Advance Health Care Directive

DISTRICT OF COLUMBIA

LIFE CARE **planning**

my values, my choices, my care

kp.org/lifecareplan

KAISER PERMANENTE®

1-B

Full name: _____

Medical record number: _____

1-A 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
- Both name a Durable Power of Attorney for Health Care AND give written orders for future health care, AND/OR
- 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: _____

2-A 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.

2-B 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: 2-C

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: 2-D

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: 3-A

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.

3-B

_____

_____

_____

_____

_____

_____

Full name: _____
Medical record number: _____

Part 2. My Values 4-A

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: 4-B

_____

_____

_____

_____

_____

_____

2. What matters most to me is:

_____

_____

_____

_____

_____

_____

3. Life would no longer be worth living if I were not able to: 4-C

_____

_____

_____

_____

_____

_____

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

5-A

Keep in mind these situations:

You have a sudden accident or stroke.

5-B *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.

5-C _____

_____

_____

_____

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.

6-A 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.

Full name: _____
Medical record number: _____

Part 4. My Hopes and Wishes (Optional)

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

7-A _____

_____

_____

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: 7-B

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: 7-C

_____

_____

_____

_____

Organ donation 7-D

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 8-A

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).

9-A 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.

9-B 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: _____

9-C (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 10-A

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.

10-B 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.

10-C 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.

11-A 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.

11-B 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.

11-C 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

11-D 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:_____

Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc. (Kaiser Health Plan) complies with applicable federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Kaiser Health Plan does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex. We also:

- Provide no cost aids and services to people with disabilities to communicate effectively with us, such as:
    - Qualified sign language interpreters
    - Written information in other formats, such as large print, audio, and accessible electronic formats
- Provide no cost language services to people whose primary language is not English, such as:
    - Qualified interpreters
    - Information written in other languages

If you need these services, call the number provided below.

District of Columbia	1-800-777-7902
Maryland	1-800-777-7902
Virginia	1-800-777-7902
TTY	711

If you believe that Kaiser Health Plan has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with the Kaiser Civil Rights Coordinator, 2101 East Jefferson Street, Rockville, MD 20852, telephone number: 1-800-777-7902. You can file a grievance by mail or phone. If you need help filing a grievance, the Kaiser Civil Rights Coordinator is available to help you. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at *https://ocrportal.hhs.gov/ocr/portal/lobby.jsf,* or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue SW., Room 509F, HHH Building, Washington, DC 20201, 1-800-368-1019, 1-800-537-7697 (TDD). Complaint forms are available at *http://www.hhs.gov/ocr/office/file/index.html.*

Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc (Kaiser Health Plan) cumple con las leyes federales de derechos civiles aplicables y no discrimina por motivo de la raza, color, nacionalidad de origen, edad, discapacidad o sexo. El Kaiser Health Plan no excluye a las personas o las trata de forma diferente por motivo de la raza, color, nacionalidad de origen, edad, discapacidad o sexo. Recuerde también:

- Nosotros les brindamos ayuda y servicios sin costo alguno a las personas que tienen una discapacidad que les impide comunicarse con nosotros en forma eficaz, tales como:
    - Intérpretes calificados de lenguaje de señas
    - Información por escrito en otros formatos, tales como letra grande, audio y otros formatos electrónicos accesibles
- Brindamos servicios de idiomas sin costo alguno a personas cuyo idioma principal no sea el inglés, tales como:
    - Intérpretes calificados
    - Información por escrito en otros idiomas

Si necesita dichos servicios, llame al número proporcionado a continuación.

District of Columbia	1-800-777-7902
Maryland	1-800-777-7902
Virginia	1-800-777-7902
Línea TTY	711

Si cree que el Kaiser Health Plan no le ha brindado dichos servicios o ha incurrido en discriminación en contra suya de otra manera por motivo de la raza, color, nacionalidad de origen, edad, discapacidad o sexo, usted puede presentar una queja ante el Kaiser Civil Rights Coordinator, 2101 East Jefferson Street, Rockville, MD 20852, número de teléfono: 1-800-777-7902. Puede presentar una queja por correo o por teléfono. Si necesita ayuda para presentar una queja, el Kaiser Civil Rights Coordinator está disponible para ayudarle. También puede presentar una queja de derechos civiles ante el Departamento de Salud y Servicios Humanos de los Estados Unidos (U.S. Department of Health and Human Services), la Oficina de Derechos Civiles (Office for Civil Rights) a través del Portal de Quejas de la Oficina de Derechos Civiles, disponible en *https://ocrportal.hhs.gov/ocr/portal/lobby.jsf*, o por correo electrónico o por teléfono: Departamento de Salud y Servicios Humanos de los Estados Unidos, 200 Independence Avenue SW., Room 509F, HHH Building, Washington, DC 20201, 1-800-368-1019, 1-800-537-7697 (TDD). Los formularios de queja están disponibles en *http://www.hhs.gov/ocr/office/file/index.html*.

Help in your Language

English: You have the right to get help in your language at no cost. If you have questions about your application or coverage through Kaiser Permanente, or if this is a notice that requires you to take action by a specific date, call the number provided for your state or region to talk to an interpreter.

አማርኛ (Amharic): ያለምንም ክፍያ በራስዎ ቋንቋ እገዛ የማግኘት መብት አለዎት። ስለ ማመልከቻዎ ወይም ከኬሰር ፐርማነንቴ Kaiser Permanente ስለሚያገኙት ሽፋን ማንኛውም ጥያቄዎች ካሉዎት፣ ወይም ይህ ማሳወቂያ በግልፅ በተጠቀሰ ቀን ማድረግ ያለብዎ ነገር እንዳለ የሚያስገድድዎ ከሆነ፣ በተጠቀሰው የስልክ ቁጥር ለአቴትዎ ወይም ለክልልዎ ደውለው ከአስተርጓሚ ጋር ይነጋገሩ።

العربية (Arabic): لك الحق في الحصول على المساعدة بلغتك دون تحمل أي تكاليف. إذا كانت لديك استفسارات بشأن طلبك أو تغطيتك التي تقدمها Kaiser Permanente، أو إذا كان هذا الإشعار الذي يتطلب منك اتخاذ إجراء خلال تاريخ محدد، يُرجى الاتصال بالرقم المخصص لولايتك أو منطقتك للتحدث إلى مترجم فوري.

Հայերեն (Armenian): Դուք ունեք Ձեր լեզվով անվճար օգնություն ստանալու իրավունք: Եթե Դուք հարցեր ունեք Ձեր դիմումի կամ Kaiser Permanente-ի միջոցով Ձեր ծածկույթի վերաբերյալ, կամ եթե սա ծանուցում է, որը պարտադրում է Ձեզ, որպեսզի գործողություններ ձեռնարկեք մինչև որոշակի ամսաթիվ, ապա զանգահարե՛ք Ձեր նահանգի կամ շրջանի համար տրամադրված հեռախոսահամարով՝ թարգմանչի հետ խոսելու համար:

Bǎsɔ́ɔ̀ Wùdù (Bassa): Ɔ mɔ̀ nì kpé ɓɛ́ m̀ ké gbo-kpá-kpá dyé dɛ́ nì mìɔùn nììn ɓídí-wùdù mú pídyi. Ɔ jŭ ké m̀ dyi dyi-diè-dɛ̀ ɓě ɓédɛ́ ɓá nì céè-dɛ̀ m̀ tò ɓó dɛ zɔ̀ jè dyíɛ ní, mɔɔ jŭ ɓá nì kũùn kpɔ̃ jè dyí dyììn dɛ́ Kaiser Permanente múɛ ní, mɔɔ ɔ dyi bɔ̌ dɔ̀ jŭ ɓɛ́ m̀ ké dɛ dɔ̀ nyu ɓó wé jɛ́ɛ́ dɔ̀ kɔ̃ nì, nìí, dá nɔ̀bà ɓɛ́ wa tòà ɓó nì ɓódɔ́ɔ̀ mɔɔ nì gbɛ̌ɛ̀ɔ̀ bìɛ, ké nì mu nyɔ-wudúún-zà-nyɔ̀ dɔ̀ gbo wùdùùn.

বাংলা (Bengali): বিনা খরচে আপনার নিজের ভাষায় সাহায্য পাওয়ার অধিকার আপনার আছে। আপনার যদি আপনার আবেদন বা Kaiser Permanente-এর মাধ্যমে পাওয়া কভারেজ নিয়ে কোনো প্রশ্ন থাকে বা এটি যদি কোনো নোটিস হয় যার ফলে আপনার একটি নির্ধারিত দিনের মধ্যে কোনো পদক্ষেপ গ্রহণ করার প্রয়োজন হয়, তাহলে দোভাষীর সাথে কথা বলতে আপনার রাজ্য বা অঞ্চলের জন্য প্রদত্ত নম্বরটিতে ফোন করুন।

California	**1-800-464-4000**
Colorado	**1-800-632-9700**
District of Columbia	**1-800-777-7902**
Georgia	**1-888-865-5813**
Hawaii	**1-800-966-5955**
Maryland	**1-800-777-7902**
Oregon	**1-800-813-2000**
Virginia	**1-800-777-7902**
Washington	**1-800-813-2000**
TTY	**711**

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Cebuano (Bisaya): Anaa moy katungod nga mangayo og tabang sa inyo pinulongan ug kini walay bayad. Kung naa mo pangutana bahin sa inyo aplikasyon o coverage sa Kaiser Permanente, o kung kaning pahibalo nanginahanglan sa inyo paglihok sa dili pa usa ka piho nga petsa, palihug lang pagtawag sa mga numero sa telepono nga gihatag sa imong estado ("state") o rehiyon ("region") para makigstorya sa usa ka interpreter.

中文 (Chinese): 您有權免費以您的語言獲得幫助。如果您對您的Kaiser Permanente申請或承保有任何疑問，或者如果本通知要求您在具體日期之前採取措施，請致電您所在的州或地區的電話，與口譯員進行溝通。

Chuuk (Chukese): Mei wor omw pwuung omw kopwe angei aninis non foosun fonuomw (Chuukese), ese kamo. Ika mei wor omw kapas eis usun omw apilikeison me/ika policy fan nemenien Kaiser Permanente, are ika ei esinesin a erenuk pwe kopwe fori pwan ekoch fofor, ka tongeni omw kopwe kori ewe nampa mei kawor faniten omw state ika fonu (asan) iwe eman chon chiakku epwe anisuk non kapasen fonuomw.

Français (French): Une assistance gratuite dans votre langue est à votre disposition. Si vous avez des questions à propos de votre demande d'inscription ou de la couverture par Kaiser Permanente, ou si cet avis vous demande de prendre des mesures à une date précise, appelez le numéro indiqué pour votre Etat ou votre région pour parler à un interprète.

Deutsch (German): Sie haben das Recht, kostenlose Hilfe in Ihrer Sprache zu erhalten. Falls Sie Fragen bezüglich Ihres Antrags oder Ihres Krankenversicherungsschutzes durch Kaiser Permanente haben oder falls Sie aufgrund dieser Benachrichtigung bis zu bestimmten Stichtagen handeln müssen, rufen Sie die für Ihren Bundesstaat oder Ihre Region aufgeführte Nummer an, um mit einem Dolmetscher zu sprechen.

ગુજરાતી (Gujarati): તમને કોઇ પણ ખર્ચ વગર તમારી ભાષામાં મદદ મેળવવાનો અધિકાર છે. જો તમને Kaiser Permanente મારફતે તમારી અરજી અથવા કવરેજ વિશે પ્રશ્નો હોય, અથવા જો આ નોટિસ હોય જેમા તમને કોઈચોક્કસ તારીખથી પગલાં લેવાની જરૂર હોય, તો દુભાષિયા સાથે વાત કરવા તમારા સ્ટેટ અથવા રીજીયન માટે પૂરા પાડવામાં આવેલ નંબર પર ફોન કરો.

Kreyòl Ayisyen (Haitian Creole): Ou gen dwa pou jwenn èd nan lang ou gratis. Si ou gen nenpòt kesyon sou aplikasyon ou an oswa asirans ou ak Kaiser Permanente, oswa si nan avi sa a gen bagay ou sipoze fè sa a avan yon sèten dat, rele nimewo nou mete pou Eta oswa rejyon ou a pou w ka pale ak yon entèprèt.

ʻōlelo Hawaiʻi (Hawaiian): He pono a ua loaʻa no kekahi kōkua me kāu ʻōlelo inā makemake a he manuahi no hoʻi. Inā he mau nīnau kāu e pili ana i kāu palapala noi ʻinikua ola kino a i ʻole i kōkua maʻō ka polokalamu kōkua ola kino Kaiser Permanente, a i ʻole inā ke haʻi nei paha kēia leka nei iāʻoe e hana koke aku i kēia ma mua o kekahi lā i waiho ʻia, e kelepona aku i ka helu i loaʻa ma kēia leka nei no kāu mokuʻāina a i ʻole panaʻāina no ka walaʻau ʻana me kekahi kanaka unuhi ʻōlelo.

हिन्दी (Hindi): आपको बिना किसी कीमत चुकाए आपकी भाषा में सहायता पाने का अधिकार है। यदि आप आपके आवेदन पत्र के विषय में या Kaiser Permanente के कवरेज के विषय में कुछ पूछना चाहते हैं या यदि यह एक नोटिस है जिसके कारण आपको किसी विशेष तिथि तक कारवाई करनी पड़ेगी तो आपके राज्य या क्षेत्र के लिए दिए गए नंबर पर फोन करके किसी दुभाषिये से बात करें।

Hmoob (Hmong): Koj muaj cai kom tau txais kev pab uas hais koj hom lus yam tsis tau them nqi. Yog koj muaj lus nug txog koj daim ntawv thov los yog cov kev pab them nyiaj tim Kaiser Permanente, los yog tias daim ntawv no yog ib tsab ntawv ceebtoom uas yuav kom koj ua ib yam dabtsi raws li hnub tau teev tseg, hu rau tus nab npawb xovtooj uas tau muab rau koj lub xeev lossis cheeb tsam kom tau tham nrog tus kws txhais lus.

Igbo (Igbo): Ị nwere ikike ịnweta enyemaka n'asụsụ gị na akwụghị ụgwọ ọ bụla. Ọ bụrụ na ị nwere ajụjụ gbasara akwụkwọ anamachọihe gị ma ọ bụ mkpuchi si na Kaiser Permanente, ma ọ bụ ọ bụrụ na nke bụ ọkwa a chọrọ ka ị mee ihe tupu otu ụbọchị, kpọọ nọmba enyere maka steeti ma ọ bụ mpaghara gị iji kwukọrịta okwu n'etiti onye ọkọwa okwu.

Iloko (Ilocano): Adda ti karbenganyo a dumawat iti tulong iti pagsasaoyo nga awan ti bayadanyo. No addaankayo kadagiti saludsod maipanggep ti aplikasionyo wenno coverage babaen ti Kaiser Permanente, wenno no daytoy ket maysa a pakdaar a kalikagumanna a rumbeng nga aramidenyo ti addang iti espesipiko a petsa, tawagan ti numero nga inpaay para ti estado wenno rehion tapno makipatang ti maysa mangipatarus iti pagsasao.

Italiano (Italian): Hai il diritto di ricevere assistenza nella tua lingua gratuitamente. In caso di domande riguardanti la tua richiesta o la copertura attraverso Kaiser Permanente, o se occorre intervenire entro una data specifica secondo quanto indicato in questa comunicazione, chiama il numero fornito per il tuo stato o la tua regione per parlare con un interprete.

日本語 (Japanese): あなたは、費用負担なしでご使用の言語で支援を受ける権利を保持しています。お申し込みまたはKaiser Permanenteの担保範囲に関してご質問があるか、または本通知により、あなたが特定の日付までに行動を起こすよう依頼されている場合、お住まいの州または地域に対して提供された電話番号に電話して、通訳とお話ください。

ខ្មែរ (Khmer): អ្នកមានសិទ្ធិទទួលបានជំនួយជាភាសារបស់អ្នកដោយឥតគិតថ្លៃ។ បើសិនអ្នកមានសំណួរណាមួយអំពីពាក្យស្នើសុំឬការធានារ៉ាប់រងតាមរយៈ Kaiser Permanente ឬប្រសិននេះគឺជាលិខិតជូនដំណឹងដែលតម្រូវឲ្យអ្នកចាត់វិធានការត្រឹមកាលបរិច្ឆេទជាក់លាក់ សូមទូរស័ព្ទទៅលេខដែលបានផ្តល់ជូនសម្រាប់រដ្ឋឬតំបន់របស់អ្នកដើម្បីនិយាយទៅកាន់អ្នកបកប្រែ។

한국어 (Korean): 귀하에게는 한국어 통역서비스를 무료로 받으실 수 있는 권리가 있습니다.
Kaiser Permanente를 통한 귀하의 보험 신청서나 보험 보장 범위에 관해 질문이 있을 경우 또는 이 통지서의 요구대로 어느 날짜까지 조취를 취해야만 하는 경우, 귀하의 주 및 지역의 제공된 전화번호로 연락해 통역사와 통화하십시오.

ลาว (Laotian): ທ່ານມີສິດທີ່ຈະໄດ້ຮັບການຊ່ວຍເຫຼືອໃນພາສາຂອງທ່ານໂດຍບໍ່ເສັງຄ່າ. ຖ້າວ່າ ທ່ານມີຄຳຖາມກ່ຽວກັບການສະໝັກຂອງທ່ານ ຫຼື ການຄຸ້ມຄອງຜ່ານ Kaiser Permanente, ຫຼື ຖ້າອັນນີ້ເປັນແຈ້ງການທີ່ຮຽກຮ້ອງໃຫ້ທ່ານດຳເນີນການພາຍໃນວັນທີທີ່ເຈາະຈົງໃດໜຶ່ງ, ໃຫ້ໂທຕາມໝາຍເລກທີ່ໃຫ້ໄວ້ສຳລັບລັດ ຫຼື ເຂດຂອງທ່ານ ເພື່ອຂໍລົມກັບນາຍພາສາ.

Kajin Majōļ (Marshallese): Ewōr jimwe eo aṃ in bōk jipañ ilo kajin eo aṃ ejjeļọk wōṇāān. Ñe ewōr aṃ kajjitōk kōn peba in aplaiki eo aṃ ak insurance eo aṃ jān Kaiser Permanente, ak ñe enaan in kōjeļā in ej aikuj bwe kwōn ṃakūtkūt ṃokta jān juon raan eo emōj an kallikkar, kaļọk nōṃba eo ej leļọk ñan state eo aṃ ak jikūṃ bwe kwōn maroñ kōnono ippān juon ri-ukōt.

Naabeehó (Navajo): T'áá ni nizaad bee níká i'doolwoł doo bik'é asíníłáágóó éí bee náhaz'ą́. Kaiser Permanente áká aná'álwo' ná bik'é azláadoo yíníkeedgo naaltsoos hadinilaa, éí bína'ídíłkid doogo, éí doodago díí naaltsoos haa'ída yoołkáałgo hait'áoda í'díílíił nilníigo éí nitsaa hahoodzojí éí doodago t'áá aadi nahós'a'di ata' dahalne'ígíí bich'į' hólne'go bee bił ahił hodíílnih.

नेपाली (Nepali): तपाईसगं कुनै शुल्क नदिइ आफ्नो भाषामा सहायता पाउने अधिकार छ । तपाईंसंग आफ्नो आवेदन बारे वा Kaiser Permanente मार्फत कवरेज बारेमा कुनै प्रश्नहरू भए, वा यो नोटिस अनुसार तपाईंले कुनै निर्धारित मितिमा कुनै कार्यवाही गर्नु पर्ने आवश्यकता भएमा, दोभाषेसंग कुराकानी गर्न तपाईंको राज्य वा क्षेत्रका लागि दिइएको नम्वरमा कल गर्नुहोस् ।

Afaan Oromoo (Oromo): Baasii malee afaan keetiin gargaarsa argachuudhaaf mirga qabda. Waa'ee iyyata keetii yookaan tajaajila Kaiser Permanente hammatu ilaalchisee gaaffii yoo qabaatte, yookaan yoo kun beeksisa guyyaa murtaa'e irratti tarkaanfii akka ati fudhattu gaafatu ta'e, lakkoofsa bilbilaa naannoo yookaan goodina keetiif kenname bilbiluudhaan turjumaana haasofsiisi.

فارسی (Persian): شما حق دارید که بدون هیچ هزینه ای به زبان خود کمک دریافت کنید. اگر درباره درخواست یا پوشش خود در Kaiser Permanente سؤالی داشته یا بر اساس این اعلامیه باید تا تاریخ مشخصی اقدامی بعمل آورید، برای صحبت با یک مترجم شفاهی با شماره تلفن ارائه شده برای ایالت یا منطقه خود تماس بگیرید.

lokaiahn Pohnpei (Pohnpeian): Komw anehki pwung en rapahki sounkawehwe en omw palien lokaia ni sohte isaihs. Ma mie iren owmi kalelapak ohng aplikeisin de iren audepe kan ohng Kaiser Permanente, de ma pakair wet me anahne komwi en mwekid ohng rahn me kileledi, ah komw anahne koahl nempe me sansalehr ohng owmi palien wehi pwe komwi en lokaiaieng owmi tungoal soun kawehwe.

Português (Portuguese): Você tem o direito de obter ajuda em seu idioma sem nenhum custo. Se você tiver dúvidas sobre sua solicitação ou cobertura por meio da Kaiser Permanente, ou se este aviso exigir que você tome alguma medida até uma data específica, ligue para o número fornecido para seu estado ou região para falar com um intérprete.

ਪੰਜਾਬੀ (Punjabi): ਤੁਹਾਨੂੰ ਬਿਨਾਂ ਕਿਸੇ ਸ਼ੁਲਕ ਤੇ ਆਪਣੀ ਭਾਸ਼ਾ ਵਿਚ ਮਦਦ ਪਾਉਣ ਦਾ ਹੱਕ ਹੈ. ਜੇਕਰ ਤੁਹਾਡੇ ਆਪਣੀ ਅਰਜ਼ੀ ਜਾਂ Kaiser Permanente ਰਾਹੀਂ ਕਵਰੇਜ ਬਾਰੇ ਸਵਾਲ ਹਨ, ਜਾਂ ਇਸ ਨੋਟਿਸ ਵਜੋਂ ਤੁਹਾਨੂੰ ਕਿਸੇ ਨਿਸ਼ਚਿਤ ਮਿਤੀ ਤੱਕ ਕਾਰਵਾਈ ਕਰਨ ਦੀ ਲੋੜ ਪਵੇ, ਤਾਂ ਦੁਭਾਸ਼ੀਏ ਨਾਲ ਗੱਲ ਕਰਨ ਲਈ ਆਪਣੇ ਰਾਜ ਜਾਂ ਇਲਾਕੇ ਲਈ ਮੁਹੱਈਆ ਕਰਵਾਏ ਗਏ ਨੰਬਰ ਤੇ ਫ਼ੋਨ ਕਰੋ.

Română (Romanian): Aveți dreptul de a solicita ajutor care să vă fie oferit în mod gratuit în limba dumneavoastră. Dacă aveți întrebări legate de solicitarea dumneavoastră sau de acoperirea oferită de Kaiser Permanente sau dacă acest aviz vă solicită să luați măsuri până la o anumită dată, sunați la numărul de telefon furnizat pentru statul sau regiunea dumneavoastră pentru a sta de vorbă cu un interpret.

Русский (Russian): У вас есть право получить бесплатную помощь на своем языке. Если у вас имеются вопросы относительно вашего заявления или медицинского страхования в Kaiser Permanente, либо если такое уведомление требует от вас каких-либо действий к определенной дате, позвоните по номеру телефона для своего штата или региона, чтобы поговорить с переводчиком.

Faa-Samoa (Samoan): E iai lou ‘aia e maua se fesoasoani i lou gagana e aunoa ma le totogi. Afai e iai ni fesili e uiga i lou tusi apalai po o puipuiga e ala mai Kaiser Permanente, po o lenei tusi e manaomia ona e gaoioi i se taimi atofaina, vili le numera ua fuafuaina mo lou setete po o oganuu e fesoota’i i se faaliliu.

Español (Spanish): Usted tiene derecho a obtener ayuda en su idioma sin costo alguno. Si tiene preguntas acerca de su solicitud o cobertura a través de Kaiser Permanente, o si este es un aviso que requiere que usted tome alguna medida antes de una fecha determinada, llame al número de teléfono que se proporciona para su estado o región para hablar con un intérprete.

Tagalog (Tagalog): Mayroon kang karapatang humingi ng tulong sa iyong wika nang walang bayad. Kung mayroon kang mga katanungan tungkol sa iyong aplikasyon o coverage sa pamamagitang ng Kaiser Permanente, o kung ito ay abisong nangangailangan ng iyong aksyon sa tiyak na petsa, tumawag sa numerong ibinigay para sa iyong estado o rehiyon para makipag-usap sa isang interpreter.

ไทย (Thai): ท่านมีสิทธิที่จะได้รับความช่วยเหลือในภาษาของท่านโดยไม่เสียค่าใช้จ่าย หากท่านมีคำถามเกี่ยวกับการสมัครของท่าน หรือความคุ้มครองผ่าน Kaiser Permanente หรือหากนี่คือหนังสือที่ต้องการให้ท่านดำเนินการภายในวันที่ที่กำหนดไว้ โปรดติดต่อหมายเลขที่ให้ไว้สำหรับรัฐหรือเขตพื้นที่ของท่านเพื่อคุยกับล่าม

Lea Faka-Tonga (Tongan): ‘Oku ‘ia ho totonu ke ke ma’u ha fakatonulea ta’etotongi. Kapau ‘oku ‘i ai ha’o fehu’i ki ho tohi kole na’e fakafonu ki he malu’i ‘inisiua ‘a e Kaiser Permanente, pea kapau ko e tohini ‘oku fiema’u keke fai ha me’a ki ai pe ko ha ‘aho na’e tuku pau atu ke fai ia, taa ki he fika kuo ‘oatu ki ho siteiti pe ko e vahefonua ‘oku ke ‘i ai ke talanoa mo ha tokotaha tene fakatonu lea atu kiate koe.

Українська (Ukrainian): У Вас є право на отримання допомоги безкоштовно на Вашій рідній мові. Якщо Ви маєте питання стосовно Вашого звернення чи страхового покриття в Kaiser Permanente, чи якщо відповідно до такого повідомлення Вам треба буде здійснити певну дію до конкретної дати, подзвоніть по номеру, що відповідає Вашій країні чи регіону, щоб поговорити з перекладачем.

اُردو (Urdu): آپ کوکوئی بھی قیمت ادا کئے بغیر اپنی زبان میں مدد حاصل کرنے کا حق ہے۔ اگر آپ کے ذہن میں اپنی درخواست یا Kaiser Permanente کے ذریعہ کوریج کے متعلق کوئی بھی سوالات ہیں، یا اگر اس نوٹس کی وجہ سے آپ کو کسی مخصوص تاریخ تک عمل انجام دینے کی ضرورت ہوگی تو، کسی مترجم سے بات چیت کرنے کے لئے آپ کی ریاست یا علاقہ کے لئے فراہم کئے گئے نمبر پر کال کریں۔

Tiếng Việt (Vietnamese): Quý vị có quyền được nhận trợ giúp miễn phí bằng ngôn ngữ của mình. Nếu quý vị có các câu hỏi về mẫu đơn hoặc mức bảo hiểm của mình thông qua Kaiser Permanente, hoặc đây là thông báo yêu cầu quý vị thực hiện vào một ngày cụ thể, hãy gọi đến số điện thoại được cung cấp cho bang hoặc khu vực của quý vị để trò chuyện với phiên dịch viên.

Yorùbá (Yoruba): O ní ẹ̀tọ́ láti rí ìrànlọ́wọ́ gbà nípa èdè rẹ láìsan owó. Bí o bá ní ìbéèrè nípa ìwé tí o kọ tàbí ìṣedéédé nípaṣẹ̀ Kaiser Permanente, tàbí ìfitọnilétí yìí jẹ́ èyí o nílò láti ìgbésẹ̀ kan ní ọjọ́ kan pató, pé nọ́mbà tí a pèsè fún ìpínlẹ̀ tàbí agbègbè rẹ láti bá òǹgbifọ̀ kan sọ̀rọ̀.

LIFE CARE **planning**

my values, my choices, my care

Need additional assistance?
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2101 E. Jefferson St., Rockville, MD 20852

60615208 MAS 4/1/17-12/31/18

Instructions

1-A Learn more about our approach to Life Care Planning.

1-B Please remember to write these items on every page:

- Your name.
- Your medical record number, which is found on your blue Kaiser insurance card.

2-A What are the qualities you should look for in agent? Learn how to choose an agent.

2-B Learn more about what is an agent and their responsibilities.

2-C Some people don't have anyone in mind to be their agent. Learn about Life Care Planning without an agent.

2-D An alternate agent would be needed if your primary agent is not available. Learn more about agents.

3-A Video: What I might consider when choosing my agent.

3-B This space may be used for any instructions related to agents and their powers. If you have a family member who has beliefs about these topics that are significantly different from yours, you may decide to exclude this person from being involved in decision-making, even informally.

4-A In a serious medical situation, where the outcome is uncertain, your agent may look to this section for guidance. You'll be doing your agent a favor by providing rich detail here.

4-B For further guidance, read your values are at the center of your life care plan.

4-C Situations where values matter.

5-A Should you ever be in a similar situation, it would be valuable for your agent to know your opinions about life sustaining treatment.

5-B Video: Get more details about this brain injury scenario.

5-C Video: Learn more accepting life sustaining treatments for a specific time period, in this scenario.

6-A CPR can save lives, but it's not as effective most people think. Read a discussion about CPR.

7-A Sometimes, our values inform not only what we want, but of what we don't want. If you have some thoughts about how you would ideally like to die, please add them here.

7-B If you are part of a faith community, please add in details of how we may contact them.

7-C Be aware that if you're interested in whole body donation, this is typically arranged well in advance and requires forms and documentation.

7-D If you're interested in organ donation, please be sure your agent is aware of this. Your agent would be responsible for arranging this at the time of death.

8-A Learn more about making this document legally valid.

9-A Learn more about making this document legally valid.

9-B Please note that a witness **may not** be your appointed health care agent. In addition remember: It must be signed by two adult witnesses.

9-C One witness cannot be related by blood, ,marriage or adoption and I am not entitle to the estate by a will.

10-A District of Columbia Declaration, signed by member.

10-B Member signs

10-C 2 Witnesses sign

11-A Learn more about sharing your values with your agent.

11-B If you have a scheduled appointment, you may hand deliver a copy to your doctor or you may visit Membership Services.

11-C If you'd like to let your doctor know you've completed your Advance Health Care Directive and who you've chosen as your agent, you may send a secure message on kp.org using this handy email template.

11-D Read more: With whom should you share your Life Care Plan?