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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

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. ▸

HEALTH CARE PROXY
for

BEARER'S NAME

SPECIAL INSTRUCTIONS

NEW YORK STATE SENATE
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Distributed by New York State Senator Liz Krueger
For more information, call (212) 490-9535

Instructions on Health Care Proxy

This is an important legal form. Before signing this form, you should understand the following facts:

1. *This form gives the person you choose as your agent the authority to make all health care decisions for you, except to the extent that you say otherwise in this form. "Health care" means any treatment, service or procedure to diagnose or treat your physical or mental condition.*
2. *Unless you say otherwise, your agent will be allowed to make all health care decisions for you, including decisions to remove or with hold life-sustaining treatment.*
3. *Unless you have given your agent oral or written instructions about artificial nutrition and hydration (nourishment and water provided by a feeding tube), he or she will not be allowed to refuse those measures for you.*
4. *Your agent will start making decisions for you when doctors decide that you are not able to make health care decisions for yourself.*

You may write on this form any information about treatment that you do not desire and/or those treatments that you want to make sure you receive. Your agent must follow your instructions (oral and written) when making decisions for you.

If you want to give your agent written instructions, do so right on the form. For example, you could say:

- *If I become terminally ill, I do/don't want to receive the following treatments...*
- *If I am in a coma or unconscious, with no hope of recovery, then I do/don't want...*
- *If I have brain damage or a brain disease that makes me unable to recognize people or speak and there is no hope that my condition will improve, I do/don't want...*

Examples of medical treatments that you may wish to give your agent special instructions about are listed below. This is not a complete list of the treatments, just a guide.

- *artificial respiration*
- *artificial nutrition and hydration (nourishment and water provided by feeding tube)*
- *cardiopulmonary resuscitation (CPR)*
- *antipsychotic medication*
- *electric shock therapy*
- *antibiotics*
- *surgical procedures*
- *dialysis*
- *transplantation*
- *blood transfusions*
- *abortion*
- *sterilization*

Talk about choosing an agent with your family and/or close friends. You should discuss this form with a doctor or another health care professional, such as a nurse or social worker, before you sign it to make sure that you understand the types of decisions that may be made for you. You may also wish to give your doctor a signed copy. You do not need a lawyer to fill out this form.

You can choose any adult (over 18), including a family member or close friend, to be your agent. If you select a doctor as your agent, he or she may have to choose between acting as your agent or as your attending doctor; a physician cannot do both at the same time. Also, if you are a patient or resident of a hospital, nursing home, or mental hygiene facility, there are special restrictions about naming someone who works for that facility as your agent. You should ask staff at the facility to explain those restrictions.

You should tell the person you choose that he or she will be your health care agent. You should discuss your health care wishes and this form with your agent. Be sure to give him or her a signed copy. Your agent cannot be sued for health care decisions made in good faith.

Even after you have signed this form, you have the right to make health care decisions for yourself as long as you are able to do so, and treatment cannot be given to you or stopped if you object. You can cancel the control given to your agent by telling him or her or your health care provider orally or in writing.

HEALTH CARE PROXY

I, _____ (BEARER'S NAME), of

_____ (STREET) _____ (CITY) _____ (STATE)

_____ (DAYTIME PHONE) _____ (EVENING PHONE)

Hereby appoint _____ (PROXY'S NAME), of

_____ (STREET) _____ (CITY) _____ (STATE)

_____ (DAYTIME PHONE) _____ (EVENING PHONE)

as my health care agent to make all health care decisions for me if I become unable to decide for myself, including decisions about artificial nutrition and hydration.

_____ (SIGNATURE (PROXY INITIATOR)) _____ (DATE)

The proxy was signed in my presence. The signer is known to me and appears to be of sound mind and to act of his/her own free will.

_____ (WITNESS) _____ (DATE)

_____ (WITNESS) _____ (DATE)

Health Care Proxy Form

1. Proxy designation

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

I, YOUR NAME hereby appoint

PROXY'S NAME | PROXY'S ADDRESS

PROXY'S CITY | PROXY'S STATE | 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

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.

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).

(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: ANY NEEDED TISSUES OR ORGANS

THE FOLLOWING NEEDED TISSUES OR ORGANS

LIMITATIONS

4. Alternate proxy designation

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

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.

NAME | ADDRESS

CITY | STATE | PHONE

5. Conditions

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.

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

CONDITIONS

6. Signature

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.

SIGNATURE | DATE

ADDRESS | CITY | STATE

Statement by Witnesses (must be 18 or older)

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.

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 SIGNATURE | DATE

ADDRESS | CITY | STATE

WITNESS 2 SIGNATURE | DATE

ADDRESS | CITY | 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.

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, YOUR NAME , 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.**

You may make changes in any of these directions, or add changes to conform them to your personal 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 stronqly about the followinq 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):

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.

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

SIGNATURE DATE

WITNESS 1 SIGNATURE DATE

ADDRESS CITY STATE

WITNESS 2 SIGNATURE DATE

ADDRESS CITY STATE

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.