Triage Health Estate Planning Toolkit: California

Part II: Understanding Estate Planning Documents in Your State

State Laws About Wills

A will is a legal document that provides instructions for what you would like to have happen to your property upon death. A will is also a place where parents can name a guardian for any minor children or adult children with developmental disabilities.

California probate courts accept written, statutory, and holographic wills. To make a valid written will in California:

1. You need to be in the right state of mind to create a will. This means you need to be:
    - At least 18 years old
    - Of "sound mind" (meaning you know what you're doing)
2. You need to sign the will, in front of two witnesses who have watched you sign (or the person your authorized to sign) the will, and understand what they are signing.
3. You might also want to make your will "self-proving," or accepted in probate court without the court needing to contact your witnesses. To do this, ask your witnesses to sign a statement that it was your intention to make the will and you did so without undue or coercive influence.

The California state legislature created the statutory will form to make this process easier. With this free will form, you can execute your will by filling in the blanks and signing it in front of two witnesses (who meet the same requirements for a written will).

The benefits of this statutory will are that it is free to complete, and you can complete them on your own, without hiring an attorney. However, statutory wills cannot be customized. Therefore, they are best for very simple estates. Part III of this toolkit includes the statutory will form.

A holographic will is one that is handwritten by you. To make a valid holographic will in California:

1. You need to be in the right state of mind to create a will. This means you need to be:
    - At least 18 years old
    - Of "sound mind" (meaning you know what you're doing)
2. Your will must be written in your handwriting and you must sign it.

If you make a holographic will, it does not need to be signed by witnesses. However, most estate planning experts do not recommend relying on holographic wills because it is more difficult to prove their validity in probate court.

State Laws About Financial Powers of Attorney

A power of attorney for financial affairs is a legal document where you (the principal) name a trusted adult (the agent) who is authorized to make financial decisions on your behalf.

California's power of attorney statutory form allows you to appoint someone to manage your finances, including assets like your property, taxes, and government benefits. You can also appoint a successor agent, and a second

successor agent, in case the first person you choose cannot be your agent. This person can make all financial decisions for you, or you can limit their powers to specific areas, like filing taxes or banking. Unless you indicate otherwise in the "special instructions" section, this document goes into effect when you sign it and your signature is notarized or it is signed by two witnesses. After that point, this document will remain in effect until you die, unless you revoke your power of attorney.

You can also create a financial power of attorney that does not go into effect until certain conditions are met (e.g., you become incapacitated).

Part III of this toolkit includes a sample form.

State Laws About Advance Directives for Health Care

An advance health care directive (AHCD) is a legal document you can use to provide written instructions, or state preferences, about your medical care in case you become unable to communicate. In California, this document contains five parts:

1. **Power of Attorney for Health Care.** You can use this form to appoint someone (an agent) to make decisions about your medical care for you, if you become unable. You can also choose an alternate person if the first person you appoint is not available. This document takes effect when your primary physician determines you can no longer understand or communicate your preferences for health care. If you are still able to make these decisions, but would like someone else to make them for you, you can indicate that on this form. Unless they are related to you, are your registered domestic partner, or a co-worker, your agent cannot be the operator or an employee of a community care or residential care facility where you are receiving care.
2. **Instructions for Health Care:** Sometimes called a "living will," this document lets you indicate your preferences for health care if you become unable to speak for yourself, and can also limit the instructions to specific circumstances.
3. **Anatomical Gift at Death:** Here you can indicate whether or not you would like to make an organ or tissue donation. Completing this section is optional.
4. **Primary Physician:** You can use this form to designate a physician you would like to be primarily responsible for your health care. Completing this section is optional.
5. **Signature and Witnessing Provisions:** In this section you sign and date the AHCD in front of two qualified witnesses or a notary.

Your witnesses must be at least 18 years old, and may not be:

- Your agent (if you have appointed one)
- Your health care provider or an employee of your provider
- The operator or an employee of a community care facility
- The operator or employee of a residential care facility for the elderly

One of your witnesses must not be related to you by blood, marriage, or adoption, or be entitled to any of your estate.

If you are executing your advance health care directive while a patient at a skilled nursing facility, one of your witnesses must be a patient advocate.

If you change your mind about who you would like to be your agent, you can change this person by telling your supervising health care provider or writing a letter expressing that you would like to revoke their appointment.

If you appoint your spouse as your agent, this will be automatically revoked if your marriage dissolves.

You can indicate that you would like to change any other instruction included in your AHCD at any time, in any way. You can simply tell your physician you would like to revoke or change your AHCD, do so in writing, or just tear up the directive.

State Laws About Conservatorships

If you do not have an advance healthcare directive and/or a financial power of attorney in place and you become incapacitated, a judge may appoint another person to act or make decisions for you, called a conservator. There are two types of conservatorships:

- **General conservatorship:** A general conservatorship is when the conservator has all powers and responsibilities except for ones found unnecessary.
- **Limited conservatorship:** A limited conservatorship is when the conservator's powers are strictly limited to up to 7 specific powers based on the needs of the conservatee. These powers are:
    1. Fix the conservatee's residence or specific dwelling
    2. Access the conservatee's confidential records and papers.
    3. Consent or withhold consent to the conservatee to marry
    4. Exercise the conservatee's right to enter into a contract
    5. Give or withhold medical consent on behalf of the conservatee
    6. Exercise or limit the conservatee's right to control social and sexual contacts and relationships
    7. Make decisions about the conservatee's education

To appoint a conservator, you must be able to show a judge that it is necessary to promote and protect the well-being of the conservatee. A judge can only appoint a conservator if other less restrictive options would not work.

Supported Decision-Making (SDM) is a less restrictive alternative to a conservatorship that does not require court involvement. SDM allows people with disabilities to retain the decision-making capacity by choosing supporters to help them make decisions. Supporters may include friends, family members, and professionals, and an individual typically has more than one supporter. Supporters must agree to help the individual understand, consider, and communicate decisions. The individual with a disability and their supporters should sign a formal document where they all agree to take part in SDM. Formalizing SDM with a signed document can help an individual with a disability have their decisions respected by others such as doctors, nurses, and lawyers.

State Laws About POLST/MOLST

A physician order for life-sustaining treatment (POLST) is a medical order completed by a seriously ill person and signed by a physician. The POLST does not replace an advance health care directive. You complete a POLST form with your doctor. In California, this form lets you indicate your preferences for:

- Cardiopulmonary resuscitation orders (also known as a "Do not resuscitate," or DNR order)
- Medical Interventions, ranging from all medical and surgical treatments available to prolong your life, selective treatments to restore your health while avoiding burdensome procedures, or comfort-focused treatments to manage symptoms and allow natural death
- Medically assisted nutrition, or food offered through surgically-placed tubes
- Additional orders or instructions for your care

You may revoke the POLST at any time in any way that shows you don't want it to continue to have effect. This form will not expire, so it is important for you and your physician to review it regularly to make sure it still reflects your wishes.

State Laws About Funeral Designation Forms

Funeral designation forms allow you to tell your loved ones what you would like to happen to your remains after you pass away. These forms can be used to choose someone to control what happens to your remains after your death, specify what you would like to have happen, and other wishes depending on your state.

California does not have a funeral designation form. They do have a Declaration for Disposition of Cremated Remains, which can be filled out by you to indicate that you will be cremated, and how your ashes will be handled.

State Laws About Death with Dignity

"Death with Dignity" laws, or physician-assisted dying/aid-in-dying laws, allow certain terminally ill people to voluntarily and legally request and receive a prescription medication from their physician to hasten their death in a peaceful, humane, and dignified way. By adding a voluntary option to the continuum of end-of-life care, these laws can give you dignity, control, and peace of mind during your final days with family and loved ones.

California's End of Life Option Act took effect in 2016, allowing adults with terminal illnesses to voluntarily request medication that would hasten death from their physicians. Qualified patients must:

- Be 18 years or older
- Be a California resident
- Be diagnosed with an incurable terminal illness with a prognosis of less than six months to live
- Be able to make medical decisions for yourself
- Be able to take (eat, drink, swallow, or inject) the aid-in-dying medication by yourself

If you would like to request aid-in-dying medication, start by talking to your physician. Your conversation could include discussing alternative and additional therapies (like comfort care or pain management), ways to involve loved ones, and the effects and process of taking an aid-in-dying medication. After this conversation, you must:

- Verbally ask for the medication twice, at least 48 hours apart.
- Submit a written request for the medication using the required form and have your request signed by two witnesses. This request should come after your second verbal request.
- After receiving all three requests, your doctor will refer you to another doctor to verify your diagnosis and prognosis.

Once you receive your aid-in-dying medication, you can choose where you administer it. However, this cannot be done in a public place.

As of January 1, 2022, if your doctor refuses to administer an aid-in-dying medication, they must inform you, document your request and their rejection, and transfer your record.

As of January 1, 2022, health care entities will need to post their current policy regarding aid-in-dying on their website.

Taking aid-in-dying medications will not affect your life insurance policy, if you have one. If you pass away after taking an aid-in-dying medication, your death certificate will indicate that you died naturally from an underlying illness.

Federal Law About HIPAA

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) is a federal law that protects the privacy of your health information. HIPAA does allow your protected health information to a be shared with your personal representative who has authority to make health care decisions for you (i.e., your health care agent or proxy).

To guarantee your agent's access to information, a HIPAA authorization form should be signed and dated by you. Also, it must identify the information to be disclosed, the purpose of the disclosure, the recipients of the information, and an expiration date. This means that any advance health care directives should be clear about the scope of your agent's authority to receive protected health care information.

You can revoke a HIPAA authorization form at any time by notifying your health care provider in writing.

Part III of this toolkit includes a sample HIPAA authorization form. For more information: www.cdc.gov/phlp/publications/topic/hipaa.html.

Triage Health Estate Planning Toolkit: California

Part III: Your State's Estate Planning Forms

- Statutory Will Form
- Power of Attorney for Financial Affairs
- Advanced Health Care Directive
- Physician Order for Life-Sustaining Treatment (POLST)
- Declaration for Disposition of Cremated Remains
- HIPAA Authorization Form

Triage Health Estate Planning Toolkit

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Part III: Your State's Estate Planning Forms

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Statutory Will

QUESTIONS AND ANSWERS ABOUT THIS CALIFORNIA STATUTORY WILL

The following information, in question and answer form, is not a part of the California Statutory Will. It is designed to help you understand about Wills and to decide if this Will meets your needs. This Will is in a simple form. The complete text of each paragraph of this Will is printed at the end of the Will.

1. *What happens if I die without a Will?* If you die without a Will, what you own (your "assets") in your name alone will be divided among your spouse, domestic partner, children, or other relatives according to state law. The court will appoint a relative to collect and distribute your assets.

2. *What can a Will do for me?* In a Will you may designate who will receive your assets at your death. You may designate someone (called an "executor") to appear before the court, collect your assets, pay your debts and taxes, and distribute your assets as you specify. You may nominate someone (called a "guardian") to raise your children who are under age 18. You may designate someone (called a "custodian") to manage assets for your children until they reach any age from 18 to 25.

3. *Does a Will avoid probate?* No. With or without a Will, assets in your name alone usually go through the court probate process. The court's first job is to determine if your Will is valid.

4. *What is community property?* Can I give away my share in my Will? If you are married and you or your spouse earned money during your marriage from work and wages, that money (and the assets bought with it) is community property. Your Will can only give away your one-half of community property. Your Will cannot give away your spouse's one-half of community property.

5. *Does my Will give away all of my assets?* Do all assets go through probate? No. Money in a joint tenancy bank account automatically belongs to the other named owner without probate. If your spouse, domestic partner, or child is on the deed to your house as a joint tenant, the house automatically passes to him or her. Life insurance and retirement plan benefits may pass directly to the named beneficiary. A Will does not necessarily control how these types of "nonprobate" assets pass at your death.

6. *Are there different kinds of Wills?* Yes. There are handwritten Wills, typewritten Wills, attorney-prepared Wills, and statutory Wills. All are valid if done precisely as the law requires. You should see a lawyer if you do not want to use this Statutory Will or if you do not understand this form.

7. *Who may use this Will?* This Will is based on California law. It is designed only for California residents. You may use this form if you are single, married, a member of a domestic partnership, or divorced. You must be age 18 or older and of sound mind.

8. *Are there any reasons why I should NOT use this Statutory Will?* Yes. This is a simple Will. It is not designed to reduce death taxes or other taxes. Talk to a lawyer to do tax planning, especially if (i) your assets will be worth more than $600,000 or the current amount excluded from estate tax under federal law at your death, (ii) you own business-related assets, (iii) you want to create a trust fund for your children's education or other purposes, (iv) you own assets in some other state, (v) you want to disinherit your spouse, domestic partner, or descendants, or (vi) you have valuable interests in pension or profit-sharing plans. You should talk to a lawyer who knows about estate planning if this Will does not meet your needs. This Will treats most adopted children like natural children. You should talk to a lawyer if you have stepchildren or foster children whom you have not adopted.

9. *May I add or cross out any words on this Will?* No. If you do, the Will may be invalid or the court may ignore the crossed out or added words. You may only fill in the blanks. You may amend this Will by a separate document (called a codicil). Talk to a lawyer if you want to do something with your assets which is not allowed in this form.

10. *May I change my Will?* Yes. A Will is not effective until you die. You may make and sign a new Will. You may change your Will at any time, but only by an amendment (called a codicil). You can give away or sell your assets before your death. Your Will only acts on what you own at death.

11. *Where should I keep my Will?* After you and the witnesses sign the Will, keep your Will in your safe deposit box or other safe place. You should tell trusted family members where your Will is kept.

12. *When should I change my Will?* You should make and sign a new Will if you marry, divorce, or terminate your domestic partnership after you sign this Will. Divorce, annulment, or termination of a domestic partnership automatically cancels all property stated to pass to a former husband, wife, or domestic partner under this Will, and revokes the designation of a former spouse or domestic partner as executor, custodian, or guardian. You should sign a new Will when you have more children, or if your spouse or a child dies, or a domestic partner dies or marries. You may want to change your Will if there is a large change in the value of your assets. You may also want to

change your Will if you enter a domestic partnership or your domestic partnership has been terminated after you sign this Will.

13. *What can I do if I do not understand something in this Will?* If there is anything in this Will you do not understand, ask a lawyer to explain it to you.

14. *What is an executor?* An "executor" is the person you name to collect your assets, pay your debts and taxes, and distribute your assets as the court directs. It may be a person or it may be a qualified bank or trust company.

15. *Should I require a bond?* You may require that an executor post a "bond." A bond is a form of insurance to replace assets that may be mismanaged or stolen by the executor. The cost of the bond is paid from the estate's assets.

16. *What is a guardian?* Do I need to designate one? If you have children under age 18, you should designate a guardian of their "persons" to raise them.

17. *What is a custodian?* Do I need to designate one? A "custodian" is a person you may designate to manage assets for someone (including a child) who is under the age of 25 and who receives assets under your Will. The custodian manages the assets and pays as much as the custodian determines is proper for health, support, maintenance, and education. The custodian delivers what is left to the person when the person reaches the age you choose (from 18 to 25). No bond is required of a custodian.

18. *Should I ask people if they are willing to serve before I designate them as executor, guardian, or custodian?* Probably yes. Some people and banks and trust companies may not consent to serve or may not be qualified to act.

19. *What happens if I make a gift in this Will to someone and that person dies before I do?* A person must survive you by 120 hours to take a gift under this Will. If that person does not, then the gift fails and goes with the rest of your assets. If the person who does not survive you is a relative of yours or your spouse, then certain assets may go to the relative's descendants.

20. *What is a trust?* There are many kinds of trusts, including trusts created by Wills (called "testamentary trusts") and trusts created during your lifetime (called "revocable living trusts"). Both kinds of trusts are long-term arrangements in which a manager (called a "trustee") invests and manages assets for someone (called a "beneficiary") on the terms you specify. Trusts are too complicated to be used in this Statutory Will. You should see a lawyer if you want to create a trust.

21. *What is a domestic partner?* You have a domestic partner if you have met certain legal requirements and filed a form entitled "Declaration of Domestic Partnership" with the Secretary of State. Notwithstanding Section 299.6 of the Family Code, if you have not filed a Declaration of Domestic Partnership with the Secretary of State, you do not meet the required definition and should not use the section of the Statutory Will form that refers to domestic partners even if you have registered your domestic partnership with another governmental entity. If you are unsure if you have a domestic partner or if your domestic partnership meets the required definition, please contact the Secretary of State's office.

INSTRUCTIONS

1. *READ THE WILL.* Read the whole Will first. If you do not understand something, ask a lawyer to explain it to you.

2. *FILL IN THE BLANKS.* Fill in the blanks. Follow the instructions in the form carefully. Do not add any words to the Will (except for filling in blanks) or cross out any words.

3. *DATE AND SIGN THE WILL AND HAVE TWO WITNESSES SIGN IT.* Date and sign the Will and have two witnesses sign it. You and the witnesses should read and follow the Notice to Witnesses found at the end of this Will.

*You do not need to have this document notarized. Notarization will not fulfill the witness requirement.

CALIFORNIA STATUTORY WILL OF

Print Your Full Name

1. Will. This is my Will. I revoke all prior Wills and codicils.

2. Specific Gift of Personal Residence. (Optional—use only if you want to give your personal residence to a different person or persons than you give the balance of your assets to under paragraph 5 below.) I give my interest in my principal personal residence at the time of my death (subject to mortgages and liens) as follows:

(Select one choice only and sign in the box after your choice.)

a. Choice One: All to my spouse or domestic partner, registered with the California Secretary of State, if my spouse or domestic partner, registered with the California Secretary of State, survives me; otherwise to my descendants (my children and the descendants of my children) who survive me.

b. Choice Two: Nothing to my spouse or domestic partner, registered with the California Secretary of State; all to my descendants (my children and the descendants of my children) who survive me.

c. Choice Three: All to the following person if he or she survives me (Insert the name of the person.):

_____

d. Choice Four: Equally among the following persons who survive me (Insert the names of two or more persons.):

_____

_____

_____

_____

3. Specific Gift of Automobiles, Household and Personal Effects. (Optional—use only if you want to give automobiles and household and personal effects to a different person or persons than you give the balance of your assets to under paragraph 5 below.) I give all of my automobiles (subject to loans), furniture, furnishings, household items, clothing, jewelry, and other tangible articles of a personal nature at the time of my death as follows:

(Select one choice only and sign in the box after your choice.)

a. Choice One: All to my spouse or domestic partner, registered with the California Secretary of State, if my spouse or domestic partner, registered

with the California Secretary of State, survives me; otherwise to my descendants (my children and the descendants of my children) who survive me.

b. Choice Two: Nothing to my spouse or domestic partner, registered with the California Secretary of State; all to my descendants (my children and the descendants of my children) who survive me.

c. Choice Three: All to the following person if he or she survives me (Insert the name of the person.):

_____

d. Choice Four: Equally among the following persons who survive me (Insert the names of two or more persons.):

_____

_____

_____

_____

4. Specific Gifts of Cash. (Optional) I make the following cash gifts to the persons named below who survive me, or to the named charity, and I sign my name in the box after each gift. If I do not sign in the box, I do not make a gift. (Sign in the box after each gift you make.)

Name of Person or Charity to receive gift (name one only—please print)	Amount of Cash Gift
	Sign your name in this box to make this gift

Name of Person or Charity to receive gift (name one only—please print)	Amount of Cash Gift
	Sign your name in this box to make this gift

Name of Person or Charity to receive gift (name one only—please print)	Amount of Cash Gift
	Sign your name in this box to make this gift

Name of Person or Charity to receive gift (name one only—please print)	Amount of Cash Gift
	Sign your name in this box to make this gift

Name of Person or Charity to receive gift (name one only—please print)	Amount of Cash Gift
	Sign your name in this box to make this gift

5. Balance of My Assets. Except for the specific gifts made in paragraphs 2, 3 and 4 above, I give the balance of my assets as follows:

(Select one choice only and sign in the box after your choice. If I sign in more than one box or if I do not sign in any box, the court will distribute my assets as if I did not make a Will.)

a. Choice One: All to my spouse or domestic partner, registered with the California Secretary of State, if my spouse or domestic partner, registered with the California Secretary of State, survives me; otherwise to my descendants (my children and the descendants of my children) who survive me.

b. Choice Two: Nothing to my spouse or domestic partner, registered with the California Secretary of State; all to my descendants (my children and the descendants of my children) who survive me.

c. Choice Three: All to the following person if he or she survives me (Insert the name of the person.):

_____

d. Choice Four: Equally among the following persons who survive me (Insert the names of two or more persons.):

_____

_____

_____

_____

6. Guardian of the Child's Person. If, at my death, I have a child under age 18, whether the child is alive at the time this will is executed or born after the date this will is executed, and the child does not have a living parent, I nominate the individual named below as First Choice as guardian of the person of that child (to raise the child). If the First Choice does not serve, then I nominate the Second Choice, and then the Third Choice, to serve. Only an individual (not a bank or trust company) may serve.

Name of First Choice for Guardian of the Person

Name of Second Choice for Guardian of the Person

Name of Third Choice for Guardian of the Person

7. Special Provision for Property of Persons Under Age 25. (Optional—unless you use this paragraph, assets that go to a child or other person who is under age 18 may be given to the parent of the person, or to the Guardian named in paragraph 6 above as guardian of the person until age 18, and the court will require a bond, and assets that go to a child or other person who is age 18 or older will be given outright to the person. By using this paragraph you may provide that a custodian will hold the assets for the person until the person reaches any age from 18 to 25 which you choose.) If a beneficiary of this Will is under the age chosen below, **I** nominate the individual or bank or trust company named below as First Choice as custodian of the property. If the First Choice does not serve, then I nominate the Second Choice, and then the Third Choice, to serve.

Name of First Choice for Custodian of Assets

Name of Second Choice for Custodian of Assets

Name of Third Choice for Custodian of Assets

Insert any age from 18 to 25 as the age for the person to receive the property:
(If you do not choose an age, age 18 will apply.)

8. Executor. I nominate the individual or bank or trust company named below as First Choice as executor. If the First Choice does not serve, then I nominate the Second Choice, and then the Third Choice, to serve.

Name of First Choice for Executor

Name of Second Choice for Executor

Name of Third Choice for Executor

9. Bond. My signature in this box means a bond is not required for any person named as executor. A bond may be required if I do not sign in this box:

No bond shall be required

(Notice: You must sign this Will in the presence of two (2) adult witnesses. The witnesses must sign their names in your presence. You must first read to them the following sentence.)

This is my Will: I ask the persons who sign below to be my witnesses.

Signed on _____ at _____
(date) (city)

Signature of Maker of Will

(Notice to Witnesses: Two (2) adults must sign as witnesses. Each witness must read the following clause before signing. The witnesses should not receive assets under this Will.)

Each of us declares under penalty of perjury under the laws of the State of California that the following is true and correct:

a. On the date written below the maker of this Will declared to us that this instrument was the maker's Will and requested us to act as witnesses to it;

b. We understand this is the maker's Will;

c. The maker signed this Will in our presence, all of us being present at the same time;

d. We now, at the maker's request, and in the maker's presence, sign below as witnesses;

e. We believe the maker is of sound mind and memory;

f. We believe that this Will was not procured by duress, menace, fraud or undue influence;

g. The maker is age 18 or older; and

h. Each of us is now age 18 or older, is a competent witness, and resides at the address set forth after his or her name.

Dated: _____ , _____

Signature of witness	Signature of witness
Print name here:	Print name here:
_____	_____
Residence address:	Residence address:
_____	_____
_____	_____

AT LEAST TWO WITNESSES MUST SIGN

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Part III: Your State's Estate Planning Forms

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Power of Attorney for Financial Affairs

Uniform Statutory Form Power of Attorney

(California Probate Code Section 4401)

NOTICE: THE POWERS GRANTED BY THIS DOCUMENT ARE BROAD AND SWEEPING. THEY ARE EXPLAINED IN THE UNIFORM STATUTORY FORM POWER OF ATTORNEY ACT (CALIFORNIA PROBATE CODE SECTIONS 4400–4465). THE POWERS LISTED IN THIS DOCUMENT DO NOT INCLUDE ALL POWERS THAT ARE AVAILABLE UNDER THE PROBATE CODE. ADDITIONAL POWERS AVAILABLE UNDER THE PROBATE CODE MAY BE ADDED BY SPECIFICALLY LISTING THEM UNDER THE SPECIAL INSTRUCTIONS SECTION OF THIS DOCUMENT. IF YOU HAVE ANY QUESTIONS ABOUT THESE POWERS, OBTAIN COMPETENT LEGAL ADVICE. THIS DOCUMENT DOES NOT AUTHORIZE ANYONE TO MAKE MEDICAL AND OTHER HEALTHCARE DECISIONS FOR YOU. YOU MAY REVOKE THIS POWER OF ATTORNEY IF YOU LATER WISH TO DO SO.

I, _____ (your name and address) appoint _____ _____ (name and address of the person appointed, or of each person appointed if you want to designate more than one) as my agent (attorney-in-fact) to act for me in any lawful way with respect to the following initialed subjects:

TO GRANT ALL OF THE FOLLOWING POWERS, INITIAL THE LINE IN FRONT OF (N) AND IGNORE THE LINES IN FRONT OF THE OTHER POWERS.

TO GRANT ONE OR MORE, BUT FEWER THAN ALL, OF THE FOLLOWING POWERS, INITIAL THE LINE IN FRONT OF EACH POWER YOU ARE GRANTING.

TO WITHHOLD A POWER, DO NOT INITIAL THE LINE IN FRONT OF IT. YOU MAY, BUT NEED NOT, CROSS OUT EACH POWER WITHHELD.

_____ (A) Real property transactions.
_____ (B) Tangible personal property transactions.
_____ (C) Stock and bond transactions.
_____ (D) Commodity and option transactions.
_____ (E) Banking and other financial institution transactions.
_____ (F) Business operating transactions.
_____ (G) Insurance and annuity transactions.
_____ (H) Estate, trust, and other beneficiary transactions.
_____ (I) Claims and litigation.
_____ (J) Personal and family maintenance.
_____ (K) Benefits from social security, medicare, medicaid, or other governmental programs, or civil or military service.
_____ (L) Retirement plan transactions.
_____ (M) Tax matters.
_____ (N) ALL OF THE POWERS LISTED ABOVE.

YOU NEED NOT INITIAL ANY OTHER LINES IF YOU INITIAL LINE (N).

SPECIAL INSTRUCTIONS:

ON THE FOLLOWING LINES YOU MAY GIVE SPECIAL INSTRUCTIONS LIMITING OR EXTENDING THE POWERS GRANTED TO YOUR AGENT.

_____
_____
_____
_____
_____

UNLESS YOU DIRECT OTHERWISE ABOVE, THIS POWER OF ATTORNEY IS EFFECTIVE IMMEDIATELY AND WILL CONTINUE UNTIL IT IS REVOKED.

This power of attorney will continue to be effective even though I become incapacitated.

STRIKE THE PRECEDING SENTENCE IF YOU DO NOT WANT THIS POWER OF ATTORNEY TO CONTINUE IF YOU BECOME INCAPACITATED.

EXERCISE OF POWER OF ATTORNEY WHERE MORE THAN ONE AGENT DESIGNATED

If I have designated more than one agent, the agents are to act _____.

IF YOU APPOINTED MORE THAN ONE AGENT AND YOU WANT EACH AGENT TO BE ABLE TO ACT ALONE WITHOUT THE OTHER AGENT JOINING, WRITE THE WORD "SEPARATELY" IN THE BLANK SPACE ABOVE. IF YOU DO NOT INSERT ANY WORD IN THE BLANK SPACE, OR IF YOU INSERT THE WORD "JOINTLY," THEN ALL OF YOUR AGENTS MUST ACT OR SIGN TOGETHER.

I agree that any third party who receives a copy of this document may act under it. Revocation of the power of attorney is not effective as to a third party until the third party has actual knowledge of the revocation. I agree to indemnify the third party for any claims that arise against the third party because of reliance on this power of attorney.

Signed this _____ day of _____, _____.

_____
(your signature)

State of _____, County of _____,

BY ACCEPTING OR ACTING UNDER THE APPOINTMENT, THE AGENT ASSUMES THE FIDUCIARY AND OTHER LEGAL RESPONSIBILITIES OF AN AGENT.

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.

CERTIFICATE OF ACKNOWLEDGMENT OF NOTARY PUBLIC

State of California
County of _____

On_____before me, _____, 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 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)

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Advance Health Care Directive

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Physician Orders for Life Sustaining Treatment (POLST)

What is a POLST?

Key Facts About POLST for Individuals and Family Members

Physician Orders for Life Sustaining Treatment (POLST) is a medical order that helps give people with serious illness more control over their care during a medical emergency. POLST can help make sure you get the care you want, and also protect you from getting medical treatments you DO NOT want.

- **POLST is voluntary.** Nursing homes and assisted living facilities may include POLST in their admission papers, but can't require you to complete a POLST if you do not wish to.

- **POLST is for people who are seriously ill or have advanced frailty**. If you are healthy, an advance directive is for you.

- **A POLST does NOT replace an advance directive,** which is still the best way to appoint someone you trust to act as your medical decisionmaker. A POLST works together with your advance directive, providing more specific detail regarding medical wishes and goals of care during a serious illness or at the end of life.

- **The POLST form should be completed by your doctor or another trained medical provider** after you've had a good conversation about the form's medical terms and options. This conversation is very important and should cover your overall health, your personal values, goals for your care, and treatment wishes. It can be helpful to include your family in the talk so they know and understand your treatment wishes.

- **The POLST form is not valid until it is signed by both you (or your designated decisionmaker) *AND* your physician, nurse practitioner, or physician assistant.**

- **Once completed and signed, a copy goes in your medical record and you keep the original bright pink POLST**. Wherever you go for medical care, the signed pink form should go with you. At home, keep your POLST in an easy to find place, like on your refrigerator, in case of a medical emergency.

- **POLST does not expire, but it should be reviewed regularly to make sure your wishes haven't changed.** You do not need to fill out a new POLST if you move from one facility to another, or change doctors. You only have to complete a new POLST if your treatment wishes change.

- **POLST is a medical order, which means licensed medical providers are required to follow its instructions** regarding CPR and other emergency medical care. The POLST form is printed on bright pink paper so it is easy to recognize, but photocopies are also considered valid.

- **You can void your POLST form at any time, verbally or in writing.** If you have changes, it is best to complete a new POLST. To void a POLST form, draw a line through sections A through D, write "VOID" in large letters, then sign and date the line.

Please go to: http://www.capolst.org/ or call (916) 489-2222 for more information.

HIPAA PERMITS DISCLOSURE OF POLST TO OTHER HEALTH CARE PROVIDERS AS NECESSARY

Physician Orders for Life-Sustaining Treatment (POLST)

EMSA #111 B
(Effective 4/1/2017)*

First follow these orders, then contact Physician / NP / PA. A copy of the signed POLST form is a legally valid physician order. Any section not completed implies full treatment for that section. **POLST complements an Advance Directive and is not intended to replace that document**.

Patient Last Name:	Date Form Prepared:
Patient First Name:	Patient Date of Birth:
Patient Middle Name:	Medical Record #: *(optional)*

A — CARDIOPULMONARY RESUSCITATION (CPR): *If patient has no pulse and is not breathing.*

If patient is NOT in cardiopulmonary arrest, follow orders in Sections B and C.

Check One

☐ **Attempt Resuscitation/CPR** (Selecting CPR in Section A **requires** selecting Full Treatment in Section B)

☐ **Do Not Attempt Resuscitation/DNR** (Allow Natural Death)

B — MEDICAL INTERVENTIONS: *If patient is found with a pulse and/or is breathing.*

Check One

☐ **Full Treatment – primary goal of prolonging life by all medically effective means.**
In addition to treatment described in Selective Treatment and Comfort-Focused Treatment, use intubation, advanced airway interventions, mechanical ventilation, and cardioversion as indicated.

☐ ***Trial Period of Full Treatment.***

☐ **Selective Treatment – goal of treating medical conditions while avoiding burdensome measures.**
In addition to treatment described in Comfort-Focused Treatment, use medical treatment, IV antibiotics, and IV fluids as indicated. Do not intubate. May use non-invasive positive airway pressure. Generally avoid intensive care.

☐ ***Request transfer to hospital only if comfort needs cannot be met in current location.***

☐ **Comfort-Focused Treatment – primary goal of maximizing comfort.**
Relieve pain and suffering with medication by any route as needed; use oxygen, suctioning, and manual treatment of airway obstruction. Do not use treatments listed in Full and Selective Treatment unless consistent with comfort goal. ***Request transfer to hospital only if comfort needs cannot be met in current location.***

Additional Orders: _____

C — ARTIFICIALLY ADMINISTERED NUTRITION: *Offer food by mouth if feasible and desired.*

Check One

☐ Long-term artificial nutrition, including feeding tubes. Additional Orders: _____

☐ Trial period of artificial nutrition, including feeding tubes. _____

☐ No artificial means of nutrition, including feeding tubes. _____

D — INFORMATION AND SIGNATURES:

Discussed with: ☐ Patient (Patient Has Capacity) ☐ Legally Recognized Decisionmaker

☐ Advance Directive dated _____, available and reviewed →
☐ Advance Directive not available
☐ No Advance Directive

Health Care Agent if named in Advance Directive:
Name: _____
Phone: _____

Signature of Physician / Nurse Practitioner / Physician Assistant (Physician/NP/PA)
My signature below indicates to the best of my knowledge that these orders are consistent with the patient's medical condition and preferences.

Print Physician/NP/PA Name:	Physician/NP/PA Phone #:	Physician/PA License #, NP Cert. #:
Physician/NP/PA Signature: *(required)*		Date:

Signature of Patient or Legally Recognized Decisionmaker
I am aware that this form is voluntary. By signing this form, the legally recognized decisionmaker acknowledges that this request regarding resuscitative measures is consistent with the known desires of, and with the best interest of, the individual who is the subject of the form.

Print Name:		Relationship: *(write self if patient)*
Signature: *(required)*	Date:	Your POLST may be added to a secure electronic registry to be accessible by health providers, as permitted by HIPAA.
Mailing Address (street/city/state/zip):	Phone Number:	

SEND FORM WITH PATIENT WHENEVER TRANSFERRED OR DISCHARGED

*Form versions with effective dates of 1/1/2009, 4/1/2011,10/1/2014 or 01/01/2016 are also valid

HIPAA PERMITS DISCLOSURE OF POLST TO OTHER HEALTH CARE PROVIDERS AS NECESSARY

Patient Information

Name (last, first, middle):	Date of Birth:	Gender: M F

NP/PA's Supervising Physician	**Preparer Name** (if other than signing Physician/NP/PA)	
Name:	Name/Title:	Phone #:

Additional Contact ☐ None

Name:	Relationship to Patient:	Phone #:

Directions for Health Care Provider

Completing POLST

- **Completing a POLST form is voluntary**. California law requires that a POLST form be followed by healthcare providers, and provides immunity to those who comply in good faith. In the hospital setting, a patient will be assessed by a physician, or a nurse practitioner (NP) or a physician assistant (PA) acting under the supervision of the physician, who will issue appropriate orders that are consistent with the patient's preferences.
- **POLST does not replace the Advance Directive**. When available, review the Advance Directive and POLST form to ensure consistency, and update forms appropriately to resolve any conflicts.
- POLST must be completed by a health care provider based on patient preferences and medical indications.
- A legally recognized decisionmaker may include a court-appointed conservator or guardian, agent designated in an Advance Directive, orally designated surrogate, spouse, registered domestic partner, parent of a minor, closest available relative, or person whom the patient's physician/NP/PA believes best knows what is in the patient's best interest and will make decisions in accordance with the patient's expressed wishes and values to the extent known.
- A legally recognized decisionmaker may execute the POLST form only if the patient lacks capacity or has designated that the decisionmaker's authority is effective immediately.
- To be valid a POLST form must be signed by (1) a physician, or by a nurse practitioner or a physician assistant acting under the supervision of a physician and within the scope of practice authorized by law and (2) the patient or decisionmaker. Verbal orders are acceptable with follow-up signature by physician/NP/PA in accordance with facility/community policy.
- If a translated form is used with patient or decisionmaker, attach it to the signed English POLST form.
- Use of original form is strongly encouraged. Photocopies and FAXes of signed POLST forms are legal and valid. A copy should be retained in patient's medical record, on Ultra Pink paper when possible.

Using POLST

- Any incomplete section of POLST implies full treatment for that section.

Section A:

- If found pulseless and not breathing, no defibrillator (including automated external defibrillators) or chest compressions should be used on a patient who has chosen "Do Not Attempt Resuscitation."

Section B:

- When comfort cannot be achieved in the current setting, the patient, including someone with "Comfort-Focused Treatment," should be transferred to a setting able to provide comfort (e.g., treatment of a hip fracture).
- Non-invasive positive airway pressure includes continuous positive airway pressure (CPAP), bi-level positive airway pressure (BiPAP), and bag valve mask (BVM) assisted respirations.
- IV antibiotics and hydration generally are not "Comfort-Focused Treatment."
- Treatment of dehydration prolongs life. If a patient desires IV fluids, indicate "Selective Treatment" or "Full Treatment."
- Depending on local EMS protocol, "Additional Orders" written in Section B may not be implemented by EMS personnel.

Reviewing POLST

It is recommended that POLST be reviewed periodically. Review is recommended when:

- The patient is transferred from one care setting or care level to another, or
- There is a substantial change in the patient's health status, or
- The patient's treatment preferences change.

Modifying and Voiding POLST

- A patient with capacity can, at any time, request alternative treatment or revoke a POLST by any means that indicates intent to revoke. It is recommended that revocation be documented by drawing a line through Sections A through D, writing "VOID" in large letters, and signing and dating this line.
- A legally recognized decisionmaker may request to modify the orders, in collaboration with the physician/NP/PA, based on the known desires of the patient or, if unknown, the patient's best interests.

This form is approved by the California Emergency Medical Services Authority in cooperation with the statewide POLST Task Force.
For more information or a copy of the form, visit **www.caPOLST.org**.

SEND FORM WITH PATIENT WHENEVER TRANSFERRED OR DISCHARGED

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Part III: Your State's Estate Planning Forms

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Funeral Designation Form

DECLARATION FOR DISPOSITION OF CREMATED OR HYDROLYZED HUMAN REMAINS

I/We hereby declare (my remains) or (the remains of)_____ in
Name of Person arrangements are for

the possession of _____ will be cremated or
Name of Funeral Establishment and Telephone Number

hydrolyzed by_____ and shall be disposed of in the following
Name of Crematory or Hydrolysis Facility and Telephone Number

manner[1]: _____
Manner, Location and Other Detail of Disposition

_____
Attach additional pages if necessary

Name of person(s) with the legal right to control disposition[2]: _____

_____

Signed _____ **Date** _____
Person(s) with legal right to control disposition to Self, if pre-arranging

Signed _____ **Date** _____
Person(s) with legal right to control disposition

Signed _____ **Date** _____
Person(s) with legal right to control disposition

Name of person(s) contracting for cremation or hydrolysis services: _____

_____

Signed _____ **Date** _____
Person(s) contracting for cremation or hydrolysis services

Signed _____ Lic. # _____ **Date** _____
Funeral Director, Employee, or Agent for Funeral Establishment
If a Funeral Director

IMPORTANT: Business and Professions Code section 7685.2(b) requires funeral establishments to complete this form, provided by the Cemetery and Funeral Bureau, when making arrangements for cremation or hydrolysis. Failure to complete this form may result in disciplinary action by the Bureau. <u>This declaration does not replace the written authorization to cremate required by Health and Safety Code sections 7110 and 7111</u>.

NOTICE REGARDING CREMATED OR HYDROLYZED HUMAN REMAINS

A person having the right to control disposition of cremated or hydrolyzed human remains may remove the remains in a durable container from the place of cremation, hydrolysis, or interment, pursuant to Health and Safety Code section 7054.6.

If the cremated or hydrolyzed remains container cannot accommodate all cremated or hydrolyzed remains of the deceased, the crematory or hydrolysis facility shall provide a larger cremated or hydrolyzed remains container at no additional cost, or place the excess in a second container that cannot easily come apart from the first, pursuant to Business and Professions Code section 7685.2.

[1] See Health and Safety Code sections 7054, 7054.6, 7116, and 7117 for legal dispositions of cremated or hydrolyzed human remains.

[2] See Health and Safety Code section 7100 for the list of person(s) with the legal right to control disposition of human remains.

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HIPAA Authorization Form

Sample HIPAA Right of Access Form for Family Member/Friend

I, _____, direct my health care and medical services providers and payers to disclose and release my protected health information described below to:

Name: *Relationship:*

_____ _____

Contact information: _____

_____

Health Information to be disclosed upon the request of the person named above -- (Check either A or B):

- ☐ A. **Disclose** my complete health record (including but not limited to diagnoses, lab tests, prognosis, treatment, and billing, for all conditions) **OR**
- ☐ B. **Disclose** my health record, as above, **BUT do not disclose** the following (check as appropriate):
  - ☐ Mental health records
  - ☐ Communicable diseases (including HIV and AIDS)
  - ☐ Alcohol/drug abuse treatment
  - ☐ Other (please specify):

    _____
    _____

Form of Disclosure (unless another format is mutually agreed upon between my provider and designee):

- ☐ An electronic record or access through an online portal
- ☐ Hard copy

This authorization shall be effective until (Check one):

- ☐ All past, present, and future periods, OR
- ☐ Date or event:_____

unless I revoke it. (NOTE: You may revoke this authorization in writing at any time by notifying your health care providers, preferably in writing.)

_____ _____
Name of the Individual Giving this Authorization Date of birth

_____ _____
Signature of the Individual Giving this Authorization Date

Note: HIPAA Authority for Right of Access: 45 C.F.R. § 164.524