my care

Advance Directive: Understanding and honoring my future health care goals

Full name: ..... Birth date: .....

My Care, My Choices

You might be healthy now, but what if you became very sick or injured in the future and couldn't speak for yourself?

How would doctors, nurses, and your loved ones know what kind of health care you would like to receive?

In Santa Barbara County, your health care providers want to understand and honor your values and health care goals.

We encourage everyone in our community to do advance care planning.

Advance Care Planning

Advance care planning is a helpful way for people of all ages to prepare for the future. Both healthy people and people with health conditions do advance care planning.

Advance care planning is:

- Making decisions now about the types of health care you would and would not want to receive if you become very sick or injured and couldn't speak for yourself in the future
- Choosing a person you want to make health care decisions for you if you're unable to do so for yourself. This person is called a health care agent and agrees to follow your health care decisions
- Talking with your doctors and loved ones about the types of health care you want to receive so they'll respect and honor your values and health care goals
- Writing down your health care goals in MyCare, an advance directive. This form guides your health care providers as to what types of health care you want. It also helps your loved ones understand your wishes in case they have to make health care decisions for you

What is an Advance Directive?

An advance directive is a legal form for people 18 years and older to fill out that says:

- The types of medical care you would like to receive if you are very sick or injured and cannot speak for yourself
- The name and contact information of the person you chose to be your health care agent

MyCare is an advance directive used by people throughout Santa Barbara County. People can also use other legal types of advance directives too.

Where in the United States is MyCare a legal document?

MyCare is legal in 42 states and the District of Columbia. MyCare does not meet the legal requirements of the following states:

- Alabama
- Indiana
- Kansas
- New Hampshire
- Ohio
- Oregon
- Texas
- Utah

If you live in a state listed above, speak with your health care provider or an attorney to learn what legal form is required for your state.

Who should complete an advance directive?

We encourage everyone over age 18 to complete an advance directive. Your advance directive will help your medical team and loved ones understand and honor your health care goals if you have a medical emergency or are seriously ill and cannot speak for yourself.

When should you review and/or update your advance directive?

- When you renew your driver's license
- When you form a long-term relationship
- When you have a child
- When you have a high-risk job
- When you belong to the military
- When you retire
- When you sign up for Medicare
- When you have your annual physical
- When you have a health condition
- When you're close to the end of your life

Can you change your advance directive?

The best way to change your advance directive is by completing a new one so your health care goals are clear. Then you need to:

- Give new copies to your doctor, loved ones, and health care agent
- Destroy the old copies so your doctors, loved ones, and health care agents don't get confused

If you are seriously ill or injured and want to change your advance directive, but cannot complete an entire new document, it is recommended you:

- Sign an addendum designating changes **OR**
- Cross out the original choices, write in your new choices, initial the change, and re-sign and date it

Who is a health care agent?

A health care agent is the person you choose to make health care decisions for you if you're unable to speak for yourself.

- It's important you talk to your health care agent about the types of health care you would want and wouldn't want so your health care agent understands and agrees to honor your decisions
- If your decisions are not known, your health care agent will make decisions based on what he or she thinks is best for you

Other names for health care agent include health care proxy and medical decision maker. If you fill out a Durable Power of Attorney for Health Care (DPAHC) form with an attorney, the person is called an agent.

How many people can be your health care agent?

It is recommended that you choose only one person to be your first health care agent. This way decisions can be made quickly, and it helps avoid disagreements.

You can choose a second and third person to be your health care agent in case your first health care agent is unavailable.

When does your health care agent make decisions for you?

For most people, a health care agent only makes health care decisions for you if you're unable to speak for yourself.

Some people want their health care agent to make health care decisions for them even if they are able to decide or speak for themselves. If you'd like your health care agent to make decisions for you now, you can write that in your advance directive.

What types of decisions does a health care agent make for you?

- Choosing your doctors and where you'll receive care
- Speaking with your medical providers
- Deciding what tests, medicine, and surgery you could have
- Planning for your medical care in California or another state
- Reviewing and releasing your medical record
- Planning for your care in a nursing home or residential care facility
- Making arrangements if you die
- Deciding if you will be cremated
- Having an autopsy

Who can be your health care agent?

A family member, friend or someone who:

- Is 18 years or older
- Knows you well
- Agrees to accept this responsibility
- Can be trusted to honor your wishes and values
- Can make difficult decisions in stressful situations
- Can be calm and think clearly when talking with your medical providers, family, and friends
- Can be contacted easily by your medical providers

Who cannot be your health care agent?

- Your doctor
- Someone who works at the hospital, clinic, or facility where you receive medical care, unless he or she is a family member or domestic partner

Full name: Birth date:

MyCare: Advance Directive

MY INFORMATION AND HEALTH CARE AGENT

I, _____,
(FULL NAME)

make this document my advance directive. I revoke any prior Advance Health Care Directive, Power of Attorney for Health Care or Natural Death Act Declaration.

My full name (first, middle, last):

Date of birth:

Address:

City/State/Zip:

Home phone: Cell phone:

Work phone: Email:

My Health Care Agent

If I'm unable to make health care decisions for myself, the person I have chosen below to be my health care agent will make health care decisions for me:

Full name (first, middle, last):

Relationship to me:

Home phone: Cell phone:

Work phone: Email:

Address:

City/State/Zip:

REQUIRED – My Information and Health Care Agent

Full name:	Birth date:

If the first person I listed cannot make health care decisions for me, then the second person I want to be my health care agent and make health care decisions for me is:

Full name (first, middle, last):	
Relationship to me:	
Home phone:	Cell phone:
Work phone:	Email:
Address:	
City/State/Zip:	

If the first person and second person(s) cannot make health care decisions for me, then the third person I want to be my health care agent and make health care decisions for me is:

Full name (first, middle, last):	
Relationship to me:	
Home phone:	Cell phone:
Work phone:	Email:
Address:	
City/State/Zip:	

Full name: Birth date:

I WANT MY HEALTH CARE AGENT TO:

_____ Decide what tests, medicine, and surgery I have

_____ Choose my doctors and the locations where I'll receive care

_____ Speak with my health care providers

_____ Plan for my health care in California or another state

_____ Review and release my medical records

_____ Plan for my care in a nursing home or residential care facility

_____ Make decisions about organ/tissue or body donation after I die

_____ Make plans for my body after I die (including autopsy)

_____ Have my body cremated

INSTRUCTIONS:

If you **agree** with the statement, initial the authorization line.

OR

If you **do NOT agree** with the statement, cross it out and initial it.

Additional information about what my health care agent CAN and CANNOT do:

MY HEALTH CARE AGENT'S AUTHORITY TO MAKE DECISIONS FOR ME:

My health care agent's authority becomes effective when my physician determines that I am unable to make my own health care decisions unless I sign the line below.

My signature below signifies that I want my health care agent to make health care decisions for me starting now, even though I am able to make decisions for myself, ***except that my health care agent may not make a health care decision for me if I object to the decision.*** *I understand and authorize this statement as proved by my signature below:*

Signature:

Please provide any additional comments or restrictions here about your health care agent:

REQUIRED – My Information and Health Care Agent

Full name: Birth date:

My Health Care Instructions

If I am unable to communicate or make my own choices, this form states my directions.

A. CPR (CARDIOPULMONARY RESUSCITATION)

If your heartbeat and/or breathing stop, CPR can be done to try to revive you. CPR may include:

- Chest compressions (forceful pushing on the chest to make the heart beat again)
- Medicine
- Electrical shocks
- Breathing tube

You have a choice about whether you would like CPR. CPR can save lives, but it's important to know these facts:

- CPR works best if done within a few minutes on a healthy adult
- While CPR may restart the heart, it may not return even people who are otherwise healthy to how healthy they were before
- The success rate of CPR is low for people with illnesses that need hospital care
- If CPR is not started quickly, brain damage may happen because the brain doesn't have enough oxygen

When CPR is performed, it can cause:

- Broken ribs
- Punctured lungs

If your heart and breathing stop, what would you want?

Choose one by initialing in the space provided or leave it blank. If this section is left blank, CPR will always be attempted.

_____ I always want CPR attempted

_____ I never want CPR given to me. I want to be comfortable and die naturally.

_____ I want CPR unless the doctor treating me states any of the following:

- I have an incurable illness or injury and am likely to die soon OR
- I am not likely to return to a life worth living that I have talked about with my health care agent and/or medical team.

If you are certain you do not want CPR, please talk to your physician, nurse practitioner, or physician assistant about completing a Physician Order for Life-Sustaining Treatment or POLST form.

Full name: Birth date:

B. LIFE SUSTAINING TREATMENTS TO KEEP YOU ALIVE LONGER

To help you explain your health care decisions to your health care providers, health care agent, and loved ones, it's important to think about what types of life sustaining treatments you would want and wouldn't want if you had a sudden, unexpected medical event that makes you very sick or injured and unable to speak for yourself.

For example:
You have a sudden, unexpected medical event, such as a heart attack, stroke, accident, aneurysm or near-drowning . Doctors find you have a brain injury. You do not know who you are or your loved ones. The doctors tell your health care agent and/or loved ones they do not think you will recover. Life-sustaining treatments are necessary to keep you alive.

Life sustaining treatments could include:

- **Ventilator:** a machine that breathes for you when your lungs aren't working. A tube is inserted either through your mouth or an incision in your neck into your airway. The tube connects to the machine. This tube may feel uncomfortable, and the nurses may give you medicine to help you. You cannot talk or eat normally when a breathing tube is in place
- **Feeding tube:** a plastic tube that is put inside your nose or into your stomach through a small incision. This plastic tube gives you food and water
- **Dialysis machine:** a machine that removes waste from your blood if your kidneys aren't working

If you had a sudden, unexpected medical event and life sustaining treatment is needed to keep you alive, what do you want?

I would want to be kept comfortable AND (choose one by initialing on the line provided):

_____ I do not want life sustaining treatment. If it has been started, I want it stopped. I want to die naturally.

_____ I want to continue life sustaining treatment only for the purpose of organ or tissue donation

_____ I want to continue life sustaining treatment

If you have other instructions about life sustaining treatments, you can provide them here:

Full name: Birth date:

C. ORGAN DONATION

Becoming an organ and tissue donor when you die can save lives and improve quality of life for other people. There are no age limits on who can donate. Below are some choices to think about.

When I die (choose one by initialing in the space provided):

_____ I want to donate any needed organs or tissues.

_____ I want to donate only these organs or tissues:

_____ I do not want to donate any of my organs or tissues, and I do not want my health care agent to choose donation for me.

_____ I want to donate my whole body to research. I understand it is best to make plans with an organization or agency beforehand.

I have made plans with:

Organization/Institution Name:

Phone:

Full name: Birth date:

Making this Document Legal

To make your advance directive legal, you must complete the following two steps:

Step 1:

You must sign and date this form. You need two adult witnesses present when you sign it or who will confirm it is your signature. Instead of two adult witnesses, you could have a notary public sign it.

My name printed:

My Signature:

Date:

Step 2:

Have two adult witnesses sign the form who you know personally or who can confirm your identity.

OR

Have it notarized by a notary public. ***If you want to use a notary public, wait until the notary public is present to sign it.***

Full name: Birth date:

Statement of Witnesses

I confirm the following are true:

- I know this person, or this person can prove to me who he/she is
- I am 18 years or older
- I am not his or her health care agent
- I am not his or her health care provider
- I do not work for his or her health care provider
- If he or she lives in a nursing home, I do not work there

One witness must also promise that:

- I am not related to this person by blood, marriage or adoption
- I will not receive money or property after he or she dies

WITNESS # 1:

Print full name:

Address:

Phone:

Signature:

Date:

WITNESS # 2:

Print full name:

Address:

Phone:

Signature:

Date:

Full name: Birth date:

Notary Public

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 Santa Barbara

On _____ before me, (here insert name and title of the officer), personally appeared_____
_____
_____
_____ ,
who proved to me on the basis of satisfactory evidence to be the person(s) whose name(s) 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 signature on the instrument the person, or the entity upon behalf of which theand 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 Public Signature Notary Public Seal

Special Witness Requirement

This section is required only for patients in a Skilled Nursing Facility. If you are a patient in a Skilled Nursing Facility, the patient advocate or ombudsman must sign the statement below.

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:

Print full name:

Address:

Date:

Full name: Birth date:

My Values

This section is recommended. You can attach more pages if necessary.

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

I'd like to tell you some things about myself such as:

- How I like to spend my time
- Who I like to spend time with
- What I like to do in my life
- What would make my life no longer worth living

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

2. What matters most to me in my life is (people, hobbies, independence, mobility, etc):

3. My life would no longer be worth living if I could not:

Full name: Birth Date:

My Wishes and Preferences

This section is recommended. You can attach more pages if necessary.

1. If I am close to dying, I want my loved ones to know that I would like these types of comfort and support listed below (people, prayers, readings, rituals, music, etc):

2. I would prefer to die in the following place:
   - ○ hospital
   - ○ skilled nursing facility
   - ○ hospice
   - ○ home
   - ○ other: _____

3. Religious or spiritual beliefs:

   My faith/spiritual tradition:

   My faith/spiritual community:

   Address:

   Phone:

   I would like my faith/spiritual community contacted if I am very sick, injured or dying.
   ○ YES ○ NO

   Additional Notes:

Full name: Birth date:

4. After my death, I would like to be:
   - ○ cremated
   - ○ buried
   - ○ I don't have a preference
   - ○ I have already made the following plan:

5. In my memorial service, I would like to include the following (people, music, rituals, readings, etc):

6. Other wishes/instructions:

Next Steps

Now that you have completed your advance directive, take these next steps:

1. **Makes copies of your advance directive.** Keep the original for yourself in a place you can easily find it.
2. **Mail, email, fax or deliver copies to Cottage Health, Sansum Clinic, or any other health care providers you may have.** If you haven't been an inpatient at Cottage Health before, the hospital will begin a new medical record for you.

Cottage Health mailing address:
Advance Care Planning Services
Cottage Health
P.O. Box 689
400 W. Pueblo Street
Santa Barbara, CA 93102

Delivery location:
Front lobby of any Cottage Health Hospital

- Santa Barbara Cottage Hospital, 400 W. Pueblo Street, Santa Barbara
- Goleta Valley Cottage Hospital, 351 S. Patterson Ave, Goleta
- Santa Ynez Valley Cottage Hospital, 2050 Viborg Rd, Solvang

Email: MyCare@sbch.org

Fax: 805.569.8364

To confirm your advance directive is in your medical record, call Cottage Medical Records at: 805.324.7306.

Sansum Clinic mailing address:
Sansum Clinic
Health Information Services
ROI Department
89 South Patterson Avenue
Santa Barbara, CA 93111

Delivery location:
Front lobby of any Sansum Clinic

Email: LGutierrez@sansumclinic.org

Fax: 805.692.4699

To confirm your advance directive is in your medical record, call: 805.692.6435.

2. **Have the conversation:**
   - Talk about your health care decisions with all of your health care agents so they understand and agree to this important job
   - Share your wishes with any family or close friends who might be involved if you are very sick or injured. When they understand your health care decisions, it can make a difficult situation easier for them
   - Speak with your doctor(s) so he or she knows what type of health care you want to receive

4. **Give copies to:**
   - Your health care agent(s)
   - Your family and close friends
   - Your primary care physician and any specialists you see
   - Your attorney

5. **Take a copy with you when:**
   - You will be away for a long time, such as taking a trip, studying abroad, or being deployed overseas
   - You go to a hospital, skilled nursing facility, or rehabilitation center. Have your advance directive put into your medical record at that location.

6. **Review it regularly to make sure it's current. Helpful times include:**
   - Your annual physical
   - When your health changes
   - When you have a new health care provider
   - When you marry, divorce, or end a relationship

7. **Change your advance directive anytime:**
   - Talk with your doctor about changes
   - Mail, email, or fax an updated copy to Cottage Health, Sansum Clinic, and other health care providers
   - Give updated copies and explain the changes to your health care agent(s), family, and close friends
   - If you have an attorney, provide him or her with an updated copy
   - Destroy your old advance directive and any copies so no one gets confused

My Checklist

Copies of this document have been given to:

- ☐ **MY FIRST HEALTH CARE AGENT:**
  - Full name:
  - Phone:
- ☐ **MY SECOND HEALTH CARE AGENT:**
  - Full name:
  - Phone:
- ☐ **MY THIRD HEALTH CARE AGENT:**
  - Full name:
  - Phone:
- ☐ **HEALTH CARE PROVIDER/CLINIC:**
  - Name:
  - Phone:

OTHERS:

- ☐ Hospital:
  - Phone:
- ☐ Attorney:
  - Phone:
- ☐ Name:
  - Phone:
- ☐ Name:
  - Phone:

If you have questions about MyCare, please contact
Cottage Health's Advance Care Planning Program at:
805.324.9102 or email: **MyCare @sbch.org**

Cottage Health
GOLETA VALLEY | SANTA BARBARA | SANTA YNEZ VALLEY

Alliance
for living and dying well
Your Life | Your Decisions | Our Support

sansum CLINIC

Ridley-Tree Cancer Center

hospice
OF SANTA BARBARA, INC.
A Volunteer Hospice Organization

Visiting Nurse & Hospice Care
THERE WHEN YOU NEED US MOST

This advance directive is in compliance with the California Probate Code 4671-4675.

This information is not intended to diagnose health problems or to take the place of medical advice or care you receive from your physician or other health care professional. If you have persistent health problems, or if you have additional questions, please consult with your doctor.