

Introduction to Your New York Health Care Proxy and Living Will

This packet contains a legal document, a New York Health Care Proxy and Living Will, that 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. You may complete Part I, Part II, or both, depending on your advance-planning needs. You must complete Part III.

Part I, Health Care Proxy, lets you name someone, your agent, to make decisions about your health care—including decisions about life-sustaining treatment—if you can no longer speak for yourself. The health care proxy is especially useful because it appoints someone to speak for you any time you are unable to make your own health-care decisions, not only at the end of life.

Part I goes into effect when your doctor or nurse practitioner determines that you are no longer able to make or communicate your health care decisions.

Part II, Living Will, lets you state your wishes about health care in the event that you can no longer speak for yourself. Part II also allows you to record your organ donation, pain relief, funeral, and other advance planning wishes. If you also complete Part I, your living will is an important source of guidance for your agent.

Part II goes into effect when your doctor or nurse practitioner determines that you are no longer able to make or communicate your health care decisions.

Part III contains the signature and witnessing provisions so that your document will be effective.

This form does not expressly address mental illness. If you would like to make advance care plans regarding mental illness, you should talk to your physician and an attorney about a durable power of attorney tailored to your needs. In addition, if you are a resident in a facility operated or licensed by the New York Office of Mental Health or the New York Office of Mental Retardation and Developmental Disabilities, there are special witnessing requirements that you should talk about with your physician and an attorney.

Note: This document will be legally binding only if the person completing them is a competent adult who is 18 years of age or older or has been married or is a parent.

Instructions for Completing Your New York Health Care Proxy and Living Will

How do I make my New York Health Care Proxy and Living Will Legal?

If you complete Part I, the health care proxy, you (or another person at your direction, if you are unable) must sign and date this document in the presence of two adult witnesses. The person you name as your agent or alternate agent cannot act as a witness.

If you only complete Part II, the living will, there are no special witnessing requirements. However, because your living will may be used as evidence of your wishes, it is best that you sign and date this document in the presence of witnesses just as if you had completed Part I.

Whom should I appoint as my agent?

Your agent is the person you appoint to make decisions about your health care if you become unable to make those decisions yourself. Your agent may be a family member or a close friend whom you trust to make serious decisions. The person you name as your agent should clearly understand your wishes and be willing to accept the responsibility of making health care decisions for you.

You can appoint a second person as your alternate agent. The alternate will step in if the first person you name as an agent is unable, unwilling, or unavailable to act for you.

You may not appoint the operator, administrator, or employee of a hospital where you are a patient or a resident or where you have applied for admission, unless the person is related to you by blood, marriage, or adoption. Your agent cannot also act as your attending physician or nurse practitioner. You cannot appoint as your agent someone who is already an agent for ten or more people, unless the agent is your spouse, child, parent, sibling, or grandparent.

Unless you specify otherwise in the space for additional instructions on page 2 of the form, if you appoint your spouse as your agent, the health care proxy will be revoked automatically if you divorce or are legally separated.

Should I add personal instructions to my New York Health Care Proxy and Living Will?

One of the strongest reasons for naming an agent is to have someone who can respond flexibly as your health care situation changes and deal with situations that you did not foresee. If you add instructions to this document it may help your agent carry out your wishes, but be careful that you do not unintentionally restrict your agent’s power to act in your best interest. In any event, be sure to talk with your agent about your future medical care and describe what you consider to be an acceptable “quality of life.”

What if I change my mind?

You may revoke your advance directive by notifying your agent or health care provider orally or in writing, or by any other act that clearly shows your intent to revoke the document. Such acts might include tearing up your advance directive, signing a written revocation, or executing a new advance directive with different terms.

**NEW YORK HEALTH CARE PROXY AND
LIVING WILL – PAGE 1 OF 6**

PART I

PRINT YOUR NAME

PRINT NAME,
HOME ADDRESS
AND TELEPHONE
NUMBER OF
YOUR AGENT

PRINT NAME, HOME
ADDRESS
AND TELEPHONE
NUMBER OF YOUR
ALTERNATE AGENT

ADD INSTRUCTIONS
HERE ONLY IF YOU WANT
TO LIMIT YOUR AGENT'S
AUTHORITY

SPECIFY THE DATE OR
CONDITIONS FOR
EXPIRATION, IF ANY

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Part I. Health Care Proxy

I, _____, hereby appoint:
(name)

(name, home address and telephone number of agent)

as my health care agent.

In the event that the person I name above is unable, unwilling, or reasonably unavailable to act as my agent, I hereby appoint

(name, home address and telephone number of agent)

as my health care agent.

This health care proxy shall take effect in the event I become unable to make my own health care decisions.

My agent has the authority to make any and all health care decisions for me, except to the extent that I state otherwise here:

Unless I revoke it, this proxy shall remain in effect indefinitely, or until the date or condition I have stated below. This proxy shall expire (specific date or conditions, if desired):

**Part II. NEW YORK HEALTH CARE PROXY AND
LIVING WILL – PAGE 3 OF 6**

PART II

This Living Will has been prepared to conform to the law in the State of New York, and is intended to be “clear and convincing” evidence of my wishes regarding the health care decisions I have indicated below.

PRINT YOUR NAME

I, _____, being of sound mind, make this statement as a directive to be followed if I become unable to participate in decisions regarding my medical care. These instructions reflect my firm and settled commitment to regarding health care under the circumstances indicated below:

LIFE-SUSTAINING TREATMENTS

I direct that my health care providers and others involved in my care provide, withhold, or withdraw treatment in accordance with the choice I have marked below: **(Initial only one box)**

INITIAL ONLY ONE
CHOICE: (a) OR (b)

(a) **Choice NOT To Prolong Life**

IF YOU DO NOT AGREE
WITH EITHER CHOICE,
YOU MAY WRITE YOUR
OWN DIRECTIONS ON
THE NEXT PAGE

I do not want my life to be prolonged if I should be in an incurable or irreversible mental or physical condition with no reasonable expectation of recovery, including but not limited to: (a) a terminal condition; (b) a permanently unconscious condition; or (c) a minimally conscious condition in which I am permanently unable to make decisions or express my wishes. While I understand that I am not legally required to be specific about future treatments if I am in the condition(s) described above I feel especially strongly about the following forms of treatment:

IF YOU INITIAL BOX (a),
YOU MAY INITIAL
SPECIFIC TREATMENTS
YOU WOULD LIKE
WITHHELD

- I do not want cardiac resuscitation.
- I do not want mechanical respiration.
- I do not want artificial nutrition and hydration.
- I do not want antibiotics.

OR

(b) **Choice To Prolong Life**

I want my life to be prolonged as long as possible within the limits of generally accepted health care standards.

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LIVING WILL – PAGE 4 OF 6**

RELIEF FROM PAIN:

Except as I state in the following space, I direct that treatment for alleviation of pain or discomfort should be provided at all times even if it hastens my death:

ADD ADDITIONAL INSTRUCTIONS HERE ONLY IF YOU WANT TO LIMIT PAIN RELIEF

OTHER WISHES:

(If you do not agree with any of the optional choices above and wish to write your own, or if you wish to add to the instructions you have given above, you may do so here.) I direct that:

ADD OTHER INSTRUCTIONS, IF ANY, REGARDING YOUR ADVANCE CARE PLANS

THESE INSTRUCTIONS CAN FURTHER ADDRESS YOUR HEALTH CARE PLANS, SUCH AS YOUR WISHES REGARDING HOSPICE TREATMENT, BUT CAN ALSO ADDRESS OTHER ADVANCE PLANNING ISSUES, SUCH AS YOUR BURIAL WISHES

ATTACH ADDITIONAL PAGES IF NEEDED

These directions express my legal right to refuse treatment, under the law of New York. I intend my instructions to be carried out unless I have rescinded them in a new writing or by clearly indicating that I have changed my mind.

My agent, if I have appointed one in Part I or elsewhere, has full authority to resolve any question regarding my health care decisions, as recorded in this document or otherwise, and what my choices may be.

ORGAN
DONATION
(OPTIONAL)

**NEW YORK HEALTH CARE PROXY AND
LIVING WILL – PAGE 5 OF 6**

OPTIONAL ORGAN DONATION:

INITIAL THE BOX THAT
AGREES WITH YOUR
WISHES ABOUT ORGAN
DONATION

Upon my death: (initial only one applicable box)

INITIAL ONLY ONE

(a) I do not give any of my organs, tissues, or parts and do not want my agent, guardian, or family to make a donation on my behalf;

(b) I give any needed organs, tissues, or parts;

OR

(c) I give the following organs, tissues, or parts only:

STRIKE THROUGH ANY
USES YOU DO NOT AGREE
TO

My gift, if I have made one, is for the following purposes:
(strike any of the following you do not want)

- (1) Transplant
- (2) Therapy
- (3) Research
- (4) Education

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**NEW YORK HEALTH CARE PROXY AND
LIVING WILL – PAGE 6 OF 6**

PART III

SIGN AND DATE
THE DOCUMENT
AND PRINT YOUR NAME
AND
ADDRESS

WITNESSING
PROCEDURE

YOUR
WITNESSES
MUST SIGN AND DATE
AND
PRINT THEIR NAMES AND
ADDRESSES HERE

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Part III. Execution

Signed _____ Date _____

Print Name _____

Address _____

I declare that the person who signed this document appeared to execute the living will willingly and free from duress. He or she signed (or asked another to sign for him or her) this document in my presence.

Witness 1

Signed _____ Date _____

Print Name _____

Address _____

Witness 2

Signed _____ Date _____

Print Name _____

Address _____

You Have Filled Out Your Health Care Directive, Now What?

1. Your New York Health Care Proxy and Living Will 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 agent and alternate agent, doctor(s), family, close friends, clergy, and anyone else who might become involved in your healthcare. 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 agent(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. You may also want to save a copy of your form in an online personal health records application, program, or service that allows you to share your medical documents with your physicians, family, and others who you want to take an active role in your advance care planning.
5. If you want to make changes to your documents after they have been signed and witnessed, you must complete a new document.
6. Remember, you can always revoke your New York document.
7. Be aware that your New York document will not be effective in the event of a medical emergency. Ambulance and hospital emergency department personnel are required to provide cardiopulmonary resuscitation (CPR) unless they are given a separate directive that states otherwise. These directives called "prehospital medical care directives" or "do not resuscitate orders" are designed for people whose poor health gives them little chance of benefiting from CPR. These directives instruct ambulance and hospital emergency personnel not to attempt CPR if your heart or breathing should stop.

Currently not all states have laws authorizing these orders. We suggest you speak to your physician if you are interested in obtaining one.