The Halachic Living Will

DURABLE POWER OF ATTORNEY/DECLARATION WITH RESPECT TO HEALTH CARE DECISIONS AND POST-MORTEM DECISIONS

FOR USE IN CALIFORNIA

The "Halachic Living Will" is designed to help ensure that all medical and post-death decisions made by others on your behalf will be made in accordance with Jewish law and custom (*halacha*). The text of this Halachic Living Will has been approved by attorneys for use in your state as of November 2003. While we do not expect that any future change in federal or state laws would materially affect the validity of this document, you may wish to show it to your own attorney to confirm its effectiveness in subsequent years.

INSTRUCTIONS

(a) In Part 1, Section 1.1, print the name, address, and telephone numbers of the person you wish to designate as your agent to make medical decisions on your behalf if, G-d forbid, you ever become incapable of making them on your own. Be sure to include all numbers (including cell phone and pager) where your agent can be reached in the event of an emergency. If the contact information for your agent changes, you should provide that updated information to everyone whom you have provided with a copy of your Halachic Living Will.

You may also insert the name, address, and telephone numbers of one or two alternate agent(s) to make such decisions if your primary agent is unable, unwilling, or unavailable to make such decisions.

It is recommended that before appointing anyone to serve as your agent or alternate agent you should ascertain that person's willingness to serve in such capacity. In addition, if you have made arrangements with a burial society (Chevra Kadisha), you may wish to advise your agents of such arrangements.

Note: The supervising health care provider or an employee of the health care institution where you are receiving care, and the operator or an employee of a community care facility or residential care facility where you are receiving care, may not serve as a health care agent unless the person is related to you by blood, marriage, or adoption, or is your coworker.

(b) Your agent's authority becomes effective when your primary physician determines that you are unable to make your own health care decisions, unless you mark the box in Section 1.3. If you mark the box in Section 1.3, your agent's authority will take effect immediately upon the execution of the Halachic Living Will.

(c) In Part 2, please print the name, address, and telephone numbers of the Orthodox Rabbi whose guidance you want your agent to follow should any questions arise as to the requirements of *halacha*.

You should then print the name, address, and telephone numbers of the Orthodox Jewish institution or organization you want your agent to contact for a referral to another Orthodox Rabbi if the Rabbi you have identified is unable, unwilling or unavailable to provide the appropriate consultation and guidance.

You are, of course, free to insert the name of any Orthodox Rabbi or institution/ organization you would like, but before doing so it is advisable to discuss the matter with the Rabbi or institution/organization to ascertain their competency and willingness to serve in such capacity.

(d) In Part 3, at the conclusion of the form, print the date, sign your name, and print your address.

(e) The form must be signed by two witnesses. The two witnesses should sign their names and insert their addresses beneath your signature. The witnesses should be age 18 or over and should be present when you sign or acknowledge your signature on the form. Neither of them should be the person you have appointed as your health care agent (or alternate agent), your health-care provider, an employee of your health-care provider, or the operator or employee of a residential care facility for the elderly. At least one of the witnesses must be a person who is NEITHER related to you by blood, marriage, or adoption, NOR entitled to any portion of your estate upon your death under a will now existing or by operation of law. Additionally, each witness must make a declaration as written in the form, stating that they comply with the requirements. The witness declarations are found in Sections 3.3 and 3.4. **Please note that if you are a patient in a skilled nursing facility, a patient advocate or ombudsman designated by the State Department of Aging must also sign the form and must declare that he or she is serving as a witness as required by law.** This additional witness requirement is found in Part 4.

(f) It is recommended that you keep the original of this form among your valuable papers in a location that is readily accessible in the event of an emergency, and that you **distribute copies to the health care agent (and alternate agent)** you have designated in Part 1, **to the Rabbi and institution/organization** you have designated in Part 2, as well as to **your doctor, your lawyer**, and anyone else who is likely to be contacted in times of emergency. We also recommend that you register a copy of this form with a national living will registry, so that it can be accessed by any health care facility via computer. Agudath Israel has made an arrangement with the New York Legal Assistance Group to register Halachic Living Wills for our constituents with the U.S. Living Will Registry at no charge. Contact our office (212-797-9000 ext. 267) for the forms that will enable you to do this.

(g) If at any time you wish to revoke the designation of an agent, you may do so only by a signed writing or by personally informing your supervising health-care provider. You may revoke all or part of this Halachic Living Will, other than the designation of an agent, at any time and in any manner that communicates an intent to revoke. If you do revoke it, to avoid possible confusion, it would be wise to try to obtain all originals and copies of the old Halachic Living Will and destroy them.

If you do not revoke this Halachic Living Will, it will remain in effect indefinitely. Obviously, if any of the persons whose names you have inserted in this form dies or becomes otherwise incapable of serving in the role you have assigned, it would be wise to execute a new form.

(h) It is recommended that you also complete the **Emergency Instructions Card** contained in the Halachic Living Will brochure, and carry it with you in your wallet or purse.

(i) If, upon consultation with your Rabbi, you would like to add to this standardized living will any additional expression of your wishes with respect to medical and/or post-mortem decisions, you may do so by attaching a rider to the standardized form. If you choose to do so, or if you have any other questions concerning this form, please consult an attorney.

These instructions are not part of the Halachic Living Will and need not be kept attached to the executed document.

Developed and published by: Agudath Israel of America • 42 Broadway, 14th Floor • New York, NY 10004 • 212-797-9000

CALIFORNIA
ADVANCE HEALTH CARE DIRECTIVE

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:

Agent

Name of Agent: _____

Address: _____

_____

Telephone:
Day:_____ Evening: _____

Cell:_____ Pager/beeper:_____

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:

First Alternate Agent

Name of First Alternate Agent:
_____

Address: _____

_____

Telephone:
Day:_____ Evening: _____

Cell:_____ Pager/beeper:_____

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:

Second Alternate Agent

Name of Second Alternate Agent:
_____

Address: _____

_____

Telephone:
Day:_____ Evening: _____

Cell:_____ Pager/beeper:_____

(1.2) AGENT'S AUTHORITY: My agent is authorized to make all health care decisions for me, consistent with the specifications described in Part 2.

(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.

(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 POST-DEATH AUTHORITY: It is also my desire, and I hereby direct, that after my death, all decisions concerning the handling and disposition of my body be made pursuant to Jewish law and custom as determined in accordance with strict Orthodox interpretation and tradition. For example, Jewish law generally requires expeditious burial and imposes special requirements with regard to the preparation of the body for burial. It is my wish that Jewish law and custom be followed with respect to these matters.

Further, subject to certain limited exceptions, Jewish law generally prohibits the performance of any autopsy or dissection. It is my wish that Jewish law and custom be followed with respect to such procedures, and with respect to all other post-mortem matters including the removal and usage of any of my body organs or tissue for transplantation or any other purposes. I direct that any health care provider in attendance at my death notify the agent and/or Orthodox Rabbi described above immediately upon my death, in addition to any other person whose consent by law must be solicited and obtained, prior to the use of any part of my body as an anatomical gift, so that appropriate decisions and arrangements can be made in accordance with my wishes. Pending such notification, and unless there is specific authorization by the Orthodox Rabbi consulted in accordance with the procedures outlined in Section 2.2 of Part 2, it is my desire, and I hereby direct, that no post-mortem procedure be performed on my body.

(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 willing, 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

(2.1) JEWISH LAW TO GOVERN HEALTH CARE DECISIONS: I am Jewish. It is my desire, and I hereby direct, that all health care decisions made for me (whether made by my agent, a guardian appointed for me, or any other person) be made pursuant to Jewish law and custom as determined in accordance with strict Orthodox interpretation and tradition. Without limiting in any way the generality of the foregoing, it is my wish that Jewish law and custom should dictate the course of my health care with respect to such matters as the performance of cardio-pulmonary resuscitation if I suffer cardiac or respiratory arrest; the performance of life-sustaining surgical procedures and the initiation or maintenance of any particular course of life-sustaining medical treatment or other form of life-support maintenance, including the provision of nutrition and hydration; and the criteria by which death shall be determined, including the method by which such criteria shall be medically ascertained or confirmed.

(2.2) ASCERTAINING THE REQUIREMENTS OF JEWISH LAW: In determining the requirements of Jewish law and custom in connection with this declaration, I direct my agent to consult with the following Orthodox Rabbi and I ask my agent to follow his guidance:

Rabbi Name of Rabbi:_____

Address:_____

_____

Telephone: Day: Evening:

_____ _____

Cell: Pager/beeper:

_____ _____

If such Orthodox Rabbi is unable, unwilling or unavailable to provide such consultation and guidance, then I direct my agent to consult with, and I ask my agent to follow the guidance of, the following Orthodox Rabbi:

Rabbi Name of Rabbi:

_____

Address:

_____

Telephone: Day: Evening:

_____ _____

Cell: Pager/beeper:

_____ _____

If both of these Orthodox Rabbis are unable, unwilling or unavailable to provide such consultation and guidance, then I direct my agent to consult with, and I ask my agent to follow the guidance of, an Orthodox Rabbi referred by the following Orthodox Jewish institution or organization:

Organization Name of Institution/Organization:

_____

Address: _____

_____

Telephone: Day: _____ Evening: _____

If such institution or organization is unable, unwilling or unavailable to make such a reference, or if the Orthodox Rabbi referred by such institution or organization is unable, unwilling or unavailable to provide such guidance, then I direct my agent to consult with, and I ask my agent to follow the guidance of, an Orthodox Rabbi whose guidance on issues of Jewish law and custom my agent in good faith believes I would respect and follow.

(2.3) DIRECTION TO HEALTH CARE PROVIDERS: Any health care provider shall rely upon and carry out the decisions of my agent, and may assume that such decisions reflect my wishes and were arrived at in accordance with the procedures set forth in this directive, unless such health care provider shall have good cause to believe that my agent has not acted in good faith in accordance with my wishes as expressed in this advance health care directive.

If the persons designated above as my agent and alternate agent are unable, unwilling or unavailable to serve in such capacity, it is my desire, and I hereby direct, that any health care provider or other person who will be making health care decisions on my behalf follow the procedures outlined above in Section 2.2 in determining the requirements of Jewish law and custom.

Pending contact with the agent and/or Orthodox Rabbi described above, it is my desire, and I hereby direct, that all health care providers undertake all essential emergency and/or life sustaining measures on my behalf.

(2.4) ACCESS TO MEDICAL RECORDS AND INFORMATION; HIPAA: My agent is my personal representative, as such term is defined under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), and accordingly all of my protected health information (as such term is defined under HIPAA) and other medical records shall be made available to my agent upon request in the same manner as such information and records would be released and disclosed to me, and my agent shall have and may exercise all of the rights I would have regarding the use and disclosure of such information and records, as required under HIPAA.

(2.5) INCONTROVERTIBLE EVIDENCE OF MY WISHES: If, for any reason, this document is deemed not legally effective as a health care proxy, or if the persons designated above in Section 1.1 as my agent and alternate agent are unable, unwilling or unavailable to serve in such capacity, I declare to my family, my doctor and anyone else whom it may concern that the wishes I have expressed herein with regard to compliance with Jewish law and custom should be treated as incontrovertible evidence of my intent and desire with respect to all health care measures and post-mortem procedures; and that it is my wish that the procedure outlined above in Section 2.2 should be followed in determining the requirements of Jewish law and custom.

(2.6) DURATION AND REVOCATION: It is my understanding and intention that unless I revoke this proxy and directive, it will remain in effect indefinitely. My signature on this document shall be deemed to constitute a revocation of any prior health care proxy, directive or other similar document I may have executed prior to today's date.

PART 3: SIGNATURE AND WITNESSES

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

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

My Signature

Signature: _____

(If you are not physically capable of signing, please ask another person to sign your name on your behalf.)

Print Name: _____

Date: _____

Address: _____

_____

Telephone: Day: _____ Evening: _____

(3.3) 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.

Witnesses

Witness 1 Signature: _____

Printed Name: _____

Residing at: _____

Date: _____

Witness 2 Signature: _____

Printed Name: _____

Residing at: _____

Date: _____

(ONE OF THESE WITNESSES MUST ALSO SIGN THE STATEMENT ON THE NEXT PAGE)

Part 3 (Continued):

(3.4) 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.

Witness 1 or 2

Signature: _____

Print name: _____

PART 4

SPECIAL WITNESS REQUIREMENT

The following statement is required **only** if you are a patient in a skilled nursing facility--a health care facility that provides 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.

Special Witness

Signature: _____

Printed Name: _____

Residing at: _____

_____

Date: _____

Developed and published by:

Agudath Israel of America • 42 Broadway, 14th Floor • New York, NY 10004 • 212-797-9000