?

You have the right to share your preferences about your health care.

This document provides guidelines to your health care agent (decision maker) and doctors to provide care that is right for you.

It is also an opportunity to reflect on what quality of life means to you, and how your preferences may impact your loved ones. Completing this document while you are able and talking about it with your loved ones may help reduce confusion and disagreement about what you may or may not want.

Who is the AHCD for?

Any adult over the age of 18 of sound mind should consider completing an Advance Health Care Directives regardless of their health status.

Choosing Your Health Care Agent(s) (Decision Maker)

This section names someone you trust to make health care decisions for you if you are unable to make them for yourself. Choosing your Health Care Agent also means sharing your values and beliefs with them and telling them what medical care you would want if you are unable to make decisions for yourself.

If your health care provider has determined that you are not able to make your own health care decisions, this form names the person(s) you choose to make health care decisions for you.

Your health care agent (decision maker) will speak on your behalf to make health care decisions for you based on the preferences you have shared with them or what they believe to be in your best interests, considering what they know about your personal values and beliefs.

Note: Talk to your agent about what is most important to you and make sure they feel able to perform this role. Be sure to let those closest to you know who you have chosen to be your agent.

Who should you choose to be your health care agent?

When choosing your health care agent, consider selecting a person who is important to you and has the ability to make hard decisions at a difficult time. Legally, your agent cannot be your doctor or another health care professional who cares for you as part of your treatment team.

You cannot anticipate every health care situation; your agent will have to make decisions in real-time based on information shared by the medical team. Having discussions with your agent about the kind of care you want and do not want will give you both a shared understanding and peace of mind.

Sometimes, a spouse or family member may be the best choice, but sometimes they are not the best choice. You know best.

A good health care agent is someone who:

- Is willing to be your health care agent and can be reasonably available
- Knows your values and beliefs well
- Is willing to honor and represent your preferences even if they are different from their own
- Will not be afraid to ask questions and speak on your behalf, even if it goes against convention or the wishes of loved ones
- Is able to make decisions under stress

- Will continue to check-in with you about your preferences over time

Note: Your health care agent may or may not be the same person you would choose as an emergency contact.

This form does not authorize your agent to make financial or other business decisions for you.

Decisions you want your Health Care Agent to make for you

You can choose to allow your health care agent to make ALL health care decisions for you if you are unable to make them for yourself. Unless you limit your agents' authority, they can make the following decisions for you:

- Say yes/no to medications, tests, treatments; select or change health care providers; and decide where you will receive care.
- Start, not start, or stop all forms of life sustaining interventions to keep you alive
- Arrange for and make decisions about the care of your body after death (including autopsy, organ donation, and what happens to your remains)

When should your Agent's authority become effective?

Your agent's authority becomes effective when your physician determines that you are unable to make your own health care decisions

Please make an "X" on the form to select one of the following:

- I understand and accept that my agent will become active when I can no longer make my own decisions, OR
- I prefer that my agent make decisions on my behalf immediately, even though I am currently able to make my own decisions

Note: if your agent is a spouse or domestic partner, the agent designation is revoked in the event of a dissolution, annulment, or termination of the marriage or domestic partnership.

Limitation on Your Agent's Authority

If you wish to limit your health care agent's authority, write below what health care decisions **YOU DO NOT** want your agent to make.

- No limits
- My agent may ***not*** do the following:

On the form, also write the names of any individuals, if any, who **YOU DO NOT** want to make health care decisions for you.

Your Values and Beliefs

This section lets you reflect on what quality of life and living well means to you. It serves as a foundation for your response to the rest of this document. Completing the **"Your Values and Beliefs"** section allows you to write down what is most important in your life. Take your time with these questions as they will help you to think through **Part 3** of this document.

It is important to understand and reflect on what matters most so you can make decisions in advance about your health care that match who you are. It is also important for your health care agent (decision maker) to understand your values and what matters most to you.

Share some things about yourself, such as what is most important in your life, what living well means to you, and what abilities you value. Also share how your belief system may influence your health care.

Check all that apply and use the space on the form to describe more.

❶ For me to live well, the following matter most to me

- ❑ Spending time and connecting with loved ones
- ❑ Making my own decisions
- ❑ Communicating meaningfully
- ❑ Being physically active
- ❑ Recognizing friends and family
- ❑ Being socially active
- ❑ Living independently
- ❑ Feeding myself without assistance
- ❑ Taking care of my personal hygiene (bathing, dressing myself)
- ❑ Living in my own home
- ❑ Working and/or volunteering
- ❑ Participating in hobbies or interests
- ❑ Honoring my spiritual beliefs and/or religion
- ❑ Other (say more below)
- ❑ It also matters to me that:

❷ This is WHY the choices I made in Question 1 matter to me. Share additional thoughts about what brings meaning to your life.

Think about what you value most. What does quality of life mean to you? These might feel like big questions, **but you already know more than you think**

- **Why are these important to you?**

❸ Only answer if this is relevant to you. How does your culture, spirituality, religion, and/or belief system influence your health care decision? How important is this to you?

- **It is important to me that:**

Choosing Your Health Care Preferences

This section along with Part 2: My values and Beliefs describes your preferences to guide your doctors and health care agent to make medical decisions for you if you are unable to make your own health care decisions AND life sustaining interventions are needed to keep you alive. Choosing your Health Care Preferences might feel uncomfortable, but doing so while you are healthy gives you a voice for a time when you might not have one.

This document represents your health care preferences.

If you are unable to make your own health care decisions and life sustaining interventions are needed to keep you alive, you are asking your health care agent to represent your health care preferences as described below.

That decision will be made in partnership with your doctors and care team and they will consider your values and beliefs, your health care preferences, and your medical condition at the time decisions need to be made.

Note: By documenting your health care preferences in this directive, your health care agent and doctors can make decisions based on what you have written rather than guessing, assuming, or trying to remember. Discuss your preferences and your values and beliefs with your agent and doctors.

Life sustaining interventions include any medical procedures, devices or medication that will be used to keep you alive.

These interventions may or may not work, and they do not treat the underlying condition or cause of illness.

Life sustaining interventions include the following:

- **Cardiopulmonary resuscitation (CPR):** an attempt to restart the heart with chest compressions if your heart and breathing were to stop.
- **Ventilator:** a machine that breathes for you when your lungs are not working. A tube is inserted either through your mouth or an incision is made in your neck into your airway. The tube connects to the machine
- **Tube feeding:** also called artificial nutrition, is a medical treatment that provides liquid food (nutrition) to the body. This is done when a person cannot eat enough by mouth or they have problems swallowing.

- **Dialysis:** a machine that removes waste from your blood if your kidneys are not working.
- **Blood transfusions or use of blood products for treatments:** the process of transferring blood or blood products into your body through a narrow tube placed within a vein in your arm.

Now that you have learned about life sustaining interventions, consider the following (select as many abilities as you would like). Share your values and health care preferences with your agent. Talk about why your choices are important to you.

Make sure they will honor your wishes even if they might be different from their own.

Think about the following:

Ⓐ **I would decline or stop life sustaining interventions if I was not able to**

- **Make my own decisions**
- **Communicate meaningfully**
- **Recognize friends and family**
- **Feed myself without assistance or tube feeding**
- **Take care of my personal hygiene (bathing, dressing myself)**
- **Engage with the community**

Based on your answers above, consider the following as you choose your health care preferences below.

Example #1: Your health care agent is being asked to make medical decisions for you because a serious medical event, illness or injury has left you unable to make your own decisions and life sustaining interventions are needed to keep you alive. Life sustaining interventions include: CPR, ventilator, tube feeding, dialysis, blood transfusions or blood products etc.

Ⓑ **Example #2: You have advanced dementia or severe brain damage that is not expected to get better.** You are not able to function in a way that is acceptable to you

In the situation described, you may not have the ability to recognize yourself or your loved ones.

The doctors have told your agent and/or family that **you are not expected to recover these abilities. Choose which of the following statements is true for you based on your values and beliefs:**

- **I do not want any life-sustaining interventions.** I would either stop or not start life sustaining interventions
- **I would want life-sustaining intervention to start or continue,** as long as medically appropriate
- **I want a limited trial of life-sustaining interventions,** as long as medically appropriate. Typically, a trial is less than two weeks
- **My preferences for a trial period are because:**

_____

_____

_____

_____

_____

_____

_____

- **Example #3: You have a serious, progressing illness that is nearing its final stage that has left you unable** to function in a way that is acceptable to you. **Examples of a serious progressing illness may include heart, kidney, and lung disease.**

  Based on your values and beliefs:

  I do not want any life-sustaining interventions. I would either stop or not start life sustaining interventions

  I would want life-sustaining intervention to start or continue, as long as medically appropriate

  I want a limited trial of life-sustaining interventions, as long as medically appropriate. Typically, a trial is less than two weeks

- **My preferences for a trial period are because:**

Ⓓ Only answer if this is relevant to you.

If you want to add any additional health care preferences, or if you wish to limit any life sustaining interventions because of your cultural, religious, or personal beliefs, write these limitation(s) in the space on the form.

- **I want these interventions (or I do not want these interventions) because:**

Do you need another form?

If you currently have a serious, progressing illness that is nearing its final stage, please discuss completing a POLST (Physician's Orders for Life-Sustaining Treatment) document with your doctor or health care team.

After-Death Preferences

This section allows you to record your preferences for how you want your body to be treated after death and what your funeral, memorial or burial wishes may be. You can also document your preferences for organ donation. Recording your After-Death Preferences might feel difficult, but it will help your loved ones follow through on your wishes during an emotional time.

Documenting your preferences for what happens to you at death and after, will help the people closest to you honor what is most important to you.

Take some time to reflect on these statements and if it helps, you can refer back to **part 2: Your Values and Beliefs**

Remember: if you are struggling or don't have all the answers, document what you know and move forward.

❶ **If you are at the end of your life, what do you want your loved ones to know that you would like around you (for example rituals, spiritual support, people, music, food, pets, etc):**

My preferences are

❷ **After death, your preferences for how you want your body to be treated (funeral, memorial, burial, or any other religious or spiritual traditions) are listed below**

Please also include any prior arrangements (such as mortuary, cemetery, donation of your body to science) you may have made.

My preferences are

Preferences for organs, tissues, and/or body parts donation.

Choose one option for organ donation:

❸ Upon your death, do you want to donate your organs, tissues, and/or body parts

Yes No

By checking the box above, and regardless of your choice in **Part 3:**

Choosing your Health Care Preferences for End of Life, do you authorize your health care agent to consent to any temporary medical procedure necessary solely to evaluate and/or maintain your organs, tissues, and/or body parts for purposes of donation?

Choose as many option as applies:

I want to donate my organs, tissues, and/or body parts for the following purposes:

- **Transplant**
- **Therapy**
- **Research**
- **Education**

Do you want to restrict your donation, tissues, and/or body parts as indicated below:

I would like to restrict....

_____

_____

_____

_____

No

I'm not sure

If you leave this part blank, it is not a refusal to donate your organs, tissues, and/or body parts. Your state-authorized donor registration should be followed, or, if none, your legally recognized decision maker listed in Part 1 may take a donation upon your death. If no health agent is named, you acknowledge that California law permits an authorized individual to make such a decision on your behalf.

Next Steps

Now that you have completed your Advance Health Care Directive (AHCD) use this checklist to ensure that you follow up on these last few steps

- **Give copies of your AHCD**
  - To your **heart care agent** (decision maker), and alternate agent(s)
  - **Bring to your next scheduled medical appointment**
  - Keep **the original**
- **Discuss your AHCD**
  - **Talk to your health care agent (decision maker)** about your values, beliefs, and your health care preferences. Use your AHCD to guide the conversation and make sure they feel able to perform this role
  - **Be sure to let your loved ones, family, and/or close friends** know who you have chosen to be your health care agent and what your health care preferences are and why.
- **Take your AHCD with you**
  - If you go to a hospital or nursing home, take a copy of your AHCD and ask that it be placed in your medical record
- **Review your AHCD regularly**
  - **Decade-** when you start a new decade of your life
  - **Death-** whenever you experience the death of a loved one
  - **Divorce/marriage-** when you experience a divorce, marriage, or other major family change
  - **Diagnosis-** when you are diagnosed with a serious health condition
  - **Decline-** when you experience a significant decline or deterioration of an existing health condition, especially if you are unable to live on your own.

Remember: you can cancel or change ANY of your preferences in your AHCD at anytime. As things change in your life or with your health, you can change who your health care agent (decision maker) is and what your medical preferences are. You must do so in writing and sign the new document, or you can inform your health care provider in-person.

ABOUT JANET BREWER

Focused on estate planning, gift planning and probate law since 1991

Janet Brewer has practiced California estate, gift planning, and probate law exclusively since 1991. She is a California certified estate planning and probate specialist – one of fewer than 200 practicing in Santa Clara County and fewer than 2,000 practicing in California (out of almost 200,000 lawyers statewide).

Advanced tax strategies for high net worth estates

Ms. Brewer specializes in preparing wills and revocable living trusts, administering estates and trusts, probating estates, forming family limited partnerships and limited liability companies, and establishing a wide variety of tax-sensitive trusts – including children's trusts, charitable trusts, and irrevocable life insurance trusts. She also prepares estate tax returns for decedents whose estates have more than $5,000,000 of assets.

CREDENTIALS

Certified Specialist in Estate Planning and Probate Law
California State Bar Board of Legal Specialization

LLM – Tax
Masters of Laws in Taxation, Golden Gate University

MBA
MBA, Golden Gate University

JD
JD, University of Denver Law

California State Bar
Member, State Bar of California

Colorado Bar
Member, Colorado Bar Association

ABOUT JANET BREWER

Experience

Janet has served as an Instructor in the CFP (certified financial planner) program at UC – Santa Cruz and has taught estate planning for the UCSC Certified Financial Planner certificate program.

In September 2009, the California State Bar Board of Trustees selected her to serve a 3-year term as a member of the Executive Committee of the Solo and Small Firms Section of the State Bar. She was also elected to serve as a member of the Board of Trustees from 2014 - 2017.

Janet is also a member of STEP (the Society of Trust and Estate Practitioners), an invitation-only group of estate planning professionals who have special expertise in the area of international estate planning. She frequently prepares estate plans for foreign nationals who own property or live in the United States and for US citizens who own property abroad.

Prior to founding her estate-planning practice, Janet worked as a corporate attorney for a number of firms, including Corvus Systems, Hewlett-Packard, Hills Bros. Coffee, and Telebit Corporation.

She received her law degree from the University of Denver Law School and was admitted to the California Bar. She earned her MBA degree from Golden Gate University and received her Masters of Laws degree in Taxation (LLM - Tax) at GGU Law School in the summer of 2010.

HONORS & AWARDS

Avvo Rating: 10.0/10 - Superb

California State Bar Executive Committee, Solo and Small Firm Section

Society of Trust and Estate Practitioners

Northern California SuperLawyers since 2007

Founding Member, Wealth Counsel