Advance Health Care Directive and Power of Attorney
Planning for Incapacity

May 30, 2024

Fullerton Community Center, Fullerton, CA

Speaker: Daniel R. York, Elder Law Attorney

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This packet contains:

1. **Outline of today's presentation - [1 page]**
2. **Legal Issues and Tools - [4 pages]**
3. **Questions to Consider in Selecting an Agent (for AHCD) - [1 page]**
4. **ADVANCE HEALTH CARE DIRECTIVE FORM (AHCD) – sample - [7 pages]**
5. **What is a POLST? - [3 pages]**

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"Ask First!"

This form is to be filled out by any person who is offering legal, financial, retirement, insurance, accounting, estate, long-term care or similar planning services. Respond to ALL categories completely; sign and date at the bottom of the page.

① **MY EDUCATION-** I have achieved the following level of education (check HIGHEST level achieved):

☐ Some High School	☐ High School Diploma	☐ Bachelors Degree
☐ GED	☐ Some College	☑ Masters or other Advanced Degree

② **MY CREDENTIAL(S)-** I have the following specialized credential(s) and training (examples: CFP, ChFC, CLU, CPA, JD, MBA, years of relevant experience):

JD (Juris Doctor), 36 plus years in law practice, Admitted to California Bar, Admitted to U.S. Federal District Court, Central District of California.

③ **MY RELEVANT LICENSE(S)-** I have the following license(s) giving me the legal authority to provide the services I am offering to you (examples: bar license (attorney); securities license; insurance license):

License Type	Covers What Activities	Issued By	License No.
Attorney and Counselor	To practice law	State Bar of California	132078

④ **LEGAL SERVICES-** (Check ONE):

☐ I DO NOT practice law, and the services I am offering to you do not involve practicing law.

☑ I DO practice law, and have an active license to practice law in California.

☐ I DO practice law, but DO NOT have an active license to practice law in California. I am, however, under the supervision of the following attorney who has an active license to practice law in California:

Name of attorney:	Telephone:
Address:	

⑤ **OUR BUSINESS RELATIONSHIP-** Check TRUE or FALSE:

☑ True / ☐ False: In our business relationship, I will at all times serve as a fiduciary and put your interests before my interests and those of my employer.

⑥ **MY COMPENSATION-** I will be paid in the following way (commission, fee, salary, etc.), by the named person or company, in connection with the services I am offering to you:

Way(s) I'll Be Paid	Payment Will Be Made By (name each person or company)
Fee for service (either agreed fixed fee or agreed hourly fee)	Client or person/entity expressly authorized by client

⑦ **FINANCIAL PRODUCTS / AFFILIATED ORGANIZATIONS-** Check TRUE or FALSE:

☐ True / ☑ False: I offer or sell annuities, insurance, mutual funds or other financial products; or I am, or my employer is, affiliated with a person or organization that offers or sells annuities, insurance, mutual funds or other financial products.

⑧ ***I certify under penalty of perjury that the responses herein are true to the best of my knowledge.***

Date: May 30, 2024	Business Name: LAW OFFICE OF DANIEL R. YORK
Signature: Dan R. York	Address: 1953 E. Chapman Ave., Fullerton, CA 92831
Print Name: Daniel Ray York	Telephone: (714) 738-3400

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Introduction

1) What is Incapacity and Why Plan?

2) How to get started

a) Medical assessment
b) Care needs now and in the future
c) Who will carry out your plan
d) Decisionmakers for med and finances
e) Gather essential documents
f) Decide on your team members
g) Meet with a qualified Elder Law Attorney

3) Legal essentials

a) Power of Attorney for Finances

- Durable vs. regular
- General vs. limited
- Immediate vs. springing
- Important powers that can be included
- Agent compensation, liability, rights, and restrictions
- What it can do that a trust cannot
- Should it be drafted by an attorney?

b) Advance Health Care Directive

c) POLST

d) HIPAA authorization

e) Organizing & keeping your plan current
f) Sharing your documents

4) Conservatorship – the alternative

a) Court-appointed vs. your nomination
b) Conservator of estate vs. person
c) Procedures and costs
d) Duration

Summary & Questions from Audience

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Legal Issues and Tools

First Task ~ Organize Papers

Legal issues relating to care planning are divided into two categories:

1. **Health Care**
2. **Financial**

Healthcare ~ Determine whether certain documents already exist. Look for:

1. Advance Health Care Directive
2. Power of Attorney for Health Care
3. Living Will
4. Directive to Physicians
5. HIPAA Authorization (means "**H**ealth **I**nsurance **P**ortability and **A**ccountability **A**ct")
6. POLST (means "**P**hysician **O**rders for **L**ife **S**ustaining **T**reatment")

Financial ~ Look for papers relating to property and financial matters:

1. Trusts
2. Wills
3. Power of Attorney for Finances
4. Deeds or Certificates of Ownership for Property
5. Annuities
6. Life Insurance
7. Long-Term Care Insurance Policies
8. Retirement Accounts/ Benefits (IRA, 401k, 403b, Pensions)
9. Veterans Benefits
10. Most-recent statements from bank, credit union, investments.

Next, you'll want to visit a qualified attorney to review these papers. *DO NOT WAIT FOR A MEDICAL CRISIS*. The person signing new documents must have legal *capacity* to understand what they are signing.

Second Task ~ Choose An Attorney

Sometimes the best choice is the original attorney who prepared the papers. If you have confidence in that person, this is an obvious choice.

However, sometimes clients lose touch with the attorney or feel that they need someone more familiar with their current life issues.

Finding An Elder Law Attorney

The attorney who practices Elder Law or Special Needs Law works primarily with people as they age and people with disabilities. Using a holistic approach, the attorney will address general estate planning issues and will counsel clients

about planning for incapacity and possible long-term care needs. The attorney typically wants to be sure the documents properly coordinate private and public resources to finance the cost of quality care. The attorney may also have suggestions for support services in your area. You can locate an elder law attorney through:

NAELA

National Academy of Elder Law Attorneys' website at www.naela.org. On the NAELA homepage, you will find a link that will help you locate an elder law attorney near you.

Third Task ~ Get Ready For The Attorney Visit

Here are a few tips as you prepare. (Each attorney has a slightly different approach):

1. Make a list: Discuss with your spouse, partner, or those helping you what questions are on your mind. Write them down.

2. Think about your care managers: If you were unable to manage your finances and health care, who would you choose for those important jobs? Do you have alternates in mind? Would they agree to serve?

3. Are there doubts about the present ability of the client to understand and sign documents? If so, mention this to the attorney very soon!

4. If the client has a serious, chronic or terminal illness, or if there is some other urgency mention it to the attorney immediately!

5. When you make the appointment, ask the attorney these questions:

    - Does the attorney offer a no-charge first visit?
    - What documents should you bring to the meeting?
    - Should you complete a questionnaire first?
    - Will the attorney want to meet privately with the client?
    - Are family members welcome? Are designated trustees, financial agents or health care agents welcome?
    - If the attorney accepts the case, what are the fees and costs? When will the client receive the legal services agreement for review? (In most cases, attorneys are required to have a written agreement for any legal work. It must be signed by both client and attorney).

Advance Care Planning Basics

1. Every adult needs an Advance Healthcare Directive:

* To name your choice of person(s) to make your health care decisions when you can no longer communicate;
* To tell those caring for you what kind of health care you want/don't want;
* To tell everyone caring for you how you feel about life support;
* To make special requests about the people or things important to you when you are ill (friends, music, clergy, pets, poetry, scripture, etc.);
* To tell everyone where you want to live in your final days;
* To make choices about organ donation, cremation, burial;
* To tell everyone how you want to be remembered

2. Complete a POLST with your doctor's help if you presently have a serious life-threatening or terminal illness. ***P****hysician* ***O****rders for* ***L****ife* ***S****ustaining* ***T****reatment* forms are detailed doctor's orders which reflect *your choices* about life support options or resuscitation. These orders are kept in your medical chart. The law requires doctors, emergency medical responders, and healthcare workers to honor these detailed choices. Similar documents are often called **DNR** (**D**o **N**ot **R**esuscitate).

3. Review AHCD and POLST information. Physicians and patients can find the latest information and download forms on Advance Care Directives and POLST.

* **POLST California**
  https://capolst.org/

* **California Department of Justice - Advance Healthcare Directives**
  https://oag.ca.gov/consumers/general/adv_hc_dir

* **Coalition for Compassionate Care of California (non-profit)**
  http://coalitionccc.org

* **Five Wishes – Changing the way we plan for end of life care**
  https://ww w.agingwithdignity.org/five-wishes/about-five-wishes

Medical Privacy and HIPAA

The *Health Information Portability and Accountability Act ~ 1996* (HIPAA) is intended to safeguard an individual's health information.

A HIPPA release is a document signed and dated by you to authorize use and disclosure of protected health information for reasons other than treatment,

payment or health care operations. An authorization must contain a description of the protected health information, the names of persons permitted to make a disclosure, the names of persons to whom the covered entity may disclose, an expiration date or event, an explanation of the individual's right to revoke, how to revoke, and a statement about potential re-disclosures.

Your doctor and other medical professionals are required by law to protect your medical privacy. This is why you are often asked to sign a form stating that you have received the provider's Privacy Statement.

IMPORTANT: The form often includes an authorization giving permission to share your medical information with other health care providers, your spouse or other person *you* designate.

Don't wait until a medical emergency to sign a HIPAA release and an Advance Health Care Directive. Every time you visit a doctor, hospital, medical lab, etc., give them a copy of your Advance Health Care Directive and ask to sign the provider's HIPAA form so that those assisting you are authorized to receive information about your care.

This handout is excerpted and adapted from: 2018-2019 Senior Resource Guide: Senior Care Steps and Services in North Orange County, California

Published by North Orange County Senior collaborative and St. Jude Medical Center, Senior services

Questions to Consider in Selecting an Agent

The following is a brief list of issues to consider in selecting an agent when executing an Advance Health Care Directive. While the ideal agent is often a spouse, domestic partner, or adult child, other individuals can also be good choices. These are a few of the more important questions to consider in choosing an individual to serve as your agent:

1. Is the proposed agent a person who knows you well, a person with whom you can easily discuss your health care wishes, and someone who you trust?

2. Does the proposed agent live near by?

3. Does the proposed agent have religious or other beliefs that would prevent him or her from carrying out your health care wishes?

4. Is the proposed agent in good health?

5. Can the proposed agent withstand tough pressure from relatives and friends?

6. Is the proposed agent willing to act as your agent?

7. Will the proposed agent benefit from your will or estate plan? (Such an individual may have potential conflicts of interest.)

8. Will the proposed agent be a forceful advocate on your behalf with your medical providers?

ADVANCE HEALTH CARE DIRECTIVE FORM

Probate Code - PROB
DIVISION 4.7. HEALTH CARE DECISIONS [4600 - 4806] (Division 4.7 added by Stats. 1999, Ch. 658, Sec. 39.)
PART 2. UNIFORM HEALTH CARE DECISIONS ACT [4670 - 4743] (Part 2 added by Stats. 1999, Ch. 658, Sec. 39.)

CHAPTER 2. Advance Health Care Directive Forms [4700 - 4701] (Chapter 2 added by Stats. 1999, Ch. 658, Sec. 39.)
4701. The statutory advance health care directive form is as follows:

ADVANCE HEALTH CARE DIRECTIVE
(California Probate Code Section 4701)
Explanation

You have the right to give instructions about your own health care. You also have the right to name someone else to make health care decisions for you. This form lets you do either or both of these things. It also lets you express your wishes regarding donation of organs and the designation of your primary physician. If you use this form, you may complete or modify all or any part of it. You are free to use a different form.

Part 1 of this form is a power of attorney for health care. Part 1 lets you name another individual as agent to make health care decisions for you if you become incapable of making your own decisions or if you want someone else to make those decisions for you now even though you are still capable. You may also name an alternate agent to act for you if your first choice is not willing, able, or reasonably available to make decisions for you. (Your agent may not be an operator or employee of a community care facility or a residential care facility where you are receiving care, or your supervising health care provider or employee of the health care institution where you are receiving care, unless your agent is related to you or is a coworker.)

Unless the form you sign limits the authority of your agent, your agent may make all health care decisions for you. This form has a place for you to limit the authority of your agent. You need not limit the authority of your agent if you wish to rely on your agent for all health care decisions that may have to be made. If you choose not to limit the authority of your agent, your agent will have the right to:

(a) Consent or refuse consent to any care, treatment, service, or procedure to maintain, diagnose, or otherwise affect a physical or mental condition.

(b) Select or discharge health care providers and institutions.

(c) Approve or disapprove diagnostic tests, surgical procedures, and programs of medication.

(d) Direct the provision, withholding, or withdrawal of artificial nutrition and hydration and all other forms of health care, including cardiopulmonary resuscitation.

(e) Donate your organs, tissues, and parts, authorize an autopsy, and direct disposition of remains.

Part 2 of this form lets you give specific instructions about any aspect of your health care, whether or not you appoint an agent. Choices are provided for you to express your wishes regarding the provision, withholding, or withdrawal of treatment to keep you alive, as well as the provision of pain relief. Space is also provided for you to add to the choices you have made or for you to write out any additional wishes. If you are satisfied to allow your agent to determine what is best for you in making end-of-life decisions, you need not fill out Part 2 of this form.

Part 3 of this form lets you express an intention to donate your bodily organs, tissues, and parts following your death.

Part 4 of this form lets you designate a physician to have primary responsibility for your health care.

After completing this form, sign and date the form at the end. The form must be signed by two qualified witnesses or acknowledged before a notary public. Give a copy of the signed and completed form to your physician, to any other health care providers you may have, to any health care institution at which you are receiving care, and to any health care agents you have named. You should talk to the person you have named as agent to make sure that he or she understands your wishes and is willing to take the responsibility.

You have the right to revoke this advance health care directive or replace this form at any time.

ONLY A SAMPLE

ADVANCE HEALTH CARE DIRECTIVE FORM

PART 1
POWER OF ATTORNEY FOR HEALTH CARE

(1.1) DESIGNATION OF AGENT: I designate the following individual as my agent to make health care decisions for me:

_____
(name of individual you choose as agent)

_____ _____ _____ _____
(address) (city) (state) (ZIP Code)

_____ _____
(home phone) (work phone)

OPTIONAL: If I revoke my agent's authority or if my agent is not willing, able, or reasonably available to make a health care decision for me, I designate as my first alternate agent:

_____
(name of individual you choose as first alternate agent)

_____ _____ _____ _____
(address) (city) (state) (ZIP Code)

_____ _____
(home phone) (work phone)

OPTIONAL: If I revoke the authority of my agent and first alternate agent or if neither is willing, able, or reasonably available to make a health care decision for me, I designate as my second alternate agent:

_____
(name of individual you choose as second alternate agent)

_____ _____ _____ _____
(address) (city) (state) (ZIP Code)

_____ _____
(home phone) (work phone)

(1.2) AGENT'S AUTHORITY: My agent is authorized to make all health care decisions for me, including decisions to provide, withhold, or withdraw artificial nutrition and hydration and all other forms of health care to keep me alive, except as I state here:

_____

_____

_____

(Add additional sheets if needed.)

(1.3) WHEN AGENT'S AUTHORITY BECOMES EFFECTIVE: My agent's authority becomes effective when my primary physician determines that I am unable to make my own health care decisions unless I mark the following box.
If I mark this box ☐, my agent's authority to make health care decisions for me takes effect immediately.

ONLY A SAMPLE

ADVANCE HEALTH CARE DIRECTIVE FORM

(1.4.) AGENT'S OBLIGATION: My agent shall make health care decisions for me in accordance with this power of attorney for health care, any instructions I give in Part 2 of this form, and my other wishes to the extent known to my agent. To the extent my wishes are unknown, my agent shall make health care decisions for me in accordance with what my agent determines to be in my best interest. In determining my best interest, my agent shall consider my personal values to the extent known to my agent.

(1.5) AGENT'S POSTDEATH AUTHORITY: My agent is authorized to donate my organs, tissues, and parts, authorize an autopsy, and direct disposition of my remains, except as I state here or in Part 3 of this form:
:

_____

_____

_____

(Add additional sheets if needed.)

(1.6) NOMINATION OF CONSERVATOR: If a conservator of my person needs to be appointed for me by a court, I nominate the agent designated in this form. If that agent is not wiling, able, or reasonably available to act as conservator, I nominate the alternate agents whom I have named, in the order designated.

PART 2
INSTRUCTIONS FOR HEALTH CARE

If you fill out this part of the form, you may strike any wording you do not want.

(2.1) END-OF-LIFE DECISIONS: I direct that my health care providers and others involved in my care provide, withhold, or withdraw treatment in accordance with the choice I have marked below:

☐ (a) Choice Not to Prolong Life

I do not want my life to be prolonged if (1) I have an incurable and irreversible condition that will result in my death within a relatively short time, (2) I become unconscious and, to a reasonable degree of medical certainty, I will not regain consciousness, or (3) the likely risks and burdens of treatment would outweigh the expected benefits, OR

☐ (b) Choice to Prolong Life

I want my life to be prolonged as long as possible within the limits of generally accepted health care standards.

(2.2) RELIEF FROM PAIN: Except as I state in the following space, I direct that treatment for alleviation of pain or discomfort be provided at all times, even if it hastens my death:

_____

_____

(Add additional sheets if needed.)

(2.3) OTHER WISHES: (If you do not agree with any of the optional choices above and wish to write your own, or if you wish to add to the instructions you have given above, you may do so here.) I direct that:

_____

_____

(Add additional sheets if needed.)

ONLY A SAMPLE

PART 3
DONATION OF ORGANS, TISSUES, AND PARTS AT DEATH
(OPTIONAL)

(3.1) ☐ Upon my death, I give my organs, tissues, and parts (mark box to indicate yes).
By checking the box above, and notwithstanding my choice in Part 2 of this form, I authorize my agent to consent to any temporary medical procedure necessary solely to evaluate and/or maintain my organs, tissues, and/or parts for purposes of donation.

My donation is for the following purposes (strike any of the following you do not want):

(a) Transplant

(b) Therapy

(c) Research

(d) Education

If you want to restrict your donation of an organ, tissue, or part in some way, please state your restriction on the following lines:

_____

If I leave this part blank, it is not a refusal to make a donation. My state-authorized donor registration should be followed, or, if none, my agent may make a donation upon my death. If no agent is named above, I acknowledge that California law permits an authorized individual to make such a decision on my behalf. (To state any limitation, preference, or instruction regarding donation, please use the lines above or in Section 1.5 of this form).

ONLY A SAMPLE

PART 4
PRIMARY PHYSICIAN
(OPTIONAL)

(4.1) I designate the following physician as my primary physician:

_____
(name of physician)

_____ _____ _____ _____
(address) (city) (state) (ZIP Code)

_____
(phone)

OPTIONAL: If the physician I have designated above is not willing, able, or reasonably available to act as my primary physician, I designate the following physician as my primary physician:

_____
(name of physician)

_____ _____ _____ _____
(address) (city) (state) (ZIP Code)

_____
(phone)

ADVANCE HEALTH CARE DIRECTIVE FORM

PART 5

(5.1) EFFECT OF COPY: A copy of this form has the same effect as the original.

(5.2) SIGNATURE: Sign and date the form here:

(date) (sign your name)

(address) (print your name)

(city) (state)

(5.3) STATEMENT OF WITNESSES: I declare under penalty of perjury under the laws of California (1) that the individual who signed or acknowledged this advance health care directive is personally known to me, or that the individual's identity was proven to me by convincing evidence (2) that the individual signed or acknowledged this advance directive in my presence, (3) that the individual appears to be of sound mind and under no duress, fraud, or undue influence, (4) that I am not a person appointed as agent by this advance directive, and (5) that I am not the individual's health care provider, an employee of the individual's health care provider, the operator of a community care facility, an employee of an operator of a community care facility, the operator of a residential care facility for the elderly, nor an employee of an operator of a residential care facility for the elderly.

First witness	Second witness
(print name)	(print name)
(address)	(address)
(city) (state)	(city) (state)
(signature of witness)	(signature of witness)
(date)	(date)

ONLY A SAMPLE

(5.4) ADDITIONAL STATEMENT OF WITNESSES: At least one of the above witnesses must also sign the following declaration:

I further declare under penalty of perjury under the laws of California that I am not related to the individual executing this advance health care directive by blood, marriage, or adoption, and to the best of my knowledge, I am not entitled to any part of the individual's estate upon his or her death under a will now existing or by operation of law.

(signature of witness) (signature of witness)

PART 6
SPECIAL WITNESS REQUIREMENT

(6.1) The following statement is required only if you are a patient in a skilled nursing facility--a health care facility that provides the following basic services: skilled nursing care and supportive care to patients whose primary need is for availability of skilled nursing care on an extended basis. The patient advocate or ombudsman must sign the following statement:

STATEMENT OF PATIENT ADVOCATE OR OMBUDSMAN

I declare under penalty of perjury under the laws of California that I am a patient advocate or ombudsman as designated by the State Department of Aging and that I am serving as a witness as required by Section 4675 of the Probate Code.

(date)	(sign your name)
(address)	(print your name)
(city) (state)	

ONLY A SAMPLE

(Amended by Stats. 2018, Ch. 287, Sec. 1. (AB 3211) Effective January 1, 2019.)

ACKNOWLEDGMENT

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 _____

On _____ before me, _____
(insert name and title of officer)

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)**

ONLY A SAMPLE

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

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

Physician Orders for Life-Sustaining Treatment (POLST)

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.
☐ Trial period of artificial nutrition, including feeding tubes.
☐ No artificial means of nutrition, including feeding tubes.

Additional Orders: _____

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