NEW YORK
STATE SENATE
Albany, NY 12247

Health Care Proxy & Living Will Information

from
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Dear Friend,

There are two ways to help ensure that your health care wishes will be respected: A health care proxy and a living will.

A health care proxy form provides specific instructions and designates someone, usually a family member, to make health care decisions for you in the event you become incapacitated.

A living will is a document in which you provide specific instructions about health care treatment. Unlike the health care proxy, a living will does not appoint an agent to make health care decisions for you.

I urge you to fill out both of these documents today. Writing a living will and appointing a health care proxy can ease the anguish of your relatives and loved ones in the event of a tragedy.

The following pages explain the health care proxy and living will and present you with an example of each.

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

Sincerely,

Jose Peralta
13th Senate District

Instructions on Health Care Proxy

Item (1)

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

Item (2)

If you want to appoint an alternate agent, write the name, home address and telephone number of the person you are selecting as your alternate agent.

Item (3)

Your Health Care Proxy will remain valid indefinitely unless you set an expiraton date or condition for its expiration. This section is optional and should be filled in only if you want your Health Care Proxy to expire.

Item (4)

If you have special instructions for your agent, write them here. Also, if you wish to limit your agent's authority in any way, you may say so here or discuss them with your health care agent. 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. If you want to give your agent broad authority, you may do so right on the form. Simply write: *I have discussed my wishes with my health care agent and alternate and they know my wishes including those about aritificial nutrition and hydration.*

If you wish to make more specific instructions you could say:

If I become terminally ill: I do/don't want to receive the following types of treatments:....

If I am in a coma or have little conscious understanding, with no hope of recovery, then I do/don't want the following types of treatments:....

If I am in a coma or have little conscious understanding, with no hope of recovery, then I do/don't want the following types of treatments:....

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 the following types of treatments:....

I have discussed with my agent my wishes about_____ and I want my agent to make all decisions about these measures.

Examples of medical treatments about which you may wish to give your agent special instructions are listed below. This is not a complete list:

- 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

Item (5)

You must date and sign this Health Care Proxy form. If you are unable to sign yourself, you may direct someone else to sign in your presence. Be sure to include your address.

Item (6)

You may state wishes or instructions about organ and /or tissue donation on this form. New York law does provide for certain individuals in order of priority to consent to an organ and/or tissue donation on your behalf: your health care agent, your decedent's agent, your spouse, if you are not legally separated, or your domestic partner, a son or daughter 18 years of age or older, either of your parents, a brother or sister 18 years of age or older, a guardian appointed by a court prior to the donor's death.

Item (7)

Two witnesses 18 years of age or older must sign this Health Care Proxy form. The person who is appointed your agent or alternate agent cannot sign as a witness.

Health Care Proxy Form

(1) I, _____

hereby appoint _____

(name, home address and telephone number)

_____

_____

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 only when and if I become unable to make my own health care decisions.

(2) Optional: Alternate Agent

If the person I appoint is unable, unwilling or unavailable to act as my health care agent, I hereby appoint_____

(name, home address and telephone number)

_____

_____

as my health care agent to make any and all health care decisions for me, except to the extent that I state otherwise.

(3) Unless I revoke it or state an expiration date or circumstances under which it will expire, this proxy shall remain in effect indefinitely. *(Optional: If you want ths proxy to expire, state the date or conditions here.)* This proxy shall expire *(specify date or conditions)*:_____

_____

_____

(4) Optional: I direct my health care agent to make health care decisions according to my wishes and limitations, as he or she knows or as stated below. *(If you want to limit your agent's authority to make health care decisions for you or to give specific instructions, you may state your wishes or limitations here.) I direct my health care agent to make health care decisions in accordance with the following* limitations and/or instructions (attach additional pages as necessary):_____

_____

_____

In order for your agent to make health care decisions for you about artificial nutrition and hydration (nourishment and water provided by feeding tube and intravenous line), your agent must reasonably know your wishes. You can either tell your agent what your wishes are or include them in this section. See instructions for sample language that you could use if you choose to include your wishes on this form, including your wishes about artificial nutrition and hydration.

(5) Your Identification (please print)

Your Name _____

Your Signature _____

Your Address _____

(6) Optional: Organ and/or Tissue Donation

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

(check any that apply)

❏ Any needed organs and/or tissues

❏ The following organs and/or tissues _____

_____

❏ Limitations _____

If you do not state your wishes or instructions about organ and/or tissue donation on this form, it will not be taken to mean that you do not wish to make a donation or prevent a person, who is otherwise authorized by law, to consent to a donation on your behalf.

Your Signature _____ Date _____

(7) Statement by Witnesses (*Witnesses must be 18 years of age or older and cannot be the health care agent or alternate.)*

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.

Date_____ Date_____

Name of Witness 1

(print) _____

Signature _____

Address _____

Name of Witness 2

(print) _____

Signature _____

Address _____

New York Living Will Form

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 and other medical personnel to withhold or withdraw treatment that serves only to prolong the process of 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) if I am 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 strong 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 instructions (insert personal instructions): _____

_____

I HEREBY APPOINT

Name: _____

Address: _____

Phone Number: _____

as my health care agent to make all health care decisions for me in conformity with the guidelines I have expressed in this document. I direct my agent to make health care decisions in accordance with my wishes and instructions as stated above or as otherwise known to him or her. I also direct my agent to abide by any limitations on his or her authority as stated above or as otherwise known to him or her.

In the event my health care agent is unable, unwilling, or unavailable to serve as such, then I **appoint as my substitute health care agent** (with the same powers that I have heretofore enumerated).

Name: _____

Address: _____

Phone Number: _____

I understand that unless I revoke it, this living will and health care proxy will remain in effect indefinitely.

These directions express my legal right to refuse treatment, under the laws of New York. Unless I have revoked this instrument or otherwise clearly and explicitly indicated that I have changed my mind, it is my unequivocal intent that my instructions as set forth in this document be faithfully carried out.

Signature: _____

Address: _____

Date: _____

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: _____

Address: _____

Witness: _____

Address: _____

KEEP THIS 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.