

**NEW YORK**  
**Advance Directive**  
**Planning for Important Healthcare Decisions**

***Caring Connections***  
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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:

- L**earn about options for end-of-life services and care
- I**mplement plans to ensure wishes are honored
- V**oice decisions to family, friends and healthcare providers
- E**ngage in personal or community efforts to improve end-of-life care

## Using these Materials

### BEFORE YOU BEGIN

1. Check to be sure that you have the materials for each state in which you may receive healthcare.
2. These materials include:
  - Instructions for preparing your advance directive, please read all the instructions.
  - Your state-specific advance directive forms, which are the pages with the gray instruction bar on the left side.

### ACTION STEPS

3. You may want to photocopy these forms before you start so you will have a clean copy if you need to start over.
4. When you begin to fill out the forms, refer to the gray instruction bars - they will guide you through the process.
5. 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.
6. 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, healthcare providers and/or faith leaders so that the form is available in the event of an emergency.

## Introduction to Your Advance Directive

This packet contains two legal documents that protect 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 use either one or both of these documents.

1. The **New York Healthcare Proxy** lets you name someone to make decisions about your medical care—including decisions about life support — if you can no longer speak for yourself. The Healthcare Proxy is especially useful because it appoints someone to speak for you any time you are unable to make your own medical decisions, not only at the end of life.

2. The **New York Living Will** lets you state your wishes about medical care in the event that you develop an irreversible condition that prevents you from making your own medical decisions. The Living Will becomes effective if you become terminally ill, permanently unconscious or minimally conscious due to brain damage and will never regain the ability to make decisions.

*Note: These documents will be legally binding only if the person completing them is a competent adult (at least 18 years old).*

## **Instructions for Completing New York Healthcare Proxy**

### **Whom should I appoint as my Healthcare Proxy?**

A proxy is the person you appoint to make decisions about your medical care if you become unable to make those decisions yourself. The person you name as your proxy should clearly understand your wishes and be willing to accept the responsibility of making medical decisions for you. Your proxy can be a family member or a close friend whom you trust to make serious decisions. You should be aware, however, that if you appoint your spouse as your proxy, his/her authority will be revoked upon divorce or legal separation, unless you specify otherwise.

The person you appoint as your proxy **cannot** be:

1. an operator, administrator or employee of a healthcare facility in which you are a resident or patient, or to which you have applied for admission, at the time you sign your proxy, unless that person is a relative by blood, marriage or adoption;
2. a physician, if that person also acts as your attending physician; or
3. anyone who is already a proxy for ten or more people, unless that person is related to you by blood, marriage or adoption.

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

### **How do I make my New York Healthcare Proxy legal?**

The law requires that (you or another person at your direction if you are unable) sign and date your Healthcare Proxy in the presence of two adult witnesses. The witnesses must sign a statement in your Healthcare Proxy to confirm that you signed the document willingly and free from duress. The person you name as your proxy or alternate proxy cannot act as a witness.

In addition, if you are a resident in a facility operated or licensed by the office of mental health or the office of mental retardation and developmental disabilities, there are special witnessing requirements.

*Note: You do not need to notarize your New York Healthcare Proxy.*

### **Should I add personal instructions to my New York Healthcare Proxy?**

One of the strongest reasons for naming an agent is to have someone who can respond flexibly as your medical situation changes and deal with situations that you did not foresee.

## **Instructions for Completing Your New York Health Care Proxy (continued)**

Talk with your agent about your future medical care and describe what you consider to be an acceptable “quality of life.” If you want to record your wishes about specific treatments or conditions, you should use the New York Living Will.

### **What if I change my mind?**

You may revoke your Healthcare Proxy by notifying your agent or a healthcare provider orally or in writing of your revocation, or by any other act that clearly shows your intent to revoke the document. A physician who is informed of your revocation must record the revocation in your medical record and notify the agent and any medical staff responsible for your care.

You may also provide that your Healthcare Proxy expires upon a specified date or upon the occurrence of a certain condition. If not, the proxy remains effective until you revoke it by one of the above methods.

## **Instructions for Completing Your New York Living Will**

### **How do I make my New York Living Will legal?**

The New York Living Will is authorized by law created by New York courts, not by legislation. For this reason, there are no specific requirements guiding its use.

*Note: You do not need to notarize your New York Living Will.*

### **Can I add personal instructions to my Living Will?**

Yes. You can add personal instructions in the part of the document called "Other directions."

If you have appointed a proxy, it is a good idea to write a statement such as, "Any questions about how to interpret or when to apply my Living Will are to be decided by my proxy."

### **What if I change my mind?**

If you decide to cancel your Living Will, follow the same procedures outlined for revoking your Healthcare Proxy.

**NEW YORK HEALTH CARE PROXY – PAGE 1 OF 3**

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INSTRUCTIONS

PRINT YOUR NAME

(1) I, \_\_\_\_\_, hereby appoint:  
(name)

PRINT NAME,  
HOME ADDRESS  
AND TELEPHONE  
NUMBER OF  
YOUR AGENT

-----  
(name, home address and telephone number of agent)

-----  
as my health care agent to make any and all health care decisions for me, except to the extent that I state otherwise. My agent does know my wishes regarding artificial nutrition and hydration.

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

ADD PERSONAL  
INSTRUCTIONS  
(IF ANY)

(2) Optional instructions: I direct my agent to make health care decisions in accord with my wishes and limitations as stated below, or as he or she otherwise knows.

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

(3) Name of substitute or fill-in agent if the person I appoint above is unable, unwilling or unavailable to act as my health care agent.

-----  
(name, home address and telephone number of alternate agent)

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NEW YORK HEALTH CARE PROXY - PAGE 2 OF 3

ORGAN DONATION (OPTIONAL)

(4) Donation of Organs at Death: Upon my death:

- [ ] I do not wish to donate my organs, tissues or parts.
[ ] I do wish to be an organ donor and upon my death I wish to donate:
[ ] (a) Any needed organs, tissues, or parts;
OR
[ ] (b) The following organs, tissues, or parts:

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- [ ] (c) My gift is for the following purposes:
(put a line through any of the following you do not want)
(i) Transplant
(ii) Therapy
(iii) Research
(iv) Education

[ ] (d) My gift, if medically acceptable is for:

PRINT NAME AND ADDRESS OF DONEE

\_\_\_\_\_  
Name of donee, if known

\_\_\_\_\_  
Address and telephone number

If the designated donee is unavailable at my death, the decision will be made by the attending physician at my death.

(5) 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):

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-----

SIGN AND DATE THE DOCUMENT AND PRINT YOUR ADDRESS

(6) Signature \_\_\_\_\_ Date \_\_\_\_\_

Address \_\_\_\_\_

\_\_\_\_\_

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WITNESSING  
PROCEDURE

**Statement by Witnesses (must be 18 or older)**

I declare that the person who signed this document appeared to execute the proxy willingly and free from duress. He or she signed (or asked another to sign for him or her) this document in my presence. I am not the person appointed as proxy by this document.

Witness 1 \_\_\_\_\_

Address \_\_\_\_\_

\_\_\_\_\_

Witness 2 \_\_\_\_\_

Address \_\_\_\_\_

\_\_\_\_\_

YOUR  
WITNESSES  
MUST SIGN AND  
PRINT THEIR  
ADDRESSES

NEW YORK LIVING WILL – PAGE 1 OF 2

This Living Will has been prepared to conform to the law in the State of New York, as set forth in the case *In re Westchester County Medical Center*, 72 N.Y.2d 517 (1988). In that case the Court established the need for “clear and convincing” evidence of a patient’s wishes and stated that the “ideal situation is one in which the patient’s wishes were expressed in some form of writing, perhaps a ‘living will.’”

PRINT YOUR NAME

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

I direct my attending physician to withhold or withdraw treatment that merely prolongs my dying, 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**.

I direct that my treatment be limited to measures to keep me comfortable and to relieve pain, including any pain that might occur by withholding or withdrawing treatment.

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:**

- 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.

However, **I do want** maximum pain relief, even if it may hasten my death.

CROSS OUT ANY STATEMENTS THAT DO NOT REFLECT YOUR WISHES

NEW YORK LIVING WILL - PAGE 2 OF 2

ADD PERSONAL INSTRUCTIONS (IF ANY)

Other directions:

SIGN AND DATE THE DOCUMENT AND PRINT YOUR ADDRESS

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.

Signed \_\_\_\_\_ Date \_\_\_\_\_

Address \_\_\_\_\_  
\_\_\_\_\_

WITNESSING PROCEDURE

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.

YOUR WITNESSES MUST SIGN AND PRINT THEIR ADDRESSES

Witness 1 \_\_\_\_\_

Address \_\_\_\_\_  
\_\_\_\_\_

Witness 2 \_\_\_\_\_

Address \_\_\_\_\_  
\_\_\_\_\_

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## **You Have Filled Out Your Advance Directive, Now What?**

1. Your New York Healthcare Proxy and New York Living Will are important legal documents. Keep the original signed documents in a secure but accessible place. Do not put the original documents in a safe deposit box or any other security box that would keep others from having access to them.
2. Give photocopies of the signed originals 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 documents placed in your medical records.
3. Be sure to talk to your agent and alternate, 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 new documents.
5. Remember, you can always revoke one or both of your New York documents.
6. Be aware that your New York documents 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 order. If you would like to receive a non-hospital do-not-resuscitate form, speak to your physician for more information. **Caring Connections does not distribute these forms.**