Advance Health Care Directive

DISTRICT OF COLUMBIA

LIFE CARE **planning**

my values, my choices, my care

kp.org/lifecareplan

KAISER PERMANENTE®

Full name: _____
Medical record number: _____

Introduction

This Durable Power of Attorney for Health Care and District of Columbia Declaration lets you share your values, your choices, and your wishes about your future health care. This form may be used to:

- Name someone you trust to make health care choices for you
- Give written instructions about your future health care
- Name both a Durable Power of Attorney for Health Care AND give written orders for future health care.
- Draft a District of Columbia Declaration, which is the District of Columbia's Living Will. It lets you state your wishes about medical care if you develop a terminal health issue and can no longer make your own medical decisions. Your declaration goes into effect when your doctor and one other doctor declare that you have an incurable condition that will lead to your death, with or without the use of life-sustaining procedures.

Part 1 Names a health care agent.

Part 2 Gives you a chance to share what is of great value to you.

Part 3 Gives written instructions about your future health care.

Part 4 Lets you guide your agent's decision-making by stating your hopes and wishes.

Part 5 Makes your Durable Power of Attorney for Health Care and/or the District of Columbia Declaration legally valid in the District of Columbia.

Part 6 Prepares you to share your wishes and this record with others.

This Durable Power of Attorney will replace any advance health care directive you have filled out in the past. In the future, if you want to cancel your Durable Power of Attorney you may do so by telling your attorney-in-fact orally or in writing, telling your health care provider orally or in writing, or executing a new Durable Power of Attorney for Health Care. If you name your spouse or domestic partner as your attorney-in-fact and your marriage or domestic union ends, your spouse or domestic partner's power to act on your behalf will automatically be canceled.

You may cancel your Declaration at any time, no matter what your mental state is, by obliterating, burning, tearing, or otherwise breaking the document, or telling another person to do so in your presence; executing, or telling another person to carry out, a dated and signed written revocation, which becomes effective when it is given to your doctor; or orally cancelling your Declaration in the presence of a witness, 18 years or older, who must sign and date a written proof of your oral revocation. An oral revocation becomes effective once it is communicated to your doctor.

Full name: _____

Medical record number: _____ Date of birth: _____

Mailing address: _____

Home phone: _____ Cell phone: _____

Work phone: _____ Email: _____

Full name: _____
Medical record number: _____

Part 1. My Durable Power of Attorney (Health Care Agent)

Choosing a health care agent: Choose someone who knows you well, whom you trust to carry out your views and values, and who is able to make hard choices in stressful times. Once you have picked your health care agent, take the time to talk about your views and care goals with that person.

This power of attorney becomes effective upon the incapacity of the principal and shall not be affected by the subsequent incapacity of the principal.

If I am not able to make or communicate my health care choices and my doctor and one other skilled health professional (either a clinical psychologist or a psychiatrist) declare in writing that I am not able to make an informed decision about my care, then I choose the following person(s) to honor my wishes and make my health care decisions.

My health care agent must make health care choices that are the same as my instructions in this document and my known desires. If my agent does not know my wishes, my agent must make health care choices that he or she believes to be in my best interest, keeping in mind what he or she knows about my personal values.

This form does not give my health care agent the power to make financial or other business decisions.

My main health care agent is:

Full name:_____ Relationship to me: _____

Home phone: _____ Cell phone:_____

Work phone: _____ Email:_____

Mailing address: _____

If I cancel my main health care agent's power or if my main agent is not willing, able, or your health care providers are not able to reach your agent to make a health care decision for me, I name the people below as my first and second alternate agents.

First alternate health care agent:

Full name:_____ Relationship to me: _____

Home phone: _____ Cell phone:_____

Work phone: _____ Email:_____

Mailing address: _____

Second alternate health care agent:

Full name:_____ Relationship to me: _____

Home phone: _____ Cell phone:_____

Work phone: _____ Email:_____

Mailing address: _____

Full name: _____

Medical record number: _____

Powers of my health care agent:

Unless I state otherwise, my health care agent has these powers when I am not able to speak for myself or make my own choices:

A. Make choices for me about my health care. This involves choices about tests, medicine, and surgery. It also involves decisions to provide, not give, or stop all forms of health care to keep me alive, as well as tube feedings and IV fluids.

B. Review and release my health records as needed to make decisions.

C. Decide which doctor, health providers, and organizations provide my health care.

D. Arrange for and make choices about whole body, organ, tissue, and/or eye donation for research and education.

More powers of my health care agent:

Check the box below if you named your spouse or domestic partner as your agent and you want your agent to carry on with being your agent even if your marriage or domestic union ends:

❑ I want my agent to stay as my health care agent even if our marriage or domestic union is dissolved, annulled, or ended.

Please provide any added comments or limits to the previous section. (For example, you may name people you would or would not want to be involved in decisions on your behalf. You may also specify choices you would not want your agent to make.) Attach extra pages as needed.

Full name: _____
Medical record number: _____

Part 2. My Values

I want my agent and loved ones to know what matters most to me, so that they can make choices about my health care that match who I am and what is of great value to me.

To give you a sense of what matters most to me, I'd like to tell you some things about myself, such as how I enjoy spending my time, whom I like to be with, and what I like to do. I'd also like to tell you about the circumstances that would make life no longer worthwhile for me.

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

2. What matters most to me is:

3. Life would no longer be worth living if I were not able to:

Full name: _____
Medical record number: _____

Part 3. My Health Care Instructions: My Choices, My Care

In the situation below, we ask you to think about a sudden unexpected event. You will always speak for yourself if you are able; in this situation below, think about what you would want if you are not able to speak for yourself.

If I become not able to communicate or make my own choices, I ask that my health care agent carries out my choices as listed below and that my doctors and health care team honor them. If my health care agent or alternate agents are not available or are not able to make choices on my behalf, this document speaks for my wishes.

Note: If you choose not to give written instructions, your health care agent will make choices based on your spoken wishes. If your wishes are unknown, your agent will make choices based on what he or she believes is in your best interest, thinking about your values.

1. Care to prolong life

Keep in mind these situations:

You have a sudden accident or stroke.

Doctors have determined you have a brain injury, leaving you not able to recognize yourself or your loved ones. The doctors have told your agent and/or family that you are not expected to get these abilities back. Life-sustaining treatments, such as a ventilator (i.e., breathing machine) or a feeding tube are needed to keep you alive. In this condition what would you want?

I would want to be kept comfortable and:

choose one

- ❑ I would want to STOP life-sustaining treatments. I realize this would likely lead me to die sooner than if I were to continue care that is keeping me alive.
- ❑ I would want life-sustaining treatments to live as long as possible.

Please give any extra instructions about life-sustaining treatments. For example, you may want to state a set timespan that you would want to be kept alive if there were no change to your health.

Full name: _____
Medical record number: _____

2. CPR (Cardiopulmonary Resuscitation)

CPR tries to bring you back to life when your heart and breathing have stopped. It may involve chest compressions (forceful pushing on the chest to make the heart contract), medicines, electrical shocks, and a breathing tube.

You have a choice about CPR. CPR can save lives. It is not as helpful as most people think. CPR works best if done quickly, within a few minutes, on a healthy adult. When CPR is performed, it can result in broken ribs, punctured lungs, or brain damage from lack of oxygen.* If you would like more information about CPR, please ask for the brochure called **CPR: My Choice.**

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

choose one

- ❑ I always want CPR attempted.
- ❑ I never want CPR attempted, but rather, want to permit a natural death.†
- ❑ I want CPR attempted unless the doctor treating me decides any of the following:
  - I have an incurable illness or injury and am dying, OR
  - I have no chance of living if my heart or breathing stops, OR
  - I have little chance of living if my heart or breathing stops and CPR would cause major pain.

* Research shows that if you are in a hospital and get CPR, you have a 22% chance of it working and you leaving the hospital alive.

Ehlenbach, W., Barnato, A. E., Curtis, J. R., et al (2009). Epidemiologic study of in-hospital cardiopulmonary resuscitation in the elderly. *New England Journal of Medicine*, 361:22-31. Girotra, S., Brahmajee K., Nallamothu, M.D., et al (2012). Trends in survival after cardiac arrest. *New England Journal of Medicine*, 167:1912-20.

† If you are certain you do not want CPR, please discuss other documents you may want to fill out with your doctor.

Part 4. My Hopes and Wishes (Optional)

1. My thoughts and feelings about where I would prefer to die:

2. I want my loved ones to know that if I am nearing my death, I would appreciate the following for comfort and support (prayers, rituals, music, etc.):

3. Religious or spiritual affiliation:

I am of the _____ faith, and am a member of (faith/spiritual group) _____ _____ in (city) _____, (phone number) _____. I would like my agent to tell them if I am seriously ill or dying. I would like to include in my funeral, if possible, the following (people, music, rituals, etc.):

4. Other wishes/instructions:

Organ donation

If you are interested in donating organs when you die, you can declare your donor status when getting or renewing a driver's license or by registering through the donor registry found at **https://www.donatelifedc.org/**.

Full name: _____

Medical record number: _____

Part 5. Making This Document Legally Valid

Durable Power of Attorney for Health Care

With this document, I plan to create a Durable Power of Attorney for Health Care, which shall take effect if I cannot make my own health care choices and shall carry on during that incapacity.

My attorney-in-fact shall make health care choices as I stated above or as I make known to my attorney-in-fact in some other way.

By my signature I indicate that I understand the purpose and effect of this document.

Print full name: _____

Address: _____

Signature: _____ Date: _____

Full name: _____

Medical record number: _____

To make your Durable Power of Attorney for Health Care legally valid in the District of Columbia, it must be signed by two adult witnesses (witnesses will sign page 9).

Two Witnesses

Your signature on your durable power of attorney for health care cannot be witnessed by you, your health care provider, or your health care provider's staff. At least one of your witnesses must be a person who is not related to you (by blood, marriage, or adoption) and who will not be left any part of your estate.

STATEMENT OF WITNESSES:

I declare that the person who signed or acknowledged this document is personally known to me, that the person signed or acknowledged this durable power of attorney for health care in my presence, and that the person appears to be of sound mind and under no threat, fraud, or undue force. I am not the person chosen as the attorney in fact by this document, nor am I the health care provider of the principal, or an employee of the health care provider of the principal.

Witness Number One:

Print full name: _____

Address: _____

Signature: _____ Date: _____

Witness Number Two:

Print full name: _____

Address: _____

Signature: _____ Date: _____

(AT LEAST ONE OF THE WITNESSES SHALL ALSO SIGN THE FOLLOWING STATEMENT)

I further declare that I am not related to the principal by blood, marriage, or adoption and that I am not entitled to any part of the estate of the principal under a currently existing will or by operation of law.

Signature: _____ Date: _____

Signature: _____ Date: _____

Full name: _____

Medical record number: _____

DISTRICT OF COLUMBIA DECLARATION

Your signature on your declaration cannot be witnessed by anyone signing on your behalf, related to you (by blood, marriage, adoption, or domestic union), who will inherit any part of your estate, who is financially in charge for your medical care, who is your attending doctor or an employee of your attending doctor, or who is an employee of a health care facility in which you are a patient. If you are a patient in an intermediate care of skilled care facility, one of your witnesses must be a patient advocate or ombudsman.

Declaration made this _____ day of _____.
(date) (month, year)

I, _____
(name)

being of sound mind, willfully and of free will make known my desires that my dying shall not be artificially prolonged under the circumstances set forth below, do declare:

If at any time I should have an incurable injury, disease, or sickness declared to be a terminal condition by two doctors who have personally examined me, one of whom shall be my attending physician, and the physicians have decided that my death will result whether or not life-sustaining methods are used and where the application of life-sustaining procedures would serve only to artificially prolong the dying process, I direct that such methods be withheld or withdrawn, and that I be permitted to die naturally with only the administration of medication or the performance of any medical procedure deemed necessary to make me comfortable or to lessen pain.

In the absence of my ability to give directions on the use of such life-sustaining methods, it is my plan that this declaration shall be honored by my family and doctor(s) as the final expression of my legal right to say no to medical or surgical treatment and accept the results from such refusal.

I know the full importance of this declaration and I am emotionally and mentally able to make this declaration.

Signed: _____ Date: _____

Address: _____

I believe the declarant to be of sound mind. I did not sign the declarant's signature above for or at the direction of the declarant. I am at least 18 years of age and am not related to the declarant by blood, marriage, adoption, or domestic union, entitled to any part of the estate of the declarant as stated by the laws of intestate succession of the District of Columbia or under any will of the declarant or codicil thereto, or directly financially responsible for declarant's medical care. I am not the declarant's attending physician, an employee of the attending physician, or an employee of the health facility in which the declarant is a patient.

Witness: _____ Date:_____

Witness: _____ Date:_____

Full name: _____

Medical record number: _____

Part 6. Next Steps

Now that you have filled out your advance health care directive, you should also take the following steps.

Discuss:

1. Review your health care wishes with the person you have asked to be your agent (if you haven't done so). Make sure he or she feels able to do this important job for you in the future.
2. Talk to the rest of your family and close friends who might be involved if you have a serious illness or injury. Make sure they know who your health care agent is and what your wishes are.

Give copies:

1. Give your health care agent a copy of your advance health care directive.
2. Give a copy of your advance health care directive to your doctor or your local Kaiser Permanente Medical Records Department.
3. Make a copy for yourself and keep it where it can be easily found.

Take with you:

1. If you go to a hospital or nursing home, take a copy of your advance health care directive and ask that it be placed in your health record.
2. Take a copy with you any time you will be away from home for an extended period of time.

Review often:

1. Review your health care wishes when any of the "Five D's" occur:

   Decade – when you start each new decade of your life

   Death – when you go through the death of a loved one

   Divorce – when you go through a divorce or other major family change

   Diagnosis – when you are diagnosed with a serious health condition

   Decline – when you feel a major drop or deterioration in your health, especially when you are not able to live on your own

Changing your advance health care directive:

If your wishes change, fill out a new advance health care directive, tell your agent and your family, and give a copy to Kaiser Permanente.

Copies of this document have been given to:

- Primary (main) health care agent — Full name:_____ Telephone:_____
- Alternate health care agent #1 — Full name:_____ Telephone:_____
- Alternate health care agent #2 — Full name:_____ Telephone:_____
- Health care provider/clinic — Name:_____ Telephone:_____
- Others: — Name:_____ Telephone:_____

Notes:

Notes:

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Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc.
4000 Garden City Drive, Hyattsville, MD 20785

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