NEW JERSEY
Advance Directive
Planning for Important Health care Decisions

Caring Connections
1731 King St., Suite 100, Alexandria, VA 22314
www.caringinfo.org
800/658-8898

CARING CONNECTIONS

Caring Connections, a program of the National Hospice and Palliative Care Organization (NHPCO), is a national consumer engagement initiative to improve care at the end of life.

Caring Connections tracks and monitors all state and federal legislation and significant court cases related to end-of-life care to ensure that our advance directives are up to date.

It's About How You LIVE

It's About How You LIVE is a national community engagement campaign encouraging individuals to make informed decisions about end-of-life care and services. The campaign encourages people to:

Learn about options for end-of-life services and care
Implement plans to ensure wishes are honored
Voice decisions to family, friends and health care providers
Engage in personal or community efforts to improve end-of-life care

Visit www.caringinfo.org to learn more about the LIVE campaign, obtain free resources, or join the effort to improve community, state and national end-of-life care.

If you would like to make a contribution to help support our work, please visit www.nationalhospicefoundation.org/donate. Contributions to national hospice programs can also be made through the Combined Health Charities or the Combined Federal Campaign by choosing #11241.

Your Advance Care Planning Packet

Using these materials

BEFORE YOU BEGIN

1. Check to be sure that you have the materials for each state in which you may receive health care.

2. These materials include:
    - Instructions for preparing your advance directive.
    - Your state-specific advance directive forms, which are the pages with the gray instruction bar on the left side.

PREPARING TO COMPLETE YOUR ADVANCE DIRECTIVE

3. Read the HIPAA Privacy Rule Summary on page 4.

4. Read all the instructions, on pages 7 through 9, as they will give you specific information about the requirements in your state.

5. Refer to the Glossary located in Appendix A if any of the terms are unclear.

ACTION STEPS

6. You may want to photocopy these forms before you start so you will have a clean copy if you need to start over.

7. When you begin to fill out the forms, refer to the gray instruction bars - they will guide you through the process.

8. Talk with your family, friends, and physicians about your advance directive. Be sure the person you appoint to make decisions on your behalf understands your wishes.

9. Once the form is completed and signed, photocopy the form and give it to the person you have appointed to make decisions on your behalf, your family, friends, health care providers and/or faith leaders so that the form is available in the event of an emergency.

If you have questions or need guidance in preparing your advance directive or about what you should do with it after you have completed it, please refer to the state-specific contacts for Legal & End-of-Life Care Resources Pertaining to Health care Advance Directives, located in Appendix B.

Summary of the HIPAA Privacy Rule

HIPAA is a federal law that gives you rights over your health information and sets rules and limits on who can look at and receive your health information.

Your Rights

You have the right to:

- Ask to see and get a copy of your health records.
- Have corrections added to your health information.
- Receive a notice that tells you how your health information may be used and shared.
- Decide if you want to give your permission before your health information can be used or shared for certain purposes, such as marketing.
- Get a report on when and why your health information was shared for certain purposes.
- If you believe your rights are being denied or your health information isn't being protected, you can:
    - File a complaint with your provider or health insurer, or
    - File a complaint with the U.S. Government.

You also have the right to ask your provider or health insurer questions about your rights. You also can learn more about your rights, including how to file a complaint from the Web site at www.hhs.gov/ocr/hipaa/ or by calling 1-866-627-7748.

Who Must Follow this Law?

- Doctors, nurses, pharmacies, hospitals, clinics, nursing homes, and many other health care providers.
- Health insurance companies, HMOs, most employer group health plans.
- Certain government programs that pay for health care, such as Medicare and Medicaid.

What Information is Protected?

- Information your doctors, nurses, and other health care providers put in your medical record.
- Conversations your doctor has had about your care or treatment with nurses and other health care professionals.
- Information about you in your health insurer's computer system.
- Billing information about you from your clinic/health care provider.
- Most other health information about you, held by those who must follow this law.

Summary of the HIPAA Privacy Rule (continued)

Providers and health insurers who are required to follow this law must keep your information private by:

- Teaching the people who work for them how your information may and may not be used and shared,
- Taking appropriate and reasonable steps to keep your health information secure.

To make sure that your information is protected in a way that does not interfere with your health care, your information can be used and shared:

- For your treatment and care coordination,
- To pay doctors and hospitals for your health care,
- With your family, relatives, friends or others you identify who are involved with your health care or your health care bills, unless you object,
- To protect the public's health, such as by reporting when the flu is in your area, or
- To make required reports to the police, such as reporting gunshot wounds.

Your health information cannot be used or shared without your written permission unless this law allows it. For example, without your authorization, your provider generally cannot:

- Give your information to your employer.
- Use or share your information for marketing or advertising purposes, or
- Share private notes about your mental health counseling sessions.

Introduction to Your Advance Directive

This packet contains to legal documents which protects your right to refuse medical treatment you do not want or to request treatment you do want in the event you lose the ability to make decisions yourself. It becomes effective once: (1) it is transmitted to your attending physician or health care institution; and (2) your attending physician and one other doctor confirms in writing that you are unable to make decisions regarding your health care. Such determination of your decision making incapacity shall be made part of your medical record and notice shall be given to your health care representative or proxy.

1. The **New Jersey Appointment of a Health care Representative** lets you name someone to make decisions about your medical care, including decisions about life-sustaining treatment, if you can no longer make health care decisions for yourself.

2. The **New Jersey Instruction Directive**. It lets you provide instruction and direction regarding your wishes about medical care in the event that you develop a terminal condition or are permanently unconscious and can no longer make your own medical decisions. The Living Will becomes effective when, in addition to the conditions for effectiveness of the Advance Directive listed in the paragraph above, your doctor and one other physician document in your medical record that you are in a terminal condition or permanently unconscious.

You may use either one or both of these documents.

Note: This document will be legally binding only if the person completing the document is a competent adult (18 years of age or older.)

Instructions Completing Your Advance Directive for Health care

How do I make my *Advance Directive for Health care* legal?

The law requires that you sign your document, or direct another to sign it;

1. in the presence of two witnesses who must be at least 18 years of age. These witnesses must also sign the document to show that they believe you to be of sound mind, that you voluntarily signed the document, and that they are not your appointed health care representative or alternate health care representative;

OR

2. before a notary public, an attorney at law, or another person authorized to administer oaths

Your advance directive becomes effective once: (1) it is transmitted to your attending physician or health care institution; and (2) your attending physician and one other doctor confirms in writing that you are unable to make decisions regarding your health care. Such determination of your decision making incapacity shall be made part of your medical record and notice shall be given to your health care representative.

Can I add personal instructions to my Living Will?

Yes. You can add personal instructions to your living will. For example, if there are any specific forms of treatment that you wish to refuse that are not already listed in the document, you may list them here. You may also direct your health care representative to consult with specified individuals such as family members in the course of making decisions. Your health care representative is required to act in good faith and within the bounds of authority granted by the advance directive.

One of the strongest reasons for naming a representative is to have someone who can respond flexibly as your medical situation changes and deal with situations that you did not foresee. Talk with your representative about your future medical care and describe what you consider to be an acceptable “quality of life.”

Instructions Completing Your Advance Directive for Health care (continued)

Whom should I appoint as my representative?

A representative is the person you appoint to make decisions about your medical care if you become unable to make those decisions yourself. (A representative may also be called an “agent” or “proxy”.) You can appoint a second person as your alternate representative. The alternate will step in if the first person you name as your representative is unable, unwilling, or unavailable to act for you. The person you name as your representative should clearly understand your wishes and be willing to accept the responsibility of making medical decisions for you.

You **can** appoint a family member, including, but not limited to your spouse or domestic partner or a close friend whom you trust to make serious decisions.

If you designate your spouse as your representative, his or her authority is automatically revoked upon divorce or legal separation, unless otherwise specified in the Advance Directive. If you designate your domestic partner, his or her authority is automatically revoked upon termination of your domestic partnership, unless otherwise specified in the Advance Directive.

You **cannot** appoint an operator, administrator or employee of your treating health care institution, unless he or she is related to you by blood, marriage, domestic partnership, or adoption. However, you can appoint a physician so long as he or she is not serving as your attending physician at the same time.

Before your representative can make decisions on your behalf, your doctor or treating health care institution must receive a copy of the Appointment of Health care Representative, and your attending physician and one other doctor must confirm that you are unable to make health care decisions.

Completing Your Directive for Health care (continued)

What if I change my mind?

You may modify at any time your entire Advance Directive, your Living Will, or your Health care Representative by complying with the same requirements for execution of any of those documents.

You may revoke your entire Advance Directive, your Living Will, or your Health care Representative at any time by:

- Announcing your revocation either orally or in writing to your health care representative, your doctor or other health care provider, or a reliable witness;
- Any other act which demonstrates your intent to revoke the document(s); or
- Executing a subsequent Advance Directive, Living Will, or Health care Representative document.

If you designate your spouse as your representative, his or her authority is automatically revoked upon divorce or legal separation, unless otherwise specified in the Advance Directive. If you designate your domestic partner, his or her authority is automatically revoked upon termination of your domestic partnership, unless otherwise specified in the Advance Directive.

INSTRUCTIONS

PRINT YOUR NAME

PRINT THE NAME, ADDRESS AND HOME AND WORK TELEPHONE NUMBERS OF YOUR HEALTH CARE REPRESENTATIVE

PRINT THE NAME, ADDRESS, AND TELEPHONE NUMBER OF YOUR FIRST ALTERNATE HEALTH CARE REPRESENTATIVE

NEW JERSEY APPOINTMENT OF A HEALTH CARE REPRESENTATIVE – PAGE 1 OF 5

I, _____, hereby appoint:
(name)

_____
(name of health care representative)

_ _
(address of health care representative)

_____

_____ (home phone number)

_____ (work phone number)

to be my health care representative to make any and all health care decisions for me, including decisions to accept or to refuse any treatment, service or procedure used to diagnose or treat my physical or mental condition, and decisions to provide, withhold or withdraw life-sustaining treatment. I direct my health care representative to make decisions on my behalf in accordance with my wishes as stated in this document, or as otherwise known to him or her. In the event my wishes are not clear, or if a situation arises that I did not anticipate, my health care representative is authorized to make decisions in my best interests.

If the person I have designated above is unable, unwilling or unavailable to act as my health care representative, I hereby designate the following person(s) to act as my health care representative, in the following order of priority:

1.Name_____

Address _____

City _____ State _____

Telephone _____

PRINT THE NAME, ADDRESS AND TELEPHONE NUMBER OF YOUR SECOND ALTERNATE HEALTH CARE REPRESENTATIVE

2. Name _____

Address _____

City _____ State _____

Telephone _____

ADD PERSONAL INSTRUCTIONS (IF ANY)

I direct that my health care representative comply with the following instructions and/or limitations (optional):

ADD INSTRUCTIONS TO BE FOLLOWED IN THE EVENT YOU ARE PREGNANT (IF ANY)

I direct that my health care representative comply with the following instructions in the event that I am pregnant when this Directive becomes effective (optional):

IF YOU HAVE NOT MADE A GIFT OR EXPLICTLY REFUSED TO MAKE A GIFT OF YOUR ORGANS ELSEWHERE, YOUR HEALTH CARE REPRESENTATIVE WILL HAVE AUTHORITY TO MAKE SUCH A GIFT, IN ACCORDANCE WITH ANY INSTRUCTIONS YOU PROVIDE.

INITIAL THE STATEMENT THAT BEST REFLECTS YOUR WISHES.

NEW JERSEY APPOINTMENT OF A HEALTH CARE REPRESENTATIVE - PAGE 3 OF 5

I authorize my agent to make this anatomical gift if medically acceptable to take effect upon my death. The words and marks below indicate my desires.

Upon my death, I wish to donate:

_____ My body for anatomical study if needed.

_____ Any needed organs, tissues, or eyes.

_____ Only the following organs, tissues, or eyes:

_____

I authorize the use of my organs, tissues, or eyes:

_____ For transplantation

_____ For therapy

_____ For research

_____ For medical education

_____ For any purpose authorized by law.

This authority granted to my patient advocate to make an anatomical gift is limited as follows (here list limitations or special wishes, if any):

NEW JERSEY APPOINTMENT OF A HEALTH CARE REPRESENTATIVE - PAGE 4 OF 5

By writing this advance directive, I inform those who may become responsible for my health care of my wishes and intend to ease the burdens of decision making which this responsibility may impose. I have discussed the terms of this designation with my health care representative(s) and my representative(s) has/have willingly agreed to accept the responsibility for acting on my behalf in accordance with this directive and my wishes. I understand the purpose and effect of this document and sign it knowingly, voluntarily and after careful deliberation.

SIGN AND DATE YOUR DOCUMENT
PRINT YOUR ADDRESS

Signed this _____ day of _____ 20 _____.

Signature _____

Address _____

City _____ State _____

WITNESSING PROCEDURE

YOUR WITNESSES MUST SIGN BELOW

I declare that the person who signed this document or asked another to sign this document on his or her behalf, did so in my presence, that he or she appears to be of sound mind and free of duress or undue influence. I am 18 years of age or older, and am not designated by this or any other document as the person's health care representative or alternate health care representative.

WITNESS #1

1. Witness _____

Address _____

City _____ State _____

WITNESS #2

Signature & Date_____

2. Witness _____

TURN TO THE NEXT PAGE TO NOTARIZE YOUR DOCUMENT

Address _____

City _____ State _____

Signature & Date _____

OR

A NOTARY PUBLIC OR ATTORNEY AT LAW SHOULD COMPLETE THIS SECTION

OR

On _____, before me came
(date)

_____,
(name of declarant)

whom I know to be such person, and the declarant did then and there execute this declaration.

Sworn before me this _____day of _____, 20 ____.

_____
Signature of:

_____ Notary Public
_____ Attorney at Law
(check one)

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NEW JERSEY INSTRUCTION DIRECTIVE – PAGE 1 OF 5

INSTRUCTIONS

If I am incapable of making an informed decision regarding my health care, I direct my loved ones and health care providers to follow my instructions as set forth below. (Initial all those that apply.)

For purposes of the provisions below, life-sustaining treatment means: the use of any medical device or procedure, artificially provided fluids, nutrition, drugs, surgery or therapy that use artificial means to sustain a vital bodily function to increase life span, which would serve only to artificially prolong my dying,

(1) If I am diagnosed as having an incurable and irreversible illness, disease, or condition and if my attending physician and at least one additional physician who has personally examined me determine that my condition is terminal:

INITIAL ALL STATEMENTS THAT REFLECT YOUR WISHES

_____ I direct that life-sustaining treatment be withheld or ended. I also direct that I be given all medically appropriate treatment and care necessary to make me comfortable and to relieve pain.

_____ I direct that life-sustaining treatment be continued, if medically appropriate.

(2) If there should come a time when I become permanently unconscious, and it is determined by my attending physician and at least one additional physician with appropriate expertise who has personally examined me, that I have totally and irreversibly lost consciousness and my ability to interact with other people and my surroundings:

_____ I direct that life-sustaining treatment be withheld or discontinued. I understand that I will not experience pain or discomfort in this condition, and I direct that I be given all medically appropriate treatment and care necessary to provide for my personal hygiene and dignity.

_____ I direct that life-sustaining treatment be continued, if medically appropriate.

INCURABLE AND IRREVERSIBLE CONDITION THAT IS NOT TERMINAL

(3) If there comes a time when I am diagnosed as having an incurable and irreversible illness, disease or condition which may not be terminal, but causes me to experience severe and worsening physical or mental deterioration, and I will never regain the ability to make decisions and express my wishes:

_____ I direct that life-sustaining measures be withheld or discontinued and that I be given all medically appropriate care necessary to make me comfortable and to relieve pain.

_____ I direct that life-sustaining treatment be continued, if medically appropriate.

EXPERIMENTAL AND/OR FUTILE TREATMENT

(4) If I am receiving life-sustaining treatment that is either (1) experimental and not a proven therapy, or (2) is likely to be ineffective or futile in prolonging life:

_____ I direct that such life-sustaining treatment be withheld or withdrawn. I also direct that I be given all medically appropriate care necessary to make me comfortable and to relieve pain.

_____ I direct that life-sustaining treatment be continued, if medically appropriate.

SPECIFIC PROCEDURES AND/OR TREATMENT

(5) If I am in the condition(s) described above I feel especially strongly about the following forms of treatment: (initial all those that apply)

_____ I do not want cardiopulmonary resuscitation (CPR).
_____ I do not want mechanical respiration.
_____ I do not want tube feeding.
_____ I do not want antibiotics.
_____ I **do** want maximum pain relief, even if it may hasten my death.

ADD INSTRUCTIONS TO BE FOLLOWED IN THE EVENT YOU ARE PREGNANT (IF ANY)

(6) Pregnancy:
If I am pregnant at the time that I am diagnosed as having any of the conditions described above, I direct that my health care provider comply with following instructions (optional):

OBJECTION TO NEW JERSEY BRAIN DEATH DEFINITION (IF ANY)

BRAIN DEATH:
The State of New Jersey has determined that an individual may be declared legally dead when there has been an irreversible cessation of all functions of the entire brain, including the brain stem (also known as whole brain death). However, individuals who do not accept this definition of brain death because of their personal religious beliefs may request that it not be applied in determining their death.

Initial the following statement only if it applies to you:

____ To declare my death on the basis of the whole brain death standard would violate my personal religious beliefs. I therefore wish my death to be declared only when my heartbeat and breathing have irreversibly stopped.

ORGAN DONATION (OPTIONAL)

ORGAN DONATION (OPTIONAL)
Under New Jersey law, you may make a gift of all or part of your body. In the space below you may make a gift yourself or state that you do not want to make a gift.

INITIAL THE STATEMENT THAT BEST REFLECTS YOUR WISHES

Initial the line next to the statement below that best reflects your wishes. You do not have to initial any of the statements. If you do not initial any of the statements, your agent or your family will have the authority to make a gift of all or part of your body under New Jersey law.

_____ I do not want to make an organ or tissue donation and I do not want my agent or family to do so.

_____ I have already signed a written agreement or donor card regarding organ and tissue donation with the following individual or

Upon my death, I wish to donate:

_____ My body for anatomical study if needed.
_____ Any needed organs, tissues, or eyes.
_____ Only the following organs, tissues, or eyes:

_____

I authorize the use of my organs, tissues, or eyes:
_____ For transplantation
_____ For therapy
_____ For research
_____ For medical education
_____ For any purpose authorized by law.

_____ I do not want to make an organ or tissue donation and I do not want my agent or family to do so.

FURTHER INSTRUCTIONS:

ADD FURTHER INSTRUCTIONS (IF ANY)

By writing this advance directive, I inform those who may become responsible for my health care of my wishes and intend to ease the burdens of decision making which this responsibility may impose. I have discussed the terms of this designation with my health care representative(s) and my representative(s) has/have willingly agreed to accept the responsibility for acting on my behalf in accordance with this directive and my wishes. I understand the purpose and effect of this document and sign it knowingly, voluntarily and after careful deliberation.

Signed this _____ day of _____ 20_____.

SIGN AND DATE YOUR DOCUMENT PRINT YOUR ADDRESS

Signature _____

Address _____

City _____ State _____

WITNESSING PROCEDURE

YOUR WITNESSES MUST SIGN BELOW

I declare that the person who signed this document or asked another to sign this document on his or her behalf, did so in my presence and he or she appears to be of sound mind and free of duress or undue influence. I am 18 years of age or older, and am not designated by this or any other document as the person's health care representative or alternate health care representative.

WITNESS #1

1. Witness _____

Address _____

City _____ State _____

Signature _____ Date _____

WITNESS #2

2. Witness _____

Address _____

City _____ State _____

Signature _____ Date _____

OR

A NOTARY PUBLIC OR ATTORNEY AT LAW SHOULD COMPLETE THIS SECTION

OR

On _____, before me came
(date)

_____,
(name of declarant)

whom I know to be such person, and the declarant did then and there execute this declaration.

Sworn before me this _____ day of _____, 20 _____.

_____
Signature of: (check one)
_____Notary Public
_____ Attorney at Law

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You Have Filled Out Your Advance Directive, Now What?

1. Your *Advance Directive for Health care* is an important legal document. Keep the original signed document in a secure but accessible place. Do not put the original document in a safe deposit box or any other security box that would keep others from having access to it.

2. Give photocopies of the signed original to your representative and alternate representative, doctor(s), family, close friends, clergy and anyone else who might become involved in your health care. If you enter a nursing home or hospital, have photocopies of your document placed in your medical records.

3. Be sure to talk to your representative(s), doctor(s), clergy, family and friends about your wishes concerning medical treatment. Discuss your wishes with them often, particularly if your medical condition changes.

4. If you want to make changes to your documents after they have been signed and witnessed, you must complete a new document.

5. Remember, you can always revoke your document.

6. Be aware that your document will not be effective in the event of a medical emergency. Ambulance personnel are required to provide cardiopulmonary resuscitation (CPR) unless they are given a separate order that states otherwise. These orders, commonly called "non-hospital do-not-resuscitate orders," are designed for people whose poor health gives them little chance of benefiting from CPR. These orders must be signed by your physician and instruct ambulance personnel not to attempt CPR if your heart or breathing should stop.

   Currently not all states have laws authorizing non-hospital do-not-resuscitate orders. We suggest you speak to your physician for more information. **Caring Connections does not distribute these forms.**

Appendix A

Glossary

Advance directive - A general term that describes two kinds of legal documents, living wills and medical powers of attorney. These documents allow a person to give instructions about future medical care should he or she be unable to participate in medical decisions due to serious illness or incapacity. Each state regulates the use of advance directives differently.

Artificial nutrition and hydration – Artificial nutrition and hydration supplements or replaces ordinary eating and drinking by giving a chemically balanced mix of nutrients and fluids through a tube placed directly into the stomach, the upper intestine or a vein.

Brain death – The irreversible loss of all brain function. Most states legally define death to include brain death.

Capacity - In relation to end-of-life decision-making, a patient has medical decision making capacity if he or she has the ability to understand the medical problem and the risks and benefits of the available treatment options. The patient's ability to understand other unrelated concepts is not relevant. The term is frequently used interchangeably with competency but is not the same. Competency is a legal status imposed by the court.

Cardiopulmonary resuscitation - Cardiopulmonary resuscitation (CPR) is a group of treatments used when someone's heart and/or breathing stops. CPR is used in an attempt to restart the heart and breathing. It may consist only of mouth-to-mouth breathing or it can include pressing on the chest to mimic the heart's function and cause blood to circulate. Electric shock and drugs also are used frequently to stimulate the heart.

Do-Not-Resuscitate (DNR) order - A DNR order is a physician's written order instructing health care providers not to attempt cardiopulmonary resuscitation (CPR) in case of cardiac or respiratory arrest. A person with a valid DNR order will not be given CPR under these circumstances. Although the DNR order is written at the request of a person or his or her family, it must be signed by a physician to be valid. A non-hospital DNR order is written for individuals who are at home and do not want to receive CPR.

***Emergency Medical Services (EMS*)**: A group of governmental and private agencies that provide emergency care, usually to persons outside of health care facilities; EMS personnel generally include paramedics, first responders and other ambulance crew.

Health care agent or representative**:** The person named in an advance directive or as permitted under state law to make health care decisions on behalf of a person who is no longer able to make medical decisions.

Hospice - Considered to be the model for quality, compassionate care for people facing a life-limiting illness or injury, hospice and palliative care involve a team-oriented approach to expert medical care, pain management, and emotional and spiritual support expressly tailored to the person's needs and wishes. Support is provided to the persons loved ones as well.

Intubation- Refers to "endotracheal intubation" the insertion of a tube through the mouth or nose into the trachea (windpipe) to create and maintain an open airway to assist breathing.

Life-sustaining treatment - Treatments (medical procedures) that replace or support an essential bodily function (may also be called life support treatments). Life-sustaining treatments include cardiopulmonary resuscitation, mechanical ventilation, artificial nutrition and hydration, dialysis, and other treatments.

Living will - A type of advance directive in which an individual documents his or her wishes about medical treatment should he or she be at the end of life and unable to communicate. It may also be called a "directive to physicians", "health care declaration," or "medical directive."

Mechanical ventilation - Mechanical ventilation is used to support or replace the function of the lungs. A machine called a ventilator (or respirator) forces air into the lungs. The ventilator is attached to a tube inserted in the nose or mouth and down into the windpipe (or trachea).

Medical power of attorney - A document that allows an individual to appoint someone else to make decisions about his or her medical care if he or she is unable to communicate. This type of advance directive may also be called a health care proxy, durable power of attorney for health care or appointment of a health care agent. The person appointed may be called a health care agent, surrogate, attorney-in-fact or proxy.

Palliative care - A comprehensive approach to treating serious illness that focuses on the physical, psychological, spiritual, and existential needs of the patient. Its goal is to achieve the best quality of life available to the patient by relieving suffering, and controlling pain and symptoms.

Power of attorney – A legal document allowing one person to act in a legal matter on another's behalf regarding to financial or real estate transactions.

Respiratory arrest**:** The cessation of breathing - an event in which an individual stops breathing. If breathing is not restored, an individual's heart eventually will stop beating, resulting in cardiac arrest.

Surrogate decision-making - Surrogate decision-making laws allow an individual or group of individuals (usually family members) to make decisions about medical treatments for a patient who has lost decision-making capacity and did not prepare an advance directive. A majority of states have passed statutes that permit surrogate decision making for patients without advance directives.

Ventilator – A ventilator, also known as a respirator, is a machine that pushes air into the lungs through a tube placed in the trachea (breathing tube). Ventilators are used when a person cannot breathe on his or her own or cannot breathe effectively enough to provide adequate oxygen to the cells of the body or rid the body of carbon dioxide.

Withholding or withdrawing treatment - Forgoing life-sustaining measures or discontinuing them after they have been used for a certain period of time.

Appendix B

Legal & End-of-Life Care Resources Pertaining to Health care Advance Directives

LEGAL SERVICES

Legal Services of New Jersey (LSNJ) coordinates the statewide network of nonprofit Legal Services programs that provide legal assistance in civil cases to low-income New Jersey residents.

Legal assistance services include:

- Housing and Tenancy
- Education
- Employment
- Divorce, Custody, and Visitation
- Seniors' Issues
- Health care Access and Related Issues
- Social Security
- Disability and more

- Must be over 60 or have a disability
- Free for individuals with low incomes

The Statewide Public Interest Legal Hotline of New Jersey can be reached Monday through Friday 9:00 to 4:30 p.m.

Call toll free: 1-888-576-5529

OR

Visit their website: http://www.lsnj.org/hotline.htm

END-OF-LIFE SERVICES

An Area Agency on Aging (AAA) is designated in each of New Jersey's 21 counties to serve as the primary entity responsible for developing comprehensive, coordinated systems of community-based services for older adults.

The role of the AAA includes:

- Caregiver Support / Respite
- Meals on Wheels
- Visiting Nurses
- Care Management
- Transportation
- Legal Support
- Prescription Plans and much more

- Must be over 18 with chronic illness and / or have a disability or 60 and older
- Free to individuals over 60 and individuals with disabilities

For more information visit their website:

http://www.state.nj.us/health/senior/sa_aaa.shtml

OR

Call toll free: 1-877-222-3737