

Jewish Advance Healthcare Directive

An easy-to-use form to make your goals, values and preferences known



CEDARS-SINAI®

Why should you have an Advance Healthcare Directive?

It is important to plan ahead and clearly state your healthcare goals, values and preferences. An Advance Healthcare Directive is the best place to do this. Your completed directive will give you and those close to you greater peace of mind. The process of filling out your directive may also help you talk with loved ones about what matters most to you.

There also is a number of resources available at Cedars-Sinai to help you complete your directive, including social workers, spiritual care experts and a free Advance Care Planning class. For information on these and other resources, please see the back cover of this document.

What should you do after you have completed your Advance Healthcare Directive?

1. Have your directive notarized or signed by two eligible witnesses.
 - Option 1: Sign the document in the presence of a notary public.
 - Option 2: Have two eligible witnesses sign the document.
2. Share copies with:
 - Your healthcare agent(s)
 - Your loved ones
 - Your main physician
 - Your lawyer
 - Your rabbi
3. Make sure it is uploaded into your electronic medical record, using one of the following options:

Upload to My CS-Link™	Fax to Cedars-Sinai	Mail to Cedars-Sinai	Email an electronic copy to Cedars-Sinai
<p>Website: mycslink.org</p> <p>Use the Advance Healthcare Directive page listed under Resources.</p> <p><i>Please include your name and date of birth on the first page.</i></p>	<p>Fax Number: 310-248-8078</p> <p><i>Please include your name and date of birth on the first page.</i></p>	<p>Mailing Address: Health Information Department 8700 Beverly Blvd. South Tower, Room 2901 Los Angeles, CA 90048</p> <p><i>Please include your name and date of birth on the first page.</i></p>	<p>Email Address: groupMNSHID@cshs.org</p> <p><i>Please include your name and date of birth on the first page.</i></p>

4. Keep the original copy in a safe (but accessible) place.

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My Name: _____

My Date of Birth: _____

PART 1:

My Healthcare Agent and Rabbi

SECTION A CHOOSING MY HEALTHCARE AGENT

- For help with filling out this section, please refer to pages 3-4 of the Step-by-Step Guide.
-

I choose the following person to speak on my behalf if at any time I am not able to (or choose not to) express my own goals, values and preferences:

Name: _____

Relationship to You: _____

Phone Number(s): _____

Email Address (if known): _____

The following people can serve as alternate agents (this is optional):

First Alternate

Name: _____

Relationship to You: _____

Phone Number(s): _____

Email Address (if known): _____

Second Alternate

Name: _____

Relationship to You: _____

Phone Number(s): _____

Email Address (if known): _____

PART 1: My Healthcare Agent and Rabbi

SECTION B CHOOSING A RABBI

- For help with filling out this section, please refer to page 5 of the Step-by-Step Guide.
-

As a Jew, it is my desire, and I hereby direct, that all decision-making about my healthcare be done in accordance with Jewish law and custom.

- To determine the requirements of Jewish law and custom, I further direct my agent to consult with the following rabbi:*

Rabbi

Name: _____

Phone Number(s): _____

Email Address (if known): _____

Street Address (if known): _____

City, State, Zip Code (if known): _____

If such rabbi is unable, unwilling or unavailable to provide such consultation and guidance, I direct my agent to consult with the following rabbi or rabbi referred by the institution or organization:

Alternate Rabbi/Institution

Name: _____

Name of Institution/Organization: _____

Phone Number(s): _____

Email Address (if known): _____

Street Address (if known): _____

City, State, Zip Code (if known): _____

Part 1 (continued)

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

SECTION C

WHEN WOULD I LIKE MY HEALTHCARE AGENT
TO BEGIN REPRESENTING ME?

- For help with filling out this section, please refer to page 5 of the Step-by-Step Guide.
-

Please complete the sentence below by initialing either option 1 or option 2:

I would like my healthcare agent to begin participating in decision-making about my healthcare...

Option 1

...only when my physician determines that I am unable to express my own goals, values and preferences.

(Initial Here)

Option 2

...from this time forward, even if I am still able to speak for myself.

(Initial Here)

PART 2 (Optional): My Healthcare Goals, Values and Preferences

SECTION A	QUALITY OF LIFE (I.E. WHAT MATTERS MOST IN THE FACE OF SEVERE ILLNESS)
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■ For help with filling out this section, please refer to pages 6-10 of the Step-by-Step Guide.

This section allows you to share some specifics about who you are and what is most important to you in the face of serious illness.

After reviewing and completing the questionnaire on pages 6-10 of the Step-by-Step Guide which correspond with this section of this Advance Healthcare Directive, you may describe your values by completing the following sentence (if you are not sure you may leave these lines blank):

My life would be worth living, and therefore I would want my life to be prolonged as long as possible, under the following circumstances:

If my physician believes that I do not have a reasonable chance of recovering to this minimal quality of life, I would not want the following procedures or medical interventions initiated:

If you would like to share additional details, please use the extra pages provided at the end of this document.

PART 3:

How Strictly Do I Want My Advance Healthcare Directive Followed?

- For help with filling out this section, please refer to page 12 of the Step-by-Step Guide.
-

Please complete the sentence below by initialing either option 1 or option 2:

I want my goals, values and preferences, as expressed in this directive...

Option 1

...to serve as a general guide.

(Initial Here)

Option 2

... to be followed strictly, under all circumstances.

(Initial Here)

PART 4 (OPTIONAL): Additional Preferences

- For help with filling out this section, please refer to page 13 of the Step-by-Step Guide.

Cadaveric Organ Donation

This section is relevant only if death has been determined as defined by Jewish Law and custom in consultation with my rabbi.

- I wish to donate any and all organs and tissues.

OR

- I do not wish to donate any of my organs or tissues.

OR

- I wish to donate only the following organs or tissues (please specify):

My Wishes for After I Die

- All decisions concerning the handling and disposition of my body and preparation for burial are to be made pursuant to Jewish law and custom as determined by my designated rabbi. Prior to contacting my designated rabbi, unless there is prior specified authorization by the rabbi, it is my desire, and I hereby direct, that no post-mortem procedure be performed on my body (e.g. subject to certain limited exceptions, Jewish law generally prohibits the performance of any autopsy).

I have the following wishes regarding funeral and burial arrangements:

If you would like to share additional details, please use the extra pages provided at the end of this document.

PART 5 (OPTIONAL): Identifying My Physician

- For help with filling out this section, please refer to page 13 of the Step-by-Step Guide.
-

You may have physicians involved in your care who understand your goals, values and preferences. If you would like them to be involved in discussions regarding your condition and treatment options, please list their names and contact information below.

Name of Physician: _____

Phone Number(s) (if known): _____

Email Address (if known): _____

Name of Physician: _____

Phone Number(s) (if known): _____

Email Address (if known): _____

Name of Physician: _____

Phone Number(s) (if known): _____

Email Address (if known): _____

Please remember also to discuss your values and choices with the physician(s) named above and provide him/her/them a copy of your directive.

PART 6: Signing My Advance Healthcare Directive

- For help with filling out this section, please refer to Part 6 of the Step-by-Step Guide (Page 14).
-

In order to make this document legal and valid, you must sign below in the presence of EITHER a **notary public** (Page 12) OR **two witnesses** (Page 13):

Name (Print):

Signature:

Date of Signature:

Signing My Advance Healthcare Directive With a Notary

Note: If you complete the section below, you do not need to complete Page 13.

NOTARIZATION

(California All-Purpose Acknowledgment, Civil Code 1189)

A notary public or other officer completing this certificate verifies only the identity of the individual who signed the document to which this certificate is attached, and not the truthfulness, accuracy or validity of that document.

State of California

County of _____



On _____ before me, _____
Date Here Insert Name and Title of the Officer

personally appeared _____
Name(s) of Signer(s)

who proved to me on the basis of satisfactory evidence to be the person(s) whose name(s) is/are subscribed to the within instrument and acknowledged to me that he/she/they executed the same in his/her/their authorized capacity(ies), and that by his/her/their signature(s) on the instrument the person(s), or the entity upon behalf of which the person(s) acted, executed the instrument.

I certify under PENALTY OF PERJURY under the laws of the State of California that the foregoing paragraph is true and correct.

WITNESS my hand and official seal.

Signature _____
Signature of Notary Public

.....
Place Notary Seal Above

Signing My Advance Healthcare Directive With Witnesses

Note: If you complete the section below, you do not need to complete Page 12.

STATEMENT OF WITNESSES

I declare under penalty of perjury under the laws of California 1) that the individual who signed or acknowledged this Advance Healthcare 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 Healthcare 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 Healthcare Directive; and 5) that I am not the individual's healthcare provider, an employee of an operator of a community care facility, nor the employee of an operator of a residential care facility for the elderly; and 6) I am over 18 years of age.

WITNESS #1

Signature of Witness #1	Date
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Printed Name of Witness #1	Phone Number
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WITNESS #2

Signature of Witness #2	Date
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Printed Name of Witness #2	Phone Number
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One of the witnesses also must 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 Healthcare 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.

Signature of Witness #1 or #2	Date
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Printed Name of Witness #1 or #2	Date
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Special Witness Requirement

Note: For nursing home or skilled nursing facility patients only, a signature from a patient advocate or ombudsman is required in addition to completing either Page 12 or Page 13.

If you are **not** a nursing home patient or skilled nursing facility patient, you may skip this section.

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.

Signature of Patient Advocate or Ombudsman

Date

Printed Name of Patient Advocate or Ombudsman

Phone Number

Additional Resources

To sign up for the free Advance Care Planning Class, call 800-700-6424.

Cedars-Sinai Supportive Care Medicine, 310-423-9520

The Cedars-Sinai Supportive Care Medicine (SCM) team helps inpatients and outpatients who are facing life-limiting or advanced illness to achieve the best possible quality of life, and also provides support for families. SCM clinicians are experts in managing a full range of symptoms, both physical and psychological; they are also specifically trained to help with Advance Care Planning and Advance Healthcare Directives.

Cedars-Sinai Spiritual Care, 310-423-5550; cedars-sinai.org/spiritualcare

Members of the Cedars-Sinai Spiritual Care Department offer spiritual care services to Cedars-Sinai patients and their loved ones. Chaplains are available to visit patients and help work through difficult issues related to end-of-life decisions and care.

Cedars-Sinai Center for Healthcare Ethics, 310-423-9636; cedars-sinai.org/ethics

For patients hospitalized at Cedars-Sinai, the center offers clinical ethics consultation. The aim is to help patients, family members, physicians and other members of the patient care team examine and discuss pertinent ethical values and goals.

Cedars-Sinai Social Work

Inpatient: 310-423-4446 | Outpatient: 310-248-8311

The following are websites that provide information on advance healthcare planning:

- Advance Health Care Directive Registry—California: sos.ca.gov/registries/advance-health-care-directive-registry
- Aging With Dignity: agingwithdignity.org
- American Hospital Association: putitinwriting.org
- California Medical Association: cmanet.org
- Caring Connections: caringinfo.org
- Coalition for Compassionate Care of California: coalitionccc.org and capolst.org (POLST forms in English and other languages)
- Hospice Association of America: hospice.nahc.org
- Donate Life California—Organ and Tissue Donor Registry: donatelifecalifornia.org
- U.S. Department of Veterans Affairs: losangeles.va.gov/patients/advance.asp

