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# *The Halachic Living Will*

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

### **FOR USE IN MINNESOTA**

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

(b) **In Section 1, print the name, address, and day and evening 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 an *alternate agent*** to make such decisions if your main 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: *Minnesota law allows virtually any competent adult* (an adult is a person 18 years of age or older) *to serve as a health care agent*. Thus, you may appoint as your agent (or alternate agent) your spouse, adult child, parent or other adult relative. However, a non relative may not serve as your agent if that individual is your health care provider on either the date that the directive is executed or the date that the agent must make health care decisions on your behalf; or if that individual is an employee of your health care provider on either of the above dates.

(c) In section 3, 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 Section 8, sign and print your name, address, phone numbers, and the date.** If you are not physically able to do these things, Minnesota law allows another person to sign and date the form on your behalf, as long as he or she does so at your direction. *You should sign the form (or have another sign the form on your behalf) before two witnesses or, as an alternative, you may acknowledge your signature (or the signature of the individual who signed on your behalf) before a Notary Public.*

(e) **If you are signing the form before witnesses, two witnesses should sign their names and insert their addresses beneath your signature in the DECLARATION OF WITNESSES Section.** These two witnesses must be competent adults. *Neither of them may be the person you have appointed as your health care agent (or alternate agent). Further, **only one of them** may be your health care provider, or an employee of your health care provider, on the date of execution of this directive.* They may, however, be your relatives.

If you are having your signature (or the signature of the individual who signed on your behalf) acknowledged before a Notary Public instead of before witnesses, the notary should complete the VERIFICATION BY NOTARY PUBLIC Section at the end of the form. The notary may not be the person that you have appointed as health care agent (or alternate agent).

Whether to use witnesses or a notary is entirely a matter of personal preference and neither method has any greater or lesser legal significance than the other.

(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 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 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 this Proxy and Directive, you may do so by executing a new one; by verbally expressing your intent to revoke it in the presence of two witnesses (who do not have to be present at the same time); by executing a statement, dated and in writing, declaring your intent to revoke; or by canceling, defacing, obliterating, burning, tearing or otherwise destroying the health care directive instrument with the intent to revoke it in whole or in part. 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, Minnesota law provides that it remains in effect indefinitely. Obviously, if any of the persons whose names you have inserted 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. Further, if one of the agents that you appoint in the directive is your spouse, that individual's status as agent is revoked by the commencement of proceedings for dissolution, annulment or termination of your marriage.

(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 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 Living Will and need not be kept attached to the executed document.

***PROXY AND DIRECTIVE***

***WITH RESPECT TO HEALTH CARE DECISIONS  
AND POST-MORTEM DECISIONS***

***FOR USE IN MINNESOTA***

I, \_\_\_\_\_, hereby declare as follows:

**1. Appointment of Agent:** 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

*Agent*

Name of Agent:  
\_\_\_\_\_

Address:  
\_\_\_\_\_

Telephone: Day: \_\_\_\_\_

Telephone: Evening: \_\_\_\_\_

Cell: \_\_\_\_\_

Pager/beeper: \_\_\_\_\_

as my health care agent 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 agent, I hereby appoint

*Alternate  
Agent*

Name of Alternate Agent:  
\_\_\_\_\_

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 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.

**3. 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 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 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.

**4. 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 directive.

If the persons designated in section 1 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 in section 3 above 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.

**5. 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.

**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.

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 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 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 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: \_\_\_\_\_

*(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: \_\_\_\_\_

Telephone: Evening: \_\_\_\_\_

### DECLARATION OF WITNESSES

I, on this \_\_\_\_\_ day of \_\_\_\_\_, 20\_\_, declare that the person who signed (or asked another to sign) this document is personally known to me and appears to be of sound mind and acting willingly and free from duress. He/She signed (or asked another to sign for him/her) this document in my presence (and that person signed in my presence). I am not the person appointed as agent by this document. Further, I, the person designated as Witness 1, declare that I am not a health care provider or an employee of a health care provider giving direct care to the patient.

*Witnesses* Witness 1:

Printed Name: \_\_\_\_\_

Residing at: \_\_\_\_\_

Witness 2:

Printed Name: \_\_\_\_\_

Residing at: \_\_\_\_\_

**VERIFICATION BY NOTARY PUBLIC**

(TO BE USED IN LIEU OF WITNESSES)

In my presence on this \_\_\_\_ day of \_\_\_\_\_, 20\_\_, \_\_\_\_\_ acknowledged his/her signature on this document or acknowledged that he/she authorized the person signing this document to sign on his/her behalf. I am not named as a health care agent or alternate health care agent in this document.

(Signature of Notary) \_\_\_\_\_

Notary Stamp