ORTHODOX JEWISH LAW

MARYLAND ADVANCE DIRECTIVE: PLANNING FOR FUTURE HEALTH CARE DECISIONS

By:_____ **Date of Birth:**_____

(Print Name) *(Month/Day/Year)*

Using this advance directive form to do health care planning is completely optional. Other forms are also valid in Maryland. No matter what form you use, talk to your family and others close to you about your wishes.

This form has two parts to state your wishes, and a third part for needed signatures. Part I of this form lets you answer this question: If you cannot (or do not want to) make your own health care decisions, who do you want to make them for you? The person you pick is called your health care agent. **Make sure you talk to your health care agent (and any back-up agents) about this important role.** Part II lets you write your preferences about efforts to extend your life in three situations: terminal condition, persistent vegetative state, and end-stage condition. In addition to your health care planning decisions, you can choose to become an organ donor after your death by filling out the form for that too.

You can fill out Parts I and II of this form, or only Part I, or only Part II. Use the form to reflect your wishes, then sign in front of two witnesses (Part III). If your wishes change, make a new advance directive.

Make sure you give a copy of the completed form to your health care agent, your doctor, and others who might need it. Keep a copy at home in a place where someone can get it if needed. Review what you have written periodically.

PART I: SELECTION OF HEALTH CARE AGENT

A. Selection of Primary Agent

I select the following individual as my agent to make health care decisions for me:

Name: _____

Address: _____

_____

Telephone Numbers: _____

(home and cell)

B. Selection of Back-up Agents
(Optional; form valid if left blank)

1. If my primary agent cannot be contacted in time or for any reason is unavailable or unable or unwilling to act as my agent, then I select the following person to act in this capacity:

Name: _____

Address: _____

_____

Telephone Numbers: _____
(home and cell)

2. If my primary agent and my first back-up agent cannot be contacted in time or for any reason are unavailable or unable or unwilling to act as my agent, then I select the following person to act in this capacity:

Name: _____

Address: _____

_____

Telephone Numbers: _____
(home and cell)

C. General Statement

It is my desire and I hereby direct that all health care decisions made for me to be made pursuant to Jewish law and custom as determined in accordance with strict Orthodox Jewish interpretation and tradition (hereinafter sometimes referred to as "Halacha"). By way of example, and without limiting in any way the generality of the foregoing, it is my wish that Halacha should dictate the course of my health care with respect to such matters as the performance or nonperformance of cardiopulmonary resuscitation if I suffer cardiac or respiratory arrest; the initiation or discontinuance of any particular course of medical treatment or other form of life sustaining procedure, including artificially administered nutrition and hydration and the method and timing of determination of death.

D. Primary Instructions

I direct that all health care decisions as well as decisions relating to the handling and disposition of my body after I die made by my agent, if any is then serving, but if not, then by my health care provider, shall be made pursuant to Jewish law and custom as determined in accordance with strict Jewish Orthodox interpretation and tradition. My agent, if any is then serving, or the health care provider, shall first consult with and shall follow the guidance of Rabbi _____ _____, if available, but if not, then the Orthodox Rabbi of the _____ Congregation,

whose decision and guidance on all issues of Halacha shall be binding as if I had so specifically provided. Pending contact with my agent and/or the said Rabbi, I direct my health care providers to undertake all essential emergency measures on my behalf and I direct that no autopsy or other postmortem procedure be performed on my body.

E. Powers and Rights of Health Care Agent

I want my agent to have full power to make health care decisions for me, including the power to:

1. Consent to the administration of medical procedures and treatments which my doctors offer, including things that are intended to keep me alive, like ventilators and feeding tubes;

2. Consent to the withholding or withdrawal of medical procedures and treatments, even if such procedures or treatments are intended to keep me alive, like ventilators and feeding tubes;

3. Decide who my doctor and other health care providers should be; and

4. Decide where I should be treated, including whether I should be in a hospital, nursing home, other medical care facility, or hospice program.

5. I also want my agent to:

   a. Ride with me in an ambulance if ever I need to be rushed to the hospital; and

   b. Be able to visit me if I am in a hospital or any other health care facility.

THIS ADVANCE DIRECTIVE DOES NOT MAKE MY AGENT RESPONSIBLE FOR ANY OF THE COSTS OF MY CARE.

This power is subject to the following conditions or limitations:
(Optional; form valid if left blank)

_____

_____

_____

_____

F. How my Agent is to Decide Specific Issues

I trust my agent's judgment. My agent shall look first to see if there is anything in Part I or Part II that decides the issue, always considering the primacy of Halacha and the specific provisions for the determination of what the Halacha requires or allows. In furtherance thereof, my agent should think about the conversations we have had, my beliefs and values (most important being the primacy of Halacha), my personality, and how I handled medical and other

important issues in the past. If what I would decide is still unclear, then my agent is to make decisions for in accordance with strict Orthodox Jewish interpretation and tradition which I hereby declare to be in my best interest.

G. People My Agent Should Consult
(Optional; form valid if left blank)

In making important decisions on my behalf, I encourage my agent to consult with the following people, if they are reasonably available. By filling this in, I do not intend to limit the number of people with whom my agent might want to consult or my agent's power to make decisions.

Name(s)	**Telephone Number(s):**
_____	_____
_____	_____
_____	_____
_____	_____

H. Access to my Health Information - Federal Privacy Law (HIPAA) Authorization

1. If, prior to the time the person selected as my agent has power to act under this document, my doctor wants to discuss with that person my capacity to make my own health care decisions, I authorize my doctor to disclose protected health information which relates to that issue.

2. Once my agent has full power to act under this document, my agent may request, receive, and review any information, oral or written, regarding my physical or mental health, including, but not limited to, medical and hospital records and other protected health information, and consent to disclosure of this information.

3. For all purposes related to this document, my agent is my personal representative under the Health Insurance Portability and Accountability Act (HIPAA). My agent may sign, as my personal representative, any release forms or other HIPAA-related materials.

4. In addition to my agent, the following individuals are hereby authorized to request, receive, and review any information, oral or written, regarding my physical or mental health, including, but not limited to, medical and hospital records and other health information otherwise protected HIPAA:

_____
Name/Relationship

_____
Name/Relationship

_____
Name/Relationship

I. Effectiveness of this Part

(Read both of these statements carefully. Then, initial **one** only.)

My agent's power is in effect:

1. Immediately after I sign this document, subject to my right to make any decision about my health care if I want and am able to.

_____

>>OR<<

2. Whenever I am not able to make informed decisions about my health care, either because the doctor in charge of my care (attending physician) decides that I have lost this ability temporarily, or my attending physician and a consulting doctor agree that I have lost this ability permanently.

_____

J. Pain Relief

No matter what my condition, give me the medicine or other treatment I need to relieve pain and suffering even if doing so would shorten my life, unless not permitted by Halacha.

If the only thing you want to do is select a health care agent, go to Part IV. If you also want to write your treatment preferences, go to Part II. If you also want to write your funeral preferences, go to Part III.

PART II: TREATMENT PREFERENCES ("LIVING WILL")

A. Additional Statement of Goals and Values

(Optional: Form valid if left blank)

I want to say something about my goals and values, and especially what's most important to me during the last part of my life:

_____

_____

_____

_____

B. Preference in Case of Terminal Condition

(If you want to state what your preference is, initial **one** only. If you do not want to state a preference here, cross through the whole section.)

If my doctors certify that my death from a terminal condition is imminent, and even if life-sustaining procedures are used there is no reasonable expectancy of recovery:

1. Try to extend my life for as long as possible, using all available interventions that are (a) permitted by Halacha and (b) in reasonable medical judgment would prevent or delay my death. If I am unable to take enough nourishment by mouth, I want to receive nutrition and fluids by tube or other medical means.

   _____

   >>OR<<

2. Keep me comfortable and allow natural death to occur. I do not want medical interventions used to try to extend my life, unless required by Halacha. If I am unable to take enough nourishment by mouth, however, I want to receive nutrition and fluids by tube or other medical means.

   _____

C. Preference in Case of Persistent Vegetative State

(If you want to state what your preference is, initial one only. If you do not want to state a preference here, cross through the whole section.)

If my doctors certify that I am in a persistent vegetative state, that is, if I am not conscious and am not aware of myself or my environment or able to interact with others, and there is no reasonable expectation that I will ever regain consciousness:

1. Try to extend my life for as long as possible, using all available interventions that are (a) permitted by Halacha and (b) in reasonable medical judgment would prevent or delay my death. If I am unable to take enough nourishment by mouth, I want to receive nutrition and fluids by tube or other medical means.

   _____

   >>OR<<

2. Keep me comfortable and allow natural death to occur. I do not want medical interventions used to try to extend my life, unless required by Halacha. If I am unable to take enough nourishment by mouth, however, I want to receive nutrition and fluids by tube or other medical means.

   _____

D. Preference in Case of End-Stage Condition
(If you want to state what your preference is, initial one only. If you do not want to state a preference here, cross through the whole section.)

If my doctors certify that I am in an end-state condition, that is, an incurable condition that will continue in its course until death and that has already resulted in loss of capacity and complete physical dependency:

1. Try to extend my life for as long as possible, using all available interventions that are (a) permitted by Halacha and (b) in reasonable medical judgment would prevent or delay my death. If I am unable to take enough nourishment by mouth, I want to receive nutrition and fluids by tube or other medical means.

   _____

   >>OR<<

2. Keep me comfortable and allow natural death to occur. I do not want medical interventions used to try to extend my life, unless required by Halacha. If I am unable to take enough nourishment by mouth, however, I want to receive nutrition and fluids by tube or other medical means.

   _____

E. In Case of Pregnancy
(Optional, for women of child-bearing years only; form valid if left blank)

If I am pregnant, my decision concerning life-sustaining procedures shall be modified as follows:

_____
_____
_____
_____

F. Anatomical Gift - Restricted
(Initial the one you want. Cross through the one you do not want.)

I direct that no matter what my condition, no parts of my body shall be preserved for or given as anatomical gifts except:

(a) as may be directed by Halacha in accordance with Paragraph A, above; or

_____

(b) none.

_____

PART III: DISPOSITION OF BODY AND FUNERAL ARRANGEMENTS

I want the following person to make decisions about the disposition of my body and my funeral arrangements: (Either initial the first or fill in the second.)

The health care agent who I named in my advance directive. _____

>>OR<<

This person:

Name: _____
Address: _____
_____
Telephone Number(s): _____
(home and cell)

I direct that my funeral arrangement shall be in accordance with Halacha. If I have written my wishes below, they should be followed. If not, the person I have named should decide based on conversations we have had, my religious menhagim customs and traditions or other beliefs and values, my personality, and how I reacted to other peoples' funeral arrangements.

My wishes about the disposition of my body and my funeral arrangements are:

_____
_____
_____

PART IV: SIGNATURE AND WITNESSES

By signing below as the Declarant, I indicate that I am emotionally and mentally competent to make this advance directive and that I understand its purpose and effect. I also understand that this document replaces any similar advance directive I may have completed before this date.

_____ _____
(Signature of Declarant) (Date)

(WITNESSES CONTINUED ON NEXT PAGE)

The Declarant signed or acknowledged signing this document in my presence and, based upon personal observation, appears to be emotionally and mentally competent to make this advance directive.

_____ _____

(Signature of Witness) (Date)

_____

Telephone Number(s):

_____ _____

(Signature of Witness) (Date)

_____

Telephone Number(s):

(**Note:** Anyone selected as a health care agent in Part I may not be a witness. Also, at least one of the witnesses must be someone who will not knowingly inherit anything from the Declarant or otherwise knowingly gain a financial benefit from the Declarant's death. Maryland law does **not** require this document to be notarized.)

Did You Remember To ...

- ☐ Fill out Part I if you want to name a health care agent?
- ☐ Name one or two back-up agents in case your first choice as health care agent is not available when needed?
- ☐ Talk to your agents and back-up agent about your values and priorities, and decide whether that's enough guidance or whether you also want to make specific health care decisions in the advance directive?
- ☐ If you want to make specific decisions, fill out Part II and Part III, choosing carefully among alternatives?
- ☐ Sign and date the advance directive in Part IV, in front of two witnesses who also need to sign?
- ☐ Make sure your health care agent (if you named one), your family, and your doctor know about your advance care planning?
- ☐ Give a copy of your advance directive to your health care agent, family members, doctor, and hospital or nursing home if you are a patient there?