NEW YORK
Advance Directive
Planning for Important Healthcare Decisions

Courtesy of CaringInfo
www.caringinfo.org
800-658-8898

CaringInfo, a program of the National Hospice and Palliative Care Organization (NHPCO), is a national consumer engagement initiative to improve care and the experience of caregiving during serious illness and at the end of life. As part of that effort, CaringInfo provides detailed guidance for completing advance directive forms in all 50 states, the District of Columbia, and Puerto Rico.

This package includes:
- 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.

BEFORE YOU BEGIN

Check to be sure that you have the materials for each state in which you may receive healthcare. Because documents are state-specific, having a state-specific document for each state where you may spend significant time can be beneficial. A new advance directive is not necessary for ordinary travel into other states. The advance directives in this package will be legally binding only if the person completing them is a competent adult who is 18 years of age or older, or an emancipated minor, or, in the state of New York, has been married, or is a parent.

ACTION STEPS

1. You may want to photocopy or print a second set of these forms before you start so you will have a clean copy if you need to start over.

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

3. 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.

4. Once the form is completed and signed, photocopy, scan, or take a photo of 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 NEW YORK ADVANCE HEALTH CARE DIRECTIVE

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.

Your New York Advance Directive has three parts. Depending on your advance planning needs, 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 healthcare decisions, not only at the end of life.

Part II, Living Will, lets you state your wishes about healthcare 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 III contains the signature and witnessing provisions so that your document will be effective.

How do I make my New York Advance Health Care Directive 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 healthcare 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 healthcare decisions for you.
You can appoint a second person as your alternate agent. An alternate agent will step in if the person you name as 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 advance directive?**

Yes! One of the most important reasons to execute an advance directive is to have your voice heard. When you name an agent and clearly communicate to them what you want and don’t want, they are in the strongest position to advocate for you. Because the future is unpredictable, be careful that you do not unintentionally restrict your agent’s power to act in your best interest. Be especially careful with the words “always” and “never.” In any event, be sure to talk with your agent and others about your future healthcare and describe what you consider to be an acceptable “quality of life.”

**When does my agent’s authority become effective?**

Part I, **Health Care Proxy**, goes into effect when your doctor or nurse practitioner determines that you are no longer able to make or communicate your healthcare decisions.

Part II, **Living Will**, goes into effect when your doctor or nurse practitioner determines that you are no longer able to make or communicate your healthcare decisions.

**Agent Limitations**

Your agent will be bound by the current laws of New York as they regard pregnancy and termination of pregnancies.

**What if I change my mind?**

You may revoke your advance directive by notifying your agent or healthcare 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.

**Mental Health Issues**

These forms do not expressely address mental illness, although you can state your wishes and grant authority to your agent regarding mental health issues. The National Resource Center on
Psychiatric Advance Directives maintains a website (https://nrc-pad.org/) with links to each state’s psychiatric advance directive forms. If you would like to make more detailed advance care plans regarding mental illness, you could talk to your physician and an attorney about a durable power of attorney tailored to your needs. 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.

**What other important facts should I know?**

Be aware that your advance directive will not be effective in the event of a medical emergency, except to identify your agent. Ambulance and hospital emergency department personnel are required to provide cardiopulmonary resuscitation (CPR) unless you have a separate physician’s order, which are typically called “prehospital medical care directives” or “do not resuscitate orders.” DNR forms may be obtained from your state health department or department of aging (https://www.hhs.gov/aging/state-resources/index.html). Another form of orders regarding CPR and other treatments are state-specific POLST (portable orders for life sustaining treatment) (https://polst.org/form-patients/). Both a POLST and a DNR form MUST be signed by a healthcare provider and MUST be presented to the emergency responders when they arrive. These directives instruct ambulance and hospital emergency personnel not to attempt CPR (or to stop it if it has begun) if your heart or breathing should stop.
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):

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________
When making health-care decisions for me, my agent should think about what action would be consistent with past conversations we have had, my treatment preferences as expressed in this or any other document, my religious and other beliefs and values, and how I have handled medical and other important issues in the past. If what I would decide is still unclear, then my agent should make decisions for me that my agent believes are in my best interest, considering the benefits, burdens, and risks of my current circumstances and treatment options.

My agent should also consider the following instructions when making health care decisions for me:

(Attach additional pages if needed)
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.

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)

[ ☐ ] (a) Choice NOT To Prolong Life

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:

[ ☐ ] 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.
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:

________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

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:

________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

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.
OPTIONAL ORGAN DONATION:

Upon my death: (initial only one applicable box)

- [ ] (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:

  ____________________________________________
  ____________________________________________

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

**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 _______________________________