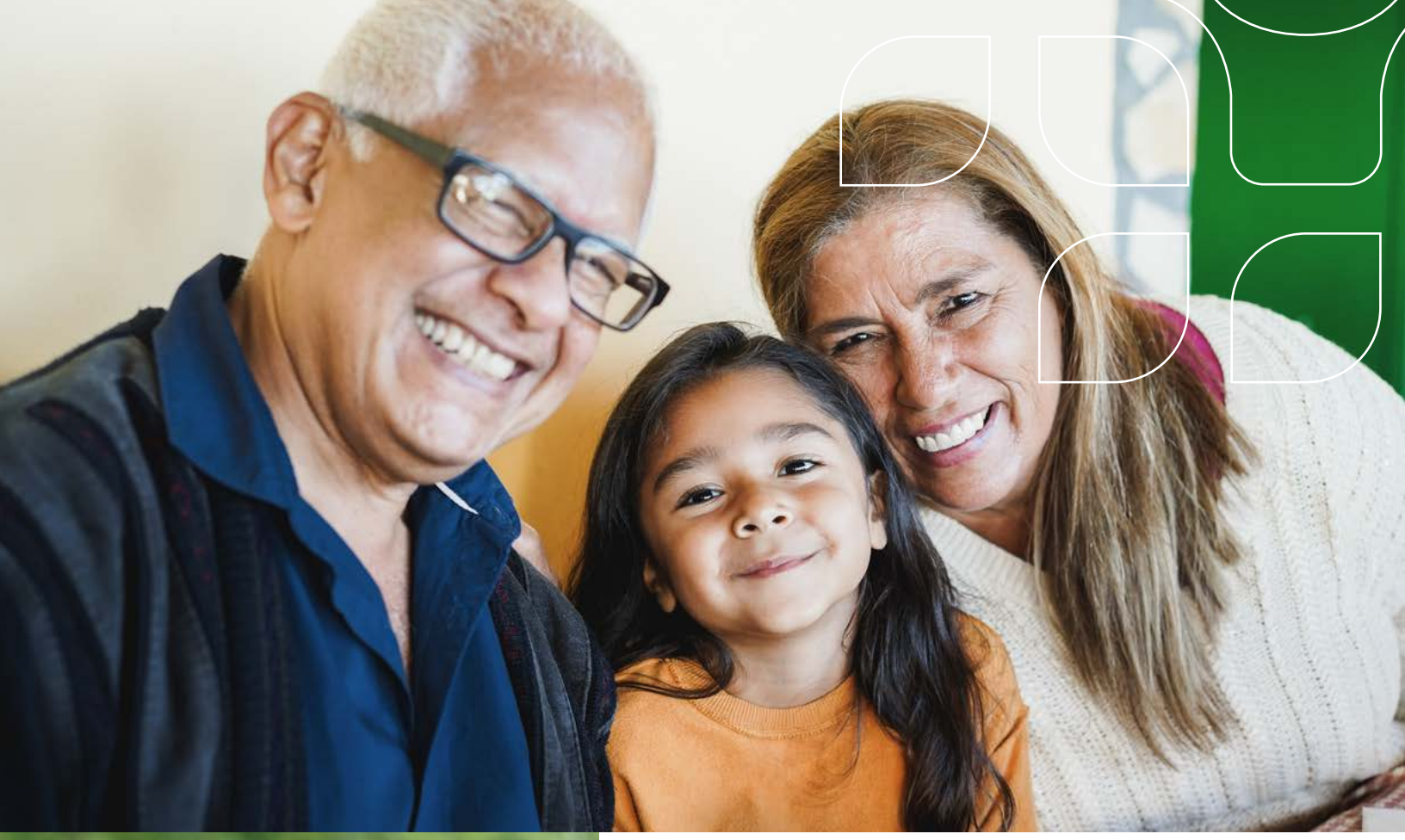
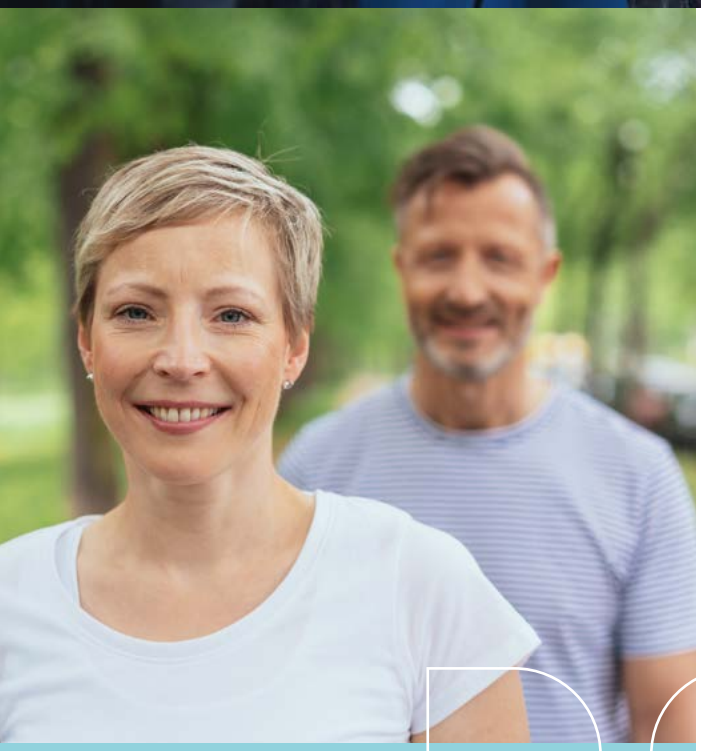
# MyCare

**Advance Directive:** Understanding and honoring my future health care goals

Full name: _____

Birth date: _____





# My health care goals

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

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

Your health care providers want to understand and honor your values and health care goals.

We encourage everyone 18 years and older to do advance care planning.

### Pages 1-5

Information about advance care planning, advance directives, and health care agents

### Pages 6-8 LEGALLY REQUIRED

Pages to fill out that state your information, your health care agent information and what you want your health care agent to do

### Pages 9-11 LEGALLY REQUIRED

Pages to fill out that state your health care instructions to your loved ones, health care agent(s) and health care providers

### Pages 12-14 LEGALLY REQUIRED

Pages to fill out with signatures required to make your advance directive legal

### Page 15

Your values and what is important to you in your life (OPTIONAL)

### Page 16-17

Your wishes and preferences which can be helpful to guide your health care agent in making decisions (OPTIONAL)

### Page 18

Instructions on what to do with your completed advance directive

# What is advance care planning?

Advance care planning is a helpful way for people who are 18 years or older to prepare for the future. Both healthy people and people with health conditions do advance care planning. Advance care planning includes completing a legal form called an advance directive that states:

- The name of the person you want to make health care decisions for you if you're unable to do so for yourself
- The types of health care you want to receive if you are seriously ill or injured and unable to speak for yourself

People who live in California can use a variety of different types of legal advance directives, including MyCare.

# Frequently asked questions

## 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.

*If you are only traveling in a state listed above, you can still use a California advance directive, such as MyCare.*

## Who should complete an advance directive?

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

## Can you change your advance directive?

Yes. You can complete a new advance directive anytime.

You are legally required to complete a new advance directive if you are changing your health care agent choices.

After completing a new advance directive, you need to:

- Give new copies to your loved ones, health care agent(s) and health care providers
- Destroy old copies so your loved ones, health care agent(s) and health care providers don't get confused

If you are seriously ill or injured and are unable to complete an entire new document, but want to make changes to your choices for CPR, life-sustaining treatment, and/or organ donation, it is recommended you:

- Sign an addendum designating changes

  OR
- Cross out original choices for CPR, life-sustaining treatment, and/or organ donation, write in your new choices, initial the change, and re-sign and date the form

## 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 are diagnosed with a health condition or have a change in your current health condition
- When you move to a care facility
- When you're close to the end of your life

# 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 they think is best for you

## 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 or second 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 begin making decisions for you now, you can do so by signing Page 8 of your MyCare document.

## What responsibilities does your health care agent have?

- Speaking with your health care providers
- Choosing your health care providers and where you'll receive care
- Deciding what tests, medicine and surgery you will have in collaboration with your health care team
- Planning for your health care in California or another state
- Reviewing and releasing your medical records
- 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 health care providers, family, and friends
- Can be contacted easily by your health care providers

## Who cannot be your health care agent?

- Your doctor
- Anyone providing or supervising health care to you

| Full name | Birth date |
|---|---|

# MyCare: Advance Directive



## My Information

I, _____ ,

(Full Name: First, Middle, Last)

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.

Date of birth:_____

Address: _____

City/State/Zip:_____

_____

Home phone Cell phone

_____

Work phone Email

## My First Health Care Agent

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

Full name (first, middle, last): _____

Relationship to me: _____

Date of birth:_____

Address: _____

City/State/Zip:_____

_____

Home phone Cell phone

_____

Work phone Email

| Full name | Birth date |
|---|---|
| | |

## My Second Health Care Agent

**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: _____

Date of birth:_____

Address: _____

City/State/Zip:_____

_____

Home phone Cell phone

_____

Work phone Email

## My Third Health Care Agent

**If the first and second person I listed 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: _____

Date of birth:_____

Address: _____

City/State/Zip:_____

_____

Home phone Cell phone

_____

Work phone Email

| Full name | Birth date |
|---|---|
| | |

## I want my health care agent to

| *Instructions: Write your initials in the Yes or No columns to state what you want your health care agent to do or not do* | **Yes** | **No** |
|---|---|---|
| 1. Speak with my health care providers | | |
| 2. Choose my health care providers and locations where I'll receive care | | |
| 3. Decide what tests, medicine and surgery I will have in collaboration with my health care team | | |
| 4. Plan for my health care in California or another state | | |
| 5. Review and release my medical records | | |
| 6. Plan for my care in a rehabilitation facility or residential care facility | | |
| 7. Follow my decisions about organ, tissue or body donation after I die | | |
| 8. Make plans for my body after I die (including autopsy) | | |
| 9. Have my body cremated | | |

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

_____

_____

## When my health care agent's authority to make decisions for me becomes effective:

**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 following statement:**

*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:*

If you want your health care agent to begin making decisions for you NOW, please sign the line below in ink. Electronic signatures will not be legally valid.

Signature: _____

| Full name | Birth date |
|---|---|

# Cardiopulmonary Resuscitation/CPR

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.**

1. _____ I ALWAYS want CPR attempted.
2. _____ I never want CPR given to me. I want to be comfortable and die naturally.
3. _____ 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.

If you have other instructions about CPR, you can provide them here:

_____

_____

_____

| Full name | Birth date |
|---|---|

# 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 <u>one</u> by initialing on the line provided):**

1. _____ I do not want life sustaining treatment. If it has been started, I want it stopped. I want to die naturally.
2. _____ I want life sustaining treatment only for the purpose of organ or tissue donation.
3. _____ 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 |
|---|---|
| | |

# 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 <u>one</u> by initialing in the space provided):

1. _____ I want to donate any needed organs or tissues.
2. _____ I want to donate only these organs or tissues:

   _____

   _____

   _____
3. _____ 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.
4. _____ 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

**You have two options to legally complete your advance directive.**

## Option 1

**Sign and date your form.** You also need two adult witnesses to sign the form who know you personally or can confirm your identity. If you are having two adult witnesses sign the form, you can sign below now.

## Option 2

**Have it notarized by a notary public.** If you want to use a notary public, **you must wait to sign the document until the notary public is with you and directs you to sign below.**

Please print and sign the completed document in ink.
Electronic signatures will not be legally valid.

My name printed: _____

My Signature: _____

Date: _____

| Full name | Birth date |
|---|---|
| | |

# Statement of Witnesses

**I declare under penalty of perjury under California law:**

- I know this person OR this person proved to me by convincing evidence who they are
- I am 18 years or older
- This person signed or acknowledged the advance directive in front of me
- This person has the ability to make decisions for themselves
- I am not this person's health care agent
- I am not this person's health care provider, and I do not work for the person's health care provider
- If this person lives in a residential care facility or a community care facility, I do not work there

## Witness 1:

Print full name: _____

Address: _____

Please print out the document and sign in ink. Electronic signatures are not legally valid.

Signature:_____ Date: _____

## Witness 2:

Print full name: _____

Address: _____

Please print out the document and sign in ink. Electronic signatures are not legally valid.

Signature:_____ Date: _____

## Additional Statement of One Witness from Above

**I declare under penalty of perjury under California law:**

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

Please print out the document and sign in ink. Electronic signatures are not legally valid.

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, _____, Notary Public, personally appeared _____, 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 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.

_____
NOTARY PUBLIC

## 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: _____

# 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:

_____

_____

_____

_____

# 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:

   _____ Home

   _____ Hospice

   _____ Skilled nursing facility

   _____ Hospital

   _____ 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: _____

   _____

   _____

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 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 Program
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

To confirm your advance directive is in your medical record, call Health Information Management at: 805-569-7306.

**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

To confirm your advance directive is in your medical record, call: 805-692-6435.

3. **Give copies to:**
   - Your health care agent(s)
   - Your family and close friends
   - Your primary care physician and any specialists you see
   - Your attorney
4. **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
5. **Change your advance directive anytime:**
   - Talk with your doctor about changes
   - Mail, email or deliver 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 your attorney with an updated copy
   - Destroy your old advance directive and any copies so no one gets confused

**To fill out a MyCare online, please visit: mycare.cottagehealth.org**
Please print out the document and sign the form in ink. Electronic signatures are not legally valid.

If you have questions about MyCare, please contact Cottage Health's Advance Care Planning Program at:
**805-324-9102** or email: **MyCare@sbch.org**

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.

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