The Halachic Medical Directive

PROXY AND DIRECTIVE WITH RESPECT TO HEALTH CARE DECISIONS AND POST-MORTEM DECISIONS

FOR USE IN MICHIGAN

The "Halachic Medical Directive" 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 Medical Directive 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. You must be an individual 18 years of age or older who is of sound mind at the time you execute this document.

INSTRUCTIONS

(a) **Please print your name on the first line of the form.**

(b) **In Section 1, print the name, address, and telephone numbers of the person you wish to designate as your patient advocate** 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 advocate can be reached in the event of an emergency. If the contact information for your advocate changes, you should provide that updated information to everyone whom you have provided with a copy of your Halachic Medical Directive.

You may also insert the name, address, and telephone numbers of an alternate advocate to make such decisions if your main advocate is unable, unwilling, or unavailable to make such decisions.

It is recommended that before appointing anyone to serve as your advocate or alternate advocate 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 advocates of such arrangements.

Note: *Michigan law allows virtually any competent adult* (an adult is a person 18 years of age or older) *to serve as a patient advocate*. Thus, you may appoint as your advocate (or alternate advocate) your spouse, adult child, parent or other adult relative.

You may also appoint a non-relative to serve as your advocate (or alternate advocate).

(c) **In section 3, please print the name, address, and telephone numbers of the Orthodox Rabbi whose guidance you want your advocate 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 advocate 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. You may list Agudath Israel of America as the organization you select; however, we are only available to be contacted on regular business hours and days.

(d) **In Section 8, sign and print your name, address, phone numbers, and the date.**

(e) **In the DECLARATION OF WITNESSES Section, two witnesses should sign their names and insert their addresses beneath your signature.** These two witnesses must be competent adults who were **in your presence** at the time you signed the document. **The following persons *may not* serve as witnesses**: your spouse, your parent, your child, your grandchild, your sibling, a presumptive heir, a known devisee at the time of witnessing, your physician or your advocate. **Further, employees of the following *may not* serve as witnesses:** your life insurance provider, your health insurance provider, a health facility treating you or a home for the aged where you reside. A witness shall not sign unless you appear to be of sound mind and under no duress, fraud or undue influence.

(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 patient advocate (and alternate advocate)** you have designated in section 1, **to the rabbi and institution/organization** you have designated in section 3, as well as to **your doctors**, **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 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 Medical Directives for our constituents with the U.S. Living Will Registry at no charge. To obtain the forms to enable you to do so, e-mail MIdirective@agudathisrael.org or call our office (212-797-9000).

(g) **Please note that this document is effective immediately for the purpose of expressing your wish that Jewish law govern your health care decisions. Before a patient advocate may exercise powers concerning your custody, care and medical treatment, the following additional steps must be taken:**

(i) A copy of this document *must be* made a part of your medical record with your attending physician and, if applicable, with the facility where you are being treated;

(ii) A copy of this document *must be* given to your advocate (or acting alternate advocate); and

(iii) Your advocate *must sign* the acceptance of the designation, which is attached as the last page of the Halachic Medical Directive.

(h) **If at any time you wish to revoke this Proxy and Directive, you may do so by executing a new one; or by notifying your advocate or health care provider, orally or in writing, of your intent to revoke it.** If at any time your advocate wishes to revoke his or her acceptance of the designation, your advocate may revoke the acceptance at any time and in any manner sufficient to communicate the intent to revoke. To avoid possible confusion, it would be wise to try to obtain all originals and copies of the old Proxy and Directive and destroy them.

If you do not revoke the Proxy and Directive, Michigan law provides that it remains in effect indefinitely. Obviously, if any of the persons you have appointed in the Proxy and Directive dies or becomes otherwise incapable of serving in the role you have assigned, it would be wise to execute a new Proxy and Directive.

(i) It is recommended that you also complete the **Emergency Instructions Card**, and carry it with you in your wallet or purse.

(j) If, upon consultation with your rabbi, you would like to add to this standardized Proxy and Directive 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 Medical Directive 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

PROXY AND DIRECTIVE

WITH RESPECT TO HEALTH CARE DECISIONS AND POST-MORTEM DECISIONS

FOR USE IN MICHIGAN

I, _____, hereby declare as follows:

1. Appointment of Patient Advocate: In recognition of the fact that there may come a time when I will become unable to make my own health care decisions because of illness, injury or other circumstances, I hereby appoint

Advocate

Name of Advocate:
_____
Address:
_____
Telephone: Day: _____ Evening: _____
Cell: _____ Pager/beeper: _____

as my patient advocate ("advocate") to make any and all health care decisions for me, consistent with my wishes as set forth in this directive.

If the person named above is unable, unwilling or unavailable to act as my advocate, I hereby appoint

Alternate Advocate

Name of Alternate Advocate:
_____
Address:
_____
Telephone: Day: _____ Evening: _____
Cell: _____ Pager/beeper: _____

to serve in such capacity.

This appointment shall take effect in the event I become unable, because of illness, injury or other circumstances, to make my own health care decisions.

2. 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 advocate, 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.

3. Ascertaining the Requirements of Jewish Law: In determining the requirements of Jewish law and custom in connection with this declaration, I direct my advocate to consult with the following Orthodox Rabbi and I ask my advocate to follow his guidance:

Rabbi Name of Rabbi:
_____
Address:
_____
Telephone: Day: Evening:
_____ _____
Cell Phone: 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 advocate to consult with, and I ask my advocate to follow the guidance of, an Orthodox Rabbi whose guidance on issues of Jewish law and custom my advocate in good faith believes I would respect and follow.

4. Direction to Health Care Providers: Any health care provider shall rely upon and carry out the decisions of my advocate, 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 advocate has not acted in good faith in accordance with my wishes as expressed in this directive.

If the persons designated in section 1 above as my advocate and alternate advocate 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 in section 3 above in determining the requirements of Jewish law and custom.

Pending contact with the advocate 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.

5. Access to Medical Records and Information; HIPAA: My patient advocate ("advocate") 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 advocate upon request in the same manner as such information and records would be released and disclosed to me, and my advocate 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.

6. Post-Mortem Decisions: 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. I further direct that my patient advocate be responsible for the disposition of my remains.

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 advocate 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 paragraph 3 above, it is my desire, and I hereby direct, that no post-mortem procedure be performed on my body.

7. 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 in section 1 above as my advocate and alternate advocate 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 in section 3 above should be followed in determining the requirements of Jewish law and custom.

8. 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.

My Signature Signature:

_____

Print Name:

_____

Date:

_____

Address:

_____

Telephone: Day: Telephone: Evening:

_____ _____

DECLARATION OF WITNESSES

I, on this _____ day of _____, 20__, declare that the person who signed this document is personally known to me and appears to be of sound mind and acting willingly and free from duress. He/She signed this document in my presence. I am not the person appointed as advocate by this document, nor am I one of the following persons in relation to the person who signed: spouse, parent, child, grandchild, sibling, physician, a presumptive heir or a known devisee at the time of witnessing. Further, I am not an employee of the following: the patient's life insurance provider, the patient's health insurance provider, a health facility treating the patient or a home for the aged where the patient resides.

Witnesses WITNESS 1:

Signature_____

Printed Name:

_____

Residing at:

_____

WITNESS 2:

Signature _____

Printed Name:

_____

Residing at:

_____

Acceptance by Patient Advocate and Alternate Advocate (if any)

(A) This designation shall not become effective unless the patient is unable to participate in medical treatment decisions.

(B) A patient advocate shall not exercise powers concerning the patient's care, custody and medical treatment that the patient, if the patient were able to participate in the decision, could not have exercised on his or her own behalf.

(C) This designation cannot be used to make a medical treatment decision to withhold or withdraw treatment from a patient who is pregnant that would result in the pregnant patient's death.

(D) A patient advocate may make a decision to withhold or withdraw treatment which would allow a patient to die only if the patient has expressed in a clear and convincing manner that the patient advocate is authorized to make such a decision, and that the patient acknowledges that such a decision could or would allow the patient's death.

(E) A patient advocate shall not receive compensation for the performance of his or her authority, rights, and responsibilities, but a patient advocate may be reimbursed for actual and necessary expenses incurred in the performance of his or her authority, rights, and responsibilities.

(F) A patient advocate shall act in accordance with the standards of care acceptable to fiduciaries when acting for the patient and shall act in a manner consistent with the patient's best interests. The known desires of the patient expressed or evidenced while the patient is able to participate in medical treatment decisions are presumed to be in the patient's best interests.

(G) A patient may revoke his or her designation at any time or in any manner sufficient to communicate an intent to revoke.

(H) A patient advocate may revoke his or her acceptance to the designation at any time and in any manner sufficient to communicate an intent to revoke.

(I) A patient admitted to a health facility or agency has the general rights accorded to patients of health care facilities pursuant to the Michigan Public Health Code as set forth in Section 20201 of the Michigan Compiled Laws.

I understand the above conditions and I accept the designation as patient advocate for

_____

Dated: _____ Signed: _____

I understand the above conditions and I accept the designation as successor patient

advocate for _____

Dated: _____ Signed: _____