State of California—Health and Human Services Agency
Department of Health Services

California Department of Health Services
SANDRA SHEWRY
Director

ARNOLD SCHWARZENEGGER
Governor

DATE: November 23, 2005

MMCD ALL Plan Letter 05010

TO: ALL MEDI-CAL MANAGED CARE HEALTH PLANS

SUBJECT: ADVANCE DIRECTIVE FORM

The purpose of this letter is to provide notification that the Medi-Cal Managed Care Division has approved the California Advance Directive Form (English and Spanish versions) for voluntary use by Medi-Cal Managed Care health plans. The document is a good source for general information and also contains several templates to assist members in developing their Advance Directives.

Health plans are required to implement and maintain written policies and procedures respecting Advance Directives in accordance with the requirements of 42 CFR 422.128 and 42 CFR 438.6(i). Therefore, if a plan elects to use the approved form, it should be incorporated into the plan's policies and procedures. Prior to making changes to the form, proposed revisions and modifications must be submitted to the plan's Contract Manager for review and approval.

Plans should follow the instructions in All Plan Letter 00003, Policy and Procedure Revisions, when requesting changes.

If you have any questions, please contact your Contract Manager.

Sincerely,

Vanessa M. Baird

Vanessa M. Baird, MPPA, Chief
Medi-Cal Managed Care Division

Enclosure

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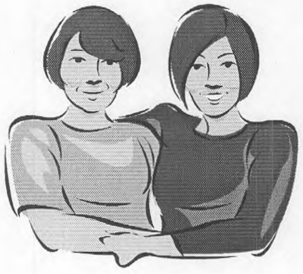
California Advance Health Care Directive

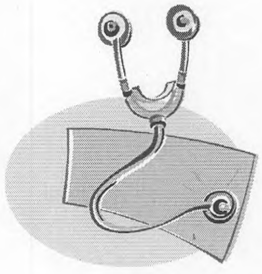
This form lets you have a say about how you want to be treated if you get very sick.



- **This form has 3 parts. It lets you:**

Part 1: Choose a health care agent.

A health care agent is a person who can make medical decisions for you if you are too sick to make them yourself.



Part 2: Make your own health care choices.

This form lets you choose the kind of health care you want.

This way, those who care for you will not have to guess what you want if you are too sick to tell them yourself.

Part 3: Sign the form.

It must be signed before it can be used.

You can fill out Part 1, Part 2, or both.
Fill out only the parts you want.
Always sign the form in Part 3.

Go to the next page

If you only want a health care agent go to **Part 1** on page 3.

If you only want to make your own health care choices go to **Part 2** on page 6.

If you want both then fill out **Part 1 and Part 2.**

Always sign the form in Part 3 on page 9.

What do I do with the form after I fill it out?

Share the form with those who care for you:

- doctors
- nurses
- social workers
- family
- friends

What if I change my mind?

- Change the form.
- Tell those that care for you about your changes

What if I have questions about the form?

- Bring it to your doctors, nurses, social workers, family or friends to answer your questions

What if I want to make health care choices that are not on this form?

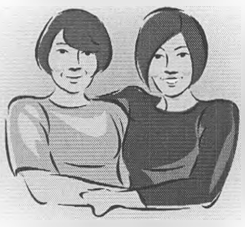
- Write your choices on a piece of paper
- Keep the paper with this form
- Share your choices with those who care for you

PART 1 Choose your health care agent

The person who can make medical decisions for you if you are too sick to make them yourself.

Whom should I choose to be my health care agent?

A family member or friend who:

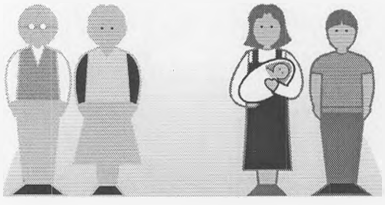


- is at least 18 years old
- knows you well
- can be there for you when you need them
- you trust to do what is best for you
- can tell your doctors about the decisions you made on this form

Your agent **cannot** be your doctor or someone who works at your hospital or clinic, unless they are a family member.

What will happen if I do not choose a health care agent?

If you are too sick to make your own decisions, your doctors will ask your closest family members to make decisions for you.

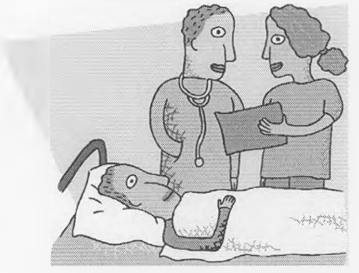


If you want your agent to be someone other than family, you must write his or her name on this form.

What kind of decisions can my health care agent make?

Agree to, say no to, change, stop or choose:

- doctors, nurses, social workers
- hospitals or clinics
- medications or tests
- what happens to your body and organs after you die



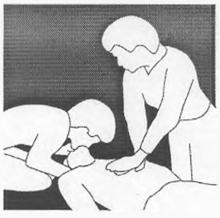
Go to the next page

Other decisions your agent can make:

Life support treatments - medical care to try to help you live longer

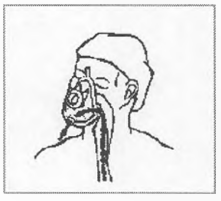
- **CPR or cardiopulmonary resuscitation**

cardio = heart pulmonary = lungs resuscitation = to bring back



This may involve:

- pressing hard on your chest to keep your blood pumping
- electrical shocks to jump start your heart
- medicines in your veins



- **Breathing machine or ventilator**

The machine pumps air into your lungs and breathes for you.

You are not able to talk when you are on the machine.

- **Dialysis**

A machine that cleans your blood if your kidneys stop working.

- **Feeding Tube**

A tube used to feed you if you cannot swallow. The tube is placed down your throat into your stomach. It can also be placed by surgery.

- **Blood transfusions**

To put blood in your veins.

- **Surgery**
- **Medicines**

End of life care - if you might die soon your health care agent can:

- call in a spiritual leader
- decide if you die at home or in the hospital

Show your health care agent this form.

Tell your agent what kind of medical care you want.

Go to the next page

Your Health Care Agent

I want this person to help make my medical decisions

first name _____ last name _____

street address _____ city _____ state _____ zip code _____

( ) – ( ) –

home phone number _____ work phone number _____

If the first person cannot do it, then I want this person to help make my medical decisions.

first name _____ last name _____

street address _____ city _____ state _____ zip code _____

( ) – ( ) –

home phone number _____ work phone number _____

Put an X next to the sentence you agree with.

- ☐ My health care agent can make decisions for me **now**.
- ☐ My health care agent will make decisions for me **only** after I cannot make my own decisions.

To make your own health care choices go to part 2 on the next page.

To sign this form go to part 3 on page 9.

PART 2 Make your own health care choices

Write down your choices so those who care for you will not have to guess.

- **Think about what makes your life worth living.**
  Put an X next to all the sentences you most agree with.

☐ **My life is only worth living if I can:**

- ○ talk to family or friends
- ○ wake up from a coma
- ○ feed, bathe, or take care of myself
- ○ be free from pain
- ○ live without being hooked up to machines
- ○ I am not sure

☐ **My life is always worth living no matter how sick I am**

- **If I am dying, it is important for me to be:**

☐ at home ☐ in the hospital ☐ I am not sure

- **Is religion or spirituality important to you?**

☐ yes ☐ no

- **What should your doctors know about your religion or spirituality?**

_____

_____

If you are sick, your doctors and nurses will always try to keep you comfortable and free from pain.

Go to the next page

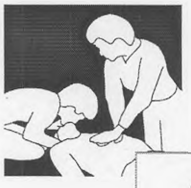
Life support treatments are used to try to keep you alive. These can be CPR, a breathing machine, feeding tubes, dialysis, blood transfusions, or medicine.

Put an X next to the sentences you most agree with.
Please read this whole page before you make your choices.

If I am so sick that I may die soon:

- ☐ Try all life support treatments that my doctors think might help.

  If the treatments **do not work** and there is little hope of getting better, **I want to stay** on life support machines.



- ☐ Try all life support treatments that my doctors think might help.

  If the treatments **do not work** and there is little hope of getting better, **I do not want to stay** on life support machines.

- ☐ Try all life support treatments that my doctors think might help **but not** these treatments. Mark what you do not want.

  - ○ CPR
  - ○ dialysis
  - ○ breathing machine
  - ○ other treatments_____
  - ○ feeding tube
  - ○ blood transfusion
  - ○ medicine

- ☐ I **do not want any** life support treatments.

- ☐ I want my **health care agent** to decide for me.

- ☐ I am not sure.

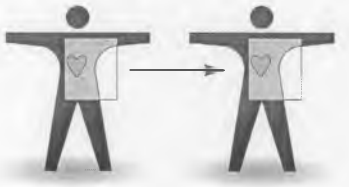
Go to the next page

Part 2: Make your own health care choices

Your doctors may ask about organ donation and autopsy after you die. Please tell us your wishes.

Put an X next to the sentences you most agree with

Donating (giving) your organs can help save lives.



- ☐ I **want** to donate my organs

  Which organs do you want to donate?

  - ○ any organs
  - ○ only_____

- ☐ I **do not** want to donate my organs.
- ☐ I want my **health care agent** to decide.
- ☐ I am not sure.

An autopsy can be done after death to find out why someone died. It is done by surgery. It can take a few days.

- ☐ I **want** an autopsy.
- ☐ I **do not** want an autopsy.
- ☐ I may want an autopsy if there are questions about my death.
- ☐ I want my **health care agent** to decide.
- ☐ I am not sure.

What should your doctors know about how you want your body to be treated after you die?

_____

_____

Go to Part 3 on the next page to sign this form

PART 3 Sign the form

Before this form can be used, you must:

- sign this form.
- have two witnesses sign the form.

If you do not have witnesses, you need a notary public.
A notary public's job is to make sure it is you signing the form.

Sign your name and write the date.

_____ / __ / __

sign your name date

print your first name print your last name

address city state zip code

Your witnesses must:

- be over 18 years of age.
- know you.
- see you sign this form.

Your witnesses cannot:

- be your health care agent, doctor, nurse, or social worker.
- benefit financially (get any money) after you die.
- work at the place that you live.
  (if you live in a nursing home, go to page 12)

Only one witness can be a family member.
The second witness must be someone other than family.

Witnesses need to sign their names on the next page.

If you do not have witnesses, take this form to a notary public and have them sign on page 10.

Have your witnesses sign their names and write the date

Witness #1

sign your name _____ / / _____ date

print your first name _____ print your last name _____

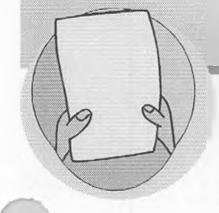
address _____ city _____ state _____ zip code _____

Witness #2

sign your name _____ / / _____ date

print your first name _____ print your last name _____

address _____ city _____ state _____ zip code _____



You are now done with this form.

Share this form with your doctors, nurses, social workers, friends, and your family.

Talk with them about your choices.

NOTARY PUBLIC

- Take this form to a notary public **ONLY** if two witnesses have not signed this form.
- Bring photo I.D. (driver's license, passport, etc.)

CERTIFICATE OF ACKNOWLEDGEMENT OF NOTARY PUBLIC

STATE OF CALIFORNIA

County of_____

On this_____day of_____in the year_____before me

_____

(print name of notary public)

personally appeared_____

(print name of person completing this form)

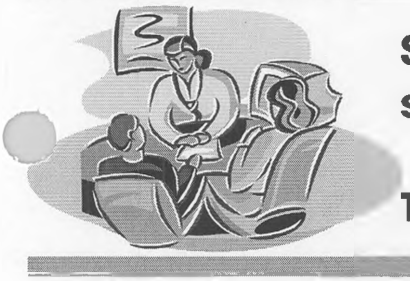
and has proved to me on the basis of satisfactory evidence, to be the person whose name is indicated on this advance health care directive, and has stated that he or she did complete this form. I declare under penalty of perjury, that the person, whose name is indicated in the advance health care directive, appears to be of sound mind and is under no duress, fraud, or undue influence.

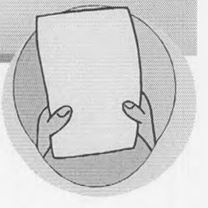
NOTARY SEAL

_____

(Signature) (Date)

You are now done with this form.





Share this form with your doctors, nurses, social workers, friends, and your family.

Talk with them about your choices.

For California Nursing Home Residents ONLY

- **Give this form to your nursing home director only if you live in a nursing home.**
- **California law requires nursing home residents to have the nursing home ombudsman as a witness of advance directives.**

STATEMENT OF THE 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."

_____ / /

sign your name date

_____

print your first name print your last name

_____

address city state zip code

Designed by Rebecca Sudore, MD & PM Creative for the San Francisco Department of Public Health