[redacted]

MONTES MEDICAL GROUP ADVANCE DIRECTIVE
DURABLE POWER OF ATTORNEY FOR HEALTH CARE AND LIVING WILL

This advance directive form is an official document where you can write down your preferences for your health care. If someday you can't make health care decisions for yourself anymore, this advance directive can help guide the people who will make decisions for you.

You can use this form to:

- Name specific people to make health care decisions for you
- Describe your preferences for how you want to be treated
- Describe your preferences for medical care, mental health care, long-term care, or other types of health care

When you complete this form, it's important that you also talk to your doctor, family, and other loved ones who may help to decide about your care. You should explain what you meant when you filled out the form.

A health care professional can help you with this form and can answer any questions that you have. If you need more space for any part of the form, you may attach extra pages. Be sure to initial and date every page that you attach.

PART I: PERSONAL INFORMATION

NAME *(Last, First, Middle)*:		LAST FOUR DIGITS OF SSN:
STREET ADDRESS:		
CITY, STATE, ZIP:		
HOME PHONE WITH AREA CODE:	WORK PHONE WITH AREA CODE:	MOBILE PHONE WITH AREA CODE:

Privacy Act Information

The information you requested on this form is solicited under the authority of 38 C.F.R §1732. It is being collected to document your preferences for your health care in the event that you can no longer speak for yourself anymore. The information you provide may be disclosed outside Montes Medical Group, Inc. as permitted by law. Possible disclosures include those that are published in the Federal Register in accordance with the Privacy Act of 1974. You may choose to fill out this form or not. But without this information Montes Medical Group, Inc.health care providers may not understand your preferences as well. If you don't fill out this form, there won't be any effect on the benefits you are entitled to receive.

NAME *(Last, First, Middle)*	LAST FOUR DIGITS OF SSN:

PART II: DURABLE POWER OF ATTORNEY FOR HEALTH CARE

This section of the advance directive form is called a Durable Power of Attorney for Health Care. It lets you appoint a specific person to make health care decisions for you in case you can't make decisions for yourself anymore. This person will be called your Health Care Agent.

Your Health Care Agent should be someone:
- You trust
- Who knows you well
- Who is familiar with your values and beliefs

If you get too sick to make decisions for yourself, your Health Care Agent will have the authority to make all health care decisions for you. This includes decisions to admit and discharge you from any hospital or other health care institution. Your Health Care Agent can also decide to start or stop any type of health care treatment. He or she can access your personal health information, including your medical records.

NOTE: Information about whether you have been tested for HIV or treated for AIDS, sickle cell anemia, substance abuse or alcoholism will only be shared with your Health Care agent under very limited circumstances. If you wish to give general permission for Montes Medical Group, Inc. to share this information with your Health Care Agent, you will need to give special written consent to Montes Medical Group, Inc. to release this information.

A - HEALTH CARE AGENT

Place your initials in the box next to your choice. Choose only one.

Initials	I don't wish to appoint a Health Care Agent right now. (Skip this section and go to Part III, Living Will.)
Initials	I appoint the person named below to make decisions about my health care if I can't decide for myself anymore.

Name *(Last, First, Middle)*:	Relationship to Me:

Street Address:	City, State, Zip:

Home Phone with Area Code:	Work Phone with Area Code:	Mobile Phone with Area Code:

NAME *(Last, First, Middle)*	LAST FOUR DIGITS OF SSN:

B - ALTERNATE HEALTH CARE AGENT

Fill out this section if you want to appoint a second person to make health care decisions for you, in case the first person isn't available.

Initials	If the person named above can't or doesn't want to make decisions for me, I appoint the person named below to act as my Health Care Agent.

Name *(Last, First, Middle)*:	Relationship to Me:

Street Address:	City, State, Zip:

Home Phone with Area Code:	Work Phone with Area Code:	Mobile Phone with Area Code:

PART III: LIVING WILL

This section of the advance directive form is called a Living Will. This section of it lets you write down how you want to be treated in case you aren't able to decide for yourself anymore. Its purpose is to help others decide about your care.

A - SPECIFIC PREFERENCES ABOUT LIFE-SUSTAINING TREATMENTS

In this section, you can indicate your preferences for life-sustaining treatments in certain situations. Some examples of life-sustaining treatments are:

- CPR (cardiopulmonary resuscitation)
- a breathing machine (mechanical ventilation)
- kidney dialysis
- a feeding tube (artificial nutrition and hydration)

Think about each situation described on the left and ask yourself, "In that situation, would I want to have life-sustaining treatments?" Place your initials in the box that best describes your treatment preference. **You may complete some, all, or none of this section. Choose only one box for each statement.**

	Yes. I would want life-sustaining treatments.	I'm not sure. It would depend on the circumstances.	**No.** I would not want life-sustaining treatments.
If I am unconscious, in a coma, or in a vegetative state and there is little or no chance of recovery.	Initials	Initials	Initials
If I have permanent, severe brain damage that makes me unable to recognize my family or friends (for example, severe dementia).	Initials	Initials	Initials

NAME *(Last, First, Middle)*	LAST FOUR DIGITS OF SSN:

	Yes. I would want life-sustaining treatments.	I'm not sure. It would depend on the circumstances.	**No.** I would not want life-sustaining treatments.
If I have a permanent condition where other people must help me with my daily needs (for example, eating, bathing, toileting).	Initials	Initials	Initials
If I need to use a breathing machine and be in bed for the rest of my life.	Initials	Initials	Initials
If I have pain or other severe symptoms that cause suffering and can't be relieved.	Initials	Initials	Initials
If I have a condition that will make me die very soon, even with life-sustaining treatments.	Initials	Initials	Initials
Other:	Initials	Initials	Initials

B - MENTAL HEALTH PREFERENCES

This section is optional. You may skip this section if you do not have a serious mental health problem or if you do not want to write down your preferences for mental health care. If you have a serious mental health condition, you might want to write down medications that have worked for you in the past and that you would want again, or you might want to write down the mental health facilities or hospitals that you like and those that you don't like. If you need more space, you may attach extra pages and use this space to refer to attached pages. Be sure to initial and date every page that you attach.

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NAME *(Last, First, Middle)*	LAST FOUR DIGITS OF SSN:

C - ADDITIONAL PREFERENCES

This section is optional. In this space, you can write other important preferences for your health care that aren't described somewhere else in this document. For example, these might be social, cultural, or faith-based preferences for care, or preferences about treatments such as feeding tubes, blood transfusions, or pain medications. If you need more space, you may attach extra pages and use this space to refer to attached pages. Be sure to initial and date every page that you attach.

D - HOW STRICTLY YOU WANT YOUR PREFERENCES FOLLOWED

Place your initials in the box next to the statement that reflects how strictly you want others to follow your preferences. Choose only one.

Initials	I want my preferences, as expressed in this Living Will, to serve as a **general guide**. I understand that in some situations, the person making decisions for me may decide something different from the preferences I express above, if they think it's in my best interests.
Initials	I want my preferences, as expressed in this Living Will, to be followed strictly, even if the person making decisions for me thinks that this isn't in my best interests.

NAME *(Last, First, Middle)*	LAST FOUR DIGITS OF SSN:

PART IV: SIGNATURES

A - YOUR SIGNATURE

By my signature below, I certify that this form accurately describes my preferences.

SIGNATURE	DATE

B - WITNESSES' SIGNATURES

Two people must witness your signature. Montes Medical Group staff may act as a witness if

- They are non-clinical staff, or
- They are a member of your family

Witness #1

I personally witnessed the signing of this advance directive. I am not appointed as Health Care Agent in this advance directive. I am not financially responsible for the care of the person making this advance directive. To the best of my knowledge, I am not named in the person's will.

SIGNATURE:	DATE:

Name *(Printed or Typed)*:

Street Address:

City, State, Zip:

Witness #2

I personally witnessed the signing of this advance directive. I am not appointed as Health Care Agent in this advance directive. I am not financially responsible for the care of the person making this advance directive. To the best of my knowledge, I am not named in the person's will.

SIGNATURE:	DATE:

Name *(Printed or Typed)*:

Street Address:

City, State, Zip:

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NAME *(Last, First, Middle)*	LAST FOUR DIGITS OF SSN:

PART V: SIGNATURE AND SEAL OF NOTARY PUBLIC *(Optional)*

This Montes Medical Group Advance Directive form is valid in Montes Medical Group faclities without being notarized. However, you may need to have it notarized to be legally binding outside the Montes Medical Group health care setting. Space for a Notary's signature and seal is included below.

On this ______ day of ________________, in the year of ______, personally appeared before me ____,

known by me to be the person who completed this document and acknowledged it as their free act and deed. IN WITNESS WHEREOF, I have set my hand and affixed my official seal in the County of ____________________, State of ________________, on the date written above.

Notary Public __________________________ Commission Expires ________________________

[SEAL]