ADVANCE HEALTH CARE DIRECTIVE CLIENT INTAKE QUESTIONNAIRE:

CONFIDENTIAL. An Advance Health Care Directive lets you (1) name a person to make health care decisions for you if you cannot make them yourself, and (2) state your own wishes about medical treatment, organ donation, and related matters. Please complete every section that applies. If a question does not apply, write "N/A." Attach additional pages if needed and note the question number.

NAME OF THE CLIENT (PRINCIPAL):

[__] Full Legal Name: _____

Other names used (maiden, prior married, aliases): _____

Date of Birth: _____ Syndicate Plan Member ID: _____

ADDRESS & CONTACTS:

Address: _____

City: _____ County: _____ State: _____ Zip: _____

Phone: _____ Alt. Phone: _____

Email: _____

Preferred method of contact:

[__] Phone [__] Text [__] Email

Primary language: _____

Will you need an interpreter? [__] Yes [__] No

Do you need any accommodation to review or sign documents (large print, reading assistance, home or hospital signing)? [__] Yes [__] No

If yes, explain: _____

PART 1 — BACKGROUND

1.1 Reason for creating your directive (check all that apply):

[__] Planning ahead / no current health concern [__] Upcoming surgery or procedure

[__] Recent diagnosis or change in health [__] Updating or replacing an existing directive

[__] Family member / caregiver request [__] Other

1.2 Do you already have an Advance Health Care Directive, living will, or health care power of attorney?

[__] Yes [__] No

If yes — date signed and state where signed: _____

Agent(s) named in that document: _____

What would you like to do with the existing document?

[__] Replace it entirely [__] Keep it and add to it [__] Not sure

1.3 Do you have a POLST or a Do-Not-Resuscitate (DNR) order? [__] Yes [__] No

1.4 Do you have a Durable Power of Attorney for finances, a will, or a living trust? [__] Yes [__] No

If yes, which documents and dates: _____

1.5 Other states where you regularly live or spend time: _____

1.6 Current residence type:

[__] Home [__] Assisted Living [__] Skilled Nursing Facility

If you are currently a patient in a skilled nursing facility, California law requires a patient advocate or ombudsman to witness your directive. Please let us know right away.

1.7 Current general health (optional — brief description): _____

_____

Health Care Providers:

Primary Physician — Name: _____

Practice / Medical Group: _____ Phone: _____

Physician Address: _____

Preferred Hospital: _____ Health Plan / Insurer: _____

PART 2 — HEALTH CARE AGENT (POWER OF ATTORNEY FOR HEALTH CARE)

Your agent must be an adult. Unless related to you by blood, marriage, registered domestic partnership, or adoption, or a co-worker, your agent generally may not be your supervising health care provider or an operator or employee of a health care facility or residential care facility where you receive care.

Primary Agent:

Full Name: _____ Relationship to You: _____

Address: _____

City: _____ State: _____ Zip: _____

Home / Cell Phone: _____ Work Phone: _____

Email: _____

Has this person agreed to serve as your agent? [__] Yes [__] No

First Alternate Agent (serves if the primary agent is unwilling, unable, or not reasonably available):

Full Name: _____ Relationship to You: _____

Address: _____

City: _____ State: _____ Zip: _____

Home / Cell Phone: _____ Work Phone: _____

Email: _____

Has this person agreed to serve as your agent? [__] Yes [__] No

Second Alternate Agent (optional):

Full Name: _____ Relationship to You: _____

Address: _____

City: _____ State: _____ Zip: _____

Home / Cell Phone: _____ Work Phone: _____

Email: _____

Has this person agreed to serve as your agent? [__] Yes [__] No

Is any person listed above your doctor, other health care provider, or an employee of a facility where you receive care? [__] Yes [__] No

If yes, explain: _____

Agent's Authority:

2.1 When should your agent's authority begin?

[__] Immediately upon signing

[__] Only when my primary physician determines I cannot make my own decisions

2.2 Are there any decisions your agent should NOT be allowed to make, or any limits on your agent's authority? _____

_____

_____

2.3 After your death, should your agent be authorized to (check all that apply):

[__] Authorize an autopsy

[__] Make anatomical gifts (organ/tissue donation)

[__] Direct disposition of my remains

2.4 If a court ever needs to appoint a conservator of your person, do you want to nominate your agent?

[__] Yes [__] No

If no, whom would you nominate? _____

2.5 Should your agent be able to access your medical records (HIPAA authorization) even before you become incapacitated? [__] Yes [__] No

2.6 Is there anyone who should NOT be involved in decisions about your care, or who should NOT receive information about your health? _____

_____

PART 3 — INSTRUCTIONS FOR HEALTH CARE

End-of-Life Decisions:

Choose the statement that best reflects your wishes if (a) you have an incurable and irreversible condition that will result in death within a relatively short time, (b) you become unconscious and, to a reasonable degree of medical certainty, will not regain consciousness, or (c) the likely risks and burdens of treatment would outweigh the expected benefits.

3.1 General preference:

[__] Choice NOT to Prolong Life — I do not want my life prolonged in these situations.

[__] Choice TO Prolong Life — I want my life prolonged as long as possible within generally accepted health care standards.

[__] Let my agent decide, based on my values and what I have told them.

[__] Not sure — I would like to discuss this.

3.2 Specific Treatments (in the situations described above):

Treatment	I want it	I do NOT want it	Agent decides	Not sure
CPR (cardiopulmonary resuscitation)	[__]	[__]	[__]	[__]
Mechanical ventilation / breathing machine	[__]	[__]	[__]	[__]
Artificial nutrition (tube feeding)	[__]	[__]	[__]	[__]
Artificial hydration (IV fluids)	[__]	[__]	[__]	[__]
Kidney dialysis	[__]	[__]	[__]	[__]
Antibiotics	[__]	[__]	[__]	[__]
Blood transfusions	[__]	[__]	[__]	[__]
Hospitalization / ICU admission	[__]	[__]	[__]	[__]

Comfort & Pain Relief:

3.3 Pain relief preference:

[__] Provide treatment for pain relief and comfort at all times, even if it may hasten my death

[__] Provide pain relief, but not if it would hasten my death

[__] Let my agent decide

3.4 If possible, where would you prefer to spend your final days?

[__] At home [__] In a hospital [__] In hospice care [__] No preference

3.5 Would you want hospice or palliative care if you had a terminal illness? [__] Yes [__] No

Personal Values & Other Wishes:

3.6 What matters most to you about your quality of life (e.g., being able to recognize loved ones, communicate, live without machines)? _____

_____

_____

3.7 Religious or spiritual affiliation: _____

Are there religious or cultural beliefs your health care providers should respect (e.g., blood products, clergy visits, rituals)? _____

_____

3.8 Are you pregnant or planning a pregnancy? [__] Yes [__] No

3.9 Any other instructions or wishes about your health care (mental health treatment, specific medications, dementia care, etc.): _____

_____

_____

PART 4 — DONATION OF ORGANS AT DEATH (OPTIONAL)

4.1 Do you wish to donate organs, tissues, or parts upon your death? [__] Yes [__] No

4.2 If yes, what may be donated?

[__] Any needed organs, tissues, or parts

[__] Only the following:

_____

4.3 Purposes (check all that apply):

[__] Transplant [__] Therapy [__] Research [__] Education

4.4 Are you already registered as a donor (e.g., DMV / Donate Life California)? [__] Yes [__] No

4.5 Any limits or wishes about donation (including religious considerations): _____

_____

PART 5 — DISPOSITION OF REMAINS & FINAL ARRANGEMENTS (OPTIONAL)

5.1 Preference:

[__] Burial [__] Cremation [__] Green / natural burial

[__] Donation to science [__] Let my agent decide [__] No preference

5.2 Preferred funeral home, cemetery, or place for ashes: _____

5.3 Do you have a prepaid funeral plan or burial plot? [__] Yes [__] No

If yes, provider and location: _____

5.4 Service or memorial wishes: _____

_____

PART 6 — SIGNING, WITNESSES & COPIES

6.1 How would you prefer to have your directive signed?

[__] Notary public [__] Two qualified witnesses [__] No preference

Witnesses must be adults who know you. A witness cannot be your agent, your health care provider or their employee, or an operator or employee of a care facility. At least one witness must not be related to you by blood, marriage, or adoption and not entitled to any part of your estate.

6.2 Possible Witnesses (if using witnesses):

Name	Relationship to You	Phone	Related / Inherits?

6.3 Who should receive a copy of your signed directive?

Name	Relationship / Role	Phone or Email

6.4 Would you like help registering your directive with the California Secretary of State's Advance Health Care Directive Registry? [__] Yes [__] No

6.5 Are you also interested in any of the following?

[__] Durable Power of Attorney (finances) [__] Will

[__] Living Trust [__] HIPAA Authorization

[__] Guardian nomination for minor children [__] POLST discussion with my doctor

PART 7 — DOCUMENT CHECKLIST

Please provide copies of the following, if available. Check each item you are including.

[__] Government-issued photo ID

[__] Existing POLST or DNR

[__] Contact information for all agents

[__] Organ donor registration (if any)

[__] Existing directive / living will

[__] Existing Durable Power of Attorney

[__] Health insurance card

[__] Prepaid funeral / burial documents

Certification:

I declare that the information provided in this questionnaire is true, correct, and complete to the best of my knowledge, and that it reflects my own wishes. I understand this information is provided to Syndicate Subscription Legal Plans in confidence for the purpose of preparing my Advance Health Care Directive.

Signed and dated this ____ day of _____, 20___

Signature: _____

Print Name: _____

Please Print and Email to STEVE@STEVEMUELLERLEGAL.COM, or save this document as a PDF and email to STEVE@STEVEMUELLERLEGAL.COM,
Your information will be reviewed within one hour.