

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

*CaringInfo*  
1731 King St., Suite 100, Alexandria, VA 22314  
[www.caringinfo.org](http://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 at the end of life.

**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:

- Learn about options for end-of-life services and care
- Implement plans to ensure wishes are honored
- Voice decisions to family, friends and healthcare providers
- Engage in personal or community efforts to improve end-of-life care

**Note:** The following is not a substitute for legal advice. While CaringInfo updates the following information and form to keep them up-to-date, changes in the underlying law can affect how the form will operate in the event you lose the ability to make decisions for yourself. If you have any questions about how the form will help ensure your wishes are carried out, or if your wishes do not seem to fit with the form, you may wish to talk to your health care provider or an attorney with experience in drafting advance directives. **If you have other questions regarding these documents, we recommend contacting your state attorney general's office.**

## 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

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 the form and give it to the person you have appointed to make decisions on your behalf, your family, friends, health care providers and/or faith leaders so that the form is available in the event of an emergency.
5. You may also want to save a copy of your form in an online personal health records application, program, or service that allows you to share your medical documents with your physicians, family, and others who you want to take an active role in your advance care planning.

## Introduction to Your New York Health Care Proxy and Living Will

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. 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 health-care decisions, not only at the end of life.

Part I goes into effect when your doctor determines that you are no longer able to make or communicate your health care decisions.

**Part II, Living Will**, lets you state your wishes about health care 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 II goes into effect when your doctor determines that you are no longer able to make or communicate your health care decisions.

**Part III** contains the signature and witnessing provisions so that your document will be effective.

This form does not expressly address mental illness. If you would like to make advance care plans regarding mental illness, you should talk to your physician and an attorney about a durable power of attorney tailored to your needs. In addition, 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.

*Note: This document will be legally binding only if the person completing them is a competent adult who is 18 years of age or older or has been married or is a parent.*

## **Instructions for Completing Your New York Health Care Proxy and Living Will**

### **How do I make my New York Health Care Proxy and Living Will 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 health care 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 health care decisions for you.

You can appoint a second person as your alternate agent. The alternate will step in if the first person you name as an 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. 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 New York Health Care Proxy and Living Will?**

One of the strongest reasons for naming an agent is to have someone who can respond flexibly as your health care situation changes and deal with situations that you did not foresee. If you add instructions to this document it may help your agent carry out your wishes, but be careful that you do not unintentionally restrict your agent's power to act in your best interest. In any event, be sure to talk with your agent about your future medical care and describe what you consider to be an acceptable "quality of life."

**What if I change my mind?**

You may revoke your advance directive by notifying your agent or health care 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.

**NEW YORK HEALTH CARE PROXY AND  
LIVING WILL – PAGE 1 OF 6**

PART I

PRINT YOUR NAME

PRINT NAME,  
HOME ADDRESS  
AND TELEPHONE  
NUMBER OF  
YOUR AGENT

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

ADD INSTRUCTIONS  
HERE ONLY IF YOU  
WANT TO LIMIT  
YOUR AGENT'S  
AUTHORITY

SPECIFY THE DATE  
OR CONDITIONS  
FOR EXPIRATION,  
IF ANY

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2017 Revised.

**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):

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_



**NEW YORK HEALTH CARE PROXY AND  
LIVING WILL – PAGE 3 OF 6**

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PART II

**Part II. Living Will**

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.

PRINT YOUR NAME

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:

INITIAL ONLY ONE  
CHOICE: (a) OR (b)

**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)**

IF YOU DO NOT  
AGREE WITH  
EITHER CHOICE,  
YOU MAY WRITE  
YOUR OWN  
DIRECTIONS ON  
THE NEXT PAGE

(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:

IF YOU INITIAL BOX  
(a), YOU MAY  
INITIAL SPECIFIC  
TREATMENTS YOU  
WOULD LIKE  
WITHHELD

- 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.





**NEW YORK HEALTH CARE PROXY AND  
LIVING WILL – PAGE 5 OF 6**

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ORGAN  
DONATION  
(OPTIONAL)

INITIAL THE BOX  
THAT AGREES WITH  
YOUR WISHES  
ABOUT ORGAN  
DONATION

INITIAL ONLY ONE

STRIKE THROUGH  
ANY USES YOU DO  
NOT AGREE TO

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**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**

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PART III

SIGN AND DATE  
THE DOCUMENT  
AND PRINT YOUR  
NAME AND  
ADDRESS

WITNESSING  
PROCEDURE

YOUR  
WITNESSES  
MUST SIGN AND  
DATE AND  
PRINT THEIR  
NAMES AND  
ADDRESSES HERE

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2017 Revised.

**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 \_\_\_\_\_  
\_\_\_\_\_

*Courtesy of CaringInfo*  
1731 King St., Suite 100, Alexandria, VA 22314  
www.caringinfo.org, 800/658-8898

## You Have Filled Out Your Health Care Directive, Now What?

1. Your New York Health Care Proxy and Living Will is an important legal document. Keep the original signed document in a secure but accessible place. Do not put the original document in a safe deposit box or any other security box that would keep others from having access to it.
2. Give photocopies of the signed original 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 document placed in your medical records.
3. Be sure to talk to your agent(s), 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. You may also want to save a copy of your form in an online personal health records application, program, or service that allows you to share your medical documents with your physicians, family, and others who you want to take an active role in your advance care planning.
5. If you want to make changes to your documents after they have been signed and witnessed, you must complete a new document.
6. Remember, you can always revoke your New York document.
7. Be aware that your New York document will not be effective in the event of a medical emergency. Ambulance and hospital emergency department personnel are required to provide cardiopulmonary resuscitation (CPR) unless they are given a separate directive that states otherwise. These directives called "prehospital medical care directives" or "do not resuscitate orders" are designed for people whose poor health gives them little chance of benefiting from CPR. These directives instruct ambulance and hospital emergency personnel not to attempt CPR if your heart or breathing should stop.

Currently not all states have laws authorizing these orders. We suggest you speak to your physician if you are interested in obtaining one. **CaringInfo does not distribute these forms.**

## Congratulations!

You've downloaded **your free, state specific advance directive**.

You are taking important steps to make sure your wishes are known. Help us keep this free.

Your generous support of the National Hospice Foundation and CaringInfo allows us to continue to provide these FREE resources, tools, and information to educate and empower individuals to access advance care planning, caregiving, hospice and grief services, and information.

**I hope you will show your support for our mission and make a tax-deductible gift today.**

Since 1992, the National Hospice Foundation has been dedicated to creating FREE resources for individuals and families facing a life-limiting illness, raising awareness for the need for hospice care, and providing ongoing professional education and skills development to hospice professionals across the nation.

Your gift strengthens the Foundation's ability to provide FREE caregiver and family resources.

Support your National Hospice Foundation by returning a **generous tax-deductible gift of \$23, \$47, \$64**, or the most generous amount you can send.

**You can help** us provide resources like this advance directive FREE by sending in your gift to help others.

**Please help to make this possible with your contribution! Cut along the dotted line and use the coupon below to return a check contribution of the most generous amount you can send. Thank you.**



**YES!** I want to support the important work of the National Hospice Foundation.

- \$23 helps us provide free advance directives
- \$47 helps us maintain our free InfoLine
- \$64 helps us provide webinars to hospice

Return to:  
National Hospice Foundation  
PO Box 824401  
Philadelphia, PA 19182-4401

AD\_2017



OR donate online today: [www.caringinfo.org/donate](http://www.caringinfo.org/donate)