



HEALTH CARE PROXY & LIVING WILL INFORMATION

Living Wills and the appointment of a person who can function as your health care proxy are important decisions we all should make related to how we wish to be treated as our life ends. These decisions are not just considerations for the frail and elderly, but choices to be made when we are alert and willing to evaluate our views on end-of-life care. Discussions with close family and friends is a good way to have opinions known, but will have greater relevance if they are also supported by a living will and a health care proxy.

In February of 2010 the New York State Senate passed the Family Health Care Decisions Act (FHCDA) that created a legal mechanism for the appointment of a health care surrogate to make health care decisions for individuals who become incapacitated. Giving patients a voice through family members and loved ones eliminates unneeded suffering and beyond the human costs it will reduce the tremendous financial costs associated with care neither the patient nor family may support.

I am very pleased to having voted for the FHCDA and know it will make facing critical medical decisions clearer; however having both a living will and a health care proxy in place will ensure that your wishes are respected.

I hope you find this information helpful. As always, if you have any questions or need further assistance, please do not hesitate to contact me.

Liz

COURTESY OF NEW YORK STATE SENATOR

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The following pages explain the Health Care Proxy and Living Will, and present you with examples of each. You can use these forms and keep them accessible with other important papers. You may also want to share them with your doctor and family.

Additionally, you'll see an abbreviated cut-out version of the Health Care Proxy form to the left that can be easily folded and kept in your wallet. ▶

NEW YORK STATE SENATE
SENATEBOV

NEW YORK STATE SENATE
Senator Liz Krueger
For more information, call
(212) 490-9535

BEARER'S NAME

for

HEALTH CARE PROXY

SPECIAL INSTRUCTIONS

Health Care Proxy Form

1. Write your name and the name, home address and telephone number of the person you are selecting as your agent.

2. If you have special instructions for your agent, you should write them here. Also, if you wish to limit your agent's authority in any way, you should say so here. If you do not state any limitations, your agent will be allowed to make all health care decisions that you could have made, including the decision to consent to or refuse life-sustaining treatment.

3. You may write the name, home address and telephone number of an alternate agent.

4. This form will remain valid indefinitely unless you set an expiration date or condition for its expiration. This section is optional and should be filled in only if you want the health care proxy to expire.

5. You must date and sign the proxy. If you are unable to sign yourself, you may direct someone else to sign in your presence. Be sure to include your address.

6. Two witnesses at least 18 years of age must sign your proxy. The person who is appointed agent or alternate agent cannot sign as a witness.

1. Proxy designation

I, hereby appoint

<input type="text" value="PROXY'S NAME"/>		<input type="text" value="PROXY'S ADDRESS"/>
<input type="text" value="PROXY'S CITY"/>	<input type="text" value="PROXY'S STATE"/>	<input type="text" value="PROXY'S PHONE"/>

as my health care agent to make any and all health care decisions for me, except to the extent that I state otherwise. This proxy shall take effect when and if I become unable to make my own health care decisions.

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 (Attach additional pages if necessary).

<input type="text"/>
<input type="text"/>
<input type="text"/>

(Unless you have given your agent oral or written instructions about artificial nutrition and hydration (feeding tubes), your agent will not be allowed to make decisions about artificial nutrition and hydration. See instructions for samples of language you could use to make your wishes clear about these treatments.)

3. Optional: Organ and/or Tissue Donation

I hereby make an anatomical gift, to be effective upon my death of:

<input type="text" value="THE FOLLOWING NEEDED TISSUES OR ORGANS"/>
<input type="text" value="LIMITATIONS"/>

4. Alternate proxy designation

Name and contact information of substitute or fill-in proxy if the person I appoint above is unable, unwilling or unavailable to act as my health care agent.

<input type="text" value="NAME"/>	<input type="text" value="ADDRESS"/>	
<input type="text" value="CITY"/>	<input type="text" value="STATE"/>	<input type="text" value="PHONE"/>

5. Conditions

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

<input type="text" value="CONDITIONS"/>
<input type="text"/>

6. Signature

<input type="text" value="SIGNATURE"/>	<input type="text" value="DATE"/>	
<input type="text" value="ADDRESS"/>	<input type="text" value="CITY"/>	<input type="text" value="STATE"/>

Statement by Witnesses (must be 18 or older)

I declare that the person who signed this document is personally known to me and appears to be of sound mind and acting of his or her own free will. He or she signed (or asked another to sign for him or her) this document in my presence.

WITNESS 1	<input type="text" value="SIGNATURE"/>	<input type="text" value="DATE"/>
<input type="text" value="ADDRESS"/>	<input type="text" value="CITY"/>	<input type="text" value="STATE"/>

WITNESS 2	<input type="text" value="SIGNATURE"/>	<input type="text" value="DATE"/>
<input type="text" value="ADDRESS"/>	<input type="text" value="CITY"/>	<input type="text" value="STATE"/>

New York Living Will

This living will is a legal document setting forth your directions regarding medical treatment. You have the right to refuse any treatment you do not want, and you may request the care you want.

You may make changes in any of these directions, or add changes to conform them to your personal wishes.

Sign and date here in the presence of two adult witnesses, who should also sign.

Keep the signed original with your personal papers at home. Give copies of the signed original to your doctor, family, lawyer and others who might be involved in your care.

This Living Will has been prepared to conform to the law in the State of New York, as set forth in the case of In re Westchester County Medical Center, 72 N.Y.2d 517 (1988). In that case the Court approved of the use of a Living Will, stating that the "ideal situation is one in which the patient's wishes were expressed in some form of writing, perhaps a 'living will.'"

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.**

These instructions apply if I am a) **in a terminal condition**; b) **permanently unconscious**; or c) **minimally conscious but have irreversible brain damage and will never regain the ability to make decisions and express my wishes.**

I direct that 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 tube feeding.
- ▶ I do not want antibiotics.
- ▶ I do want maximum pain relief.

Other directions (insert personal instructions):

<input type="text"/>
<input type="text"/>
<input type="text"/>
<input type="text"/>

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 writing or by clearly indicating that I have changed my mind.

<input type="text" value="SIGNATURE"/>	<input type="text" value="DATE"/>
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WITNESS 1	<input type="text" value="SIGNATURE"/>	<input type="text" value="DATE"/>
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<input type="text" value="ADDRESS"/>	<input type="text" value="CITY"/>	<input type="text" value="STATE"/>
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WITNESS 2	<input type="text" value="SIGNATURE"/>	<input type="text" value="DATE"/>
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<input type="text" value="ADDRESS"/>	<input type="text" value="CITY"/>	<input type="text" value="STATE"/>
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