DOWNLOAD COVERSHEET:

This is a standard advance directive for your state, made available to you as a courtesy by Lifecare Directives, LLC. You should be aware that extensive research has demonstrated that there are significant drawbacks to using a very brief state-standard document. As one researcher has noted, "the development of statutory forms occurs in the legislative arena, [so] their content is the result of a political rather than a 'scientific' process." Because of "political compromise, ...many of the forms ultimately passed by the legislatures are not optimal from a consumer perspective" (see: Hoffmann, Diane E; Zimmerman, S; Tompkins, C. The dangers of directives, or the false security of forms. *Journal of Law, Medicine & Ethics*. 1996;24(1) (Spring):5-17).

American Bar Association concurs, noting that "The statutory advance directive is not necessarily the exclusive, or even the best, pathway for individuals to follow," and suggesting that revised and enhanced documents "may be especially helpful as a...replacement for statutory forms where restrictions in a statutory directive prevents the individual from fully expressing his or her wishes" (see: American Bar Association. (1991). *Patient Self Determination Act State Law Guide*. Government printing office, Washington, DC).

Lifecare Directives staff have reviewed more than 6,000 medical, legal, academic, and news media articles on advance directives, as well as reviewing hundreds of document forms. They have also conducted formal research with scores of medical, legal, and academic processionals along with more than 1,000 lay public participants. From this process, more than 30 additional key living will and medical power of attorney enhancements have been identified that should be included in any living will (or "health care instruction" or "declaration") and medical power of attorney (or "proxy") forms that you may use.

Please consider obtaining the *Lifecare Advance Healthcare Directive* to obtain these important additions and benefits. To better understand the important enhancements available through this combined living will and medical power of attorney, you may wish to obtain the booklet, "*Should I Use a Shorter Standard Directive?*" available through Lifecare Directives, LLC.

If you have any other questions about this document or other Lifecare resources, please do not hesitate to contact our staff who will make every effort to fully respond your inquiries and address any questions you may have. We can be reached at the following:

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~ Lifecare Directives ~

Health Care Advance Directive

For

New York Residents

Standard State Statutory
Advance Directive for
Health Care Choices

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Health Care Advance Directive

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Important Notice:

An advance directive is not a substitute for medical, legal or other necessary advice or direction. This document should not be construed as offering counseling, medical, legal, financial, or estate planning or advice, nor any other similar guidance or direction. Such counsel should be obtained from qualified, certified, and licensed professionals in your locale who are experienced in the specific areas of concern. Completion of this document constitutes acceptance of its content both in whole and in part, as well as a determination of its utility for the purposes indicated. Lifecare Directives, LLC, and all involved in this document's design, publication, and distribution assume no liability for its use, including that which may arise from omissions, technical inaccuracies, and typographical errors. Diligent efforts notwithstanding, this document is not warrantied to be in compliance with state and local laws. All warranties, including those of merchantability, fitness for a particular purpose, and non-infringement are expressly disclaimed. The utilizer agrees to seek appropriate outside review prior to completion. The utilizer and all heirs, assigns, designees, devisees, representatives, and all others involved, agree to assume all liability for its use and any subsequent outcomes, and to release and hold harmless all involved in its design, publication, advertising and distribution. The utilizer also agrees that any physician, health care provider, agent, proxy, surrogate, representative, mediator, court officer, and all others relying on the document's content are similarly free of all liability, when they act in good faith and with due diligence to follow the recorded wishes and directions.

Health Care
Advance Directive
For New York Residents

_____ _____

Print Full Name *Date of Birth*

Your right *(when age 18 or older): To Document Your Personal Wishes, and to have these wishes followed ~~*

In the state of New York you have the right to document your personal wishes, and to appoint an individual to represent you in making health care decisions, if you are ever unable to make or communicate these decisions for yourself. Even so, there are no formal statutes in the state of New York supporting the use of a living will. However, prior court rulings have resulted in sufficient case law and precedence to allow the use of a *non*-statutory living will. Thus, a living will document is provided here which is legally sufficient for public use.

The New York state legislature *has* formally enacted statutes by which to appoint another individual to represent you by "proxy" if you are ever unable to speak for yourself. Known as the Health Care Proxy, this document was designed by the state legislature for use by the public, and therefore it is in full compliance with all applicable state laws.

There is an introduction to each document that summarizes its scope and purpose, as well as providing directions for completion. Read each carefully to ensure that they are both fully and properly filled out. You should know that you are not required to complete either document, and you can complete one without completing the other. Use either or both documents to secure your rights and wishes as seems necessary and proper. If there is anything you do not understand about these documents, you should seek further counsel and guidance.

New York Living Will
and Personal Instructions

(*Pursuant to In re: Westchester County Medical Center 72 N.Y.2d 517 (1988)*)

INTRODUCTION: *This living will is established upon common law, and upon case law in the state of New York as set forth in the case* In re: Westchester County Medical Center*, 72 N.Y.2d 517 (1988). In this case the Court concluded that "clear and convincing" evidence is needed of a person's treatment wishes, and suggested that the "ideal situation is one in which the patient's wishes were expressed in some form of writing, perhaps a 'living will'." To this end, your health care wishes may be herein documented, to be followed at any time your are left unable to make or communicate your own desires.*

Be It Hereby Known That:

I (*print your full name*), _____,
being of sound mind and acting without coercion on duress, do make this statement as a directive of my wishes to be followed if I become unable to make or communicate decisions regarding my medical care.

These instructions and directives reflect my desires regarding the refusal of medical treatment under the circumstances I have indicated below:

(*initial if this represents your wishes*)

_____ I request that treatment which merely **prolongs my dying** should be withheld or withdrawn if I am diagnosed as being in an incurable or irreversible mental or physical condition, from which there is no reasonable expectation of recovery.

These instructions shall also apply if I am:

(*initial any or all that apply*)

_____ Diagnosed with a **terminal condition** (and given six months or less to live);

_____ Diagnosed as being **permanently unconscious**, whereby I have no response to the environment around me, nor am I aware of my personal being or living;

_____ Diagnosed as being **minimally conscious**, but where I have suffered irreversible brain damage sufficient that I will never again possess the ability to make personal decisions and express my wishes.

In the situations indicated above, I direct that any medical treatment be limited to those measures necessary to keep me comfortable, and to relieve any pain or discomfort I may experience – including any pain or distress that might occur by withholding or withdrawing treatment.

(Cross out Any Statements with Which You Do Not Agree)

I understand that I am <u>not</u> legally required to make specific decisions about future treatments if I am in the condition(s) I have described above. However, I want it known that I feel especially strongly about refusing the following forms of treatment which may particularly prolong the dying process:

(*initial all that apply*)

_____ 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.

However, I **do want** maximum pain relief, even if it may unintentionally hasten my death.

(Add Any Further Personal Instructions Desired)

Other directions: _____

_____

_____

_____

These directions express my legal right to refuse treatment under the laws of New York. I intend my instructions to be carried out, unless I have clearly indicated that I have changed my mind, or unless I revoke or revise these instructions in a new writing.

(Sign Only in the Presence of Two Witnesses, Below)

Signed: _____

Date: _____

Address: _____

(Your Witnesses must Also Sign this Statement, below, and Print Their Names and Addresses)

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 this document (or asked another to sign for him or her) in my presence.

Witness #1:

Signed: _____

Printed Name: _____

Address: _____

Witness #2:

Signed: _____

Printed Name: _____

Address: _____

NEW YORK HEALTH CARE PROXY

For Designation of a Health Care Agent

(Pursuant to the Consolidated Laws of New York Article 29-C:§2980-§2994)

INTRODUCTION: *This document allows you to name an individual to speak for you, in the event you ever become unable to make or communicate health care decisions. The person you name must be at least 18 years of age. This document need not be notarized, but it must be witnessed by two adults to be legally binding and valid.*

Be it Known That:

I (*print your full name*): _____,

~~ do hereby appoint:

Agent: _____

Address: _____

Telephone: _____

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

NOTE: *Although not necessary, and neither encouraged nor discouraged, you may wish to state instructions or wishes, and limit your agent`s authority. Unless your agent knows your wishes about artificial nutrition and hydration, your agent will not have authority to decide about artificial nutrition and hydration. If you choose to state instructions, wishes, or limits, please do so below*:

_____

_____

_____

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 the person I appoint above is unable, unwilling or unavailable to act as my health care agent, I hereby appoint (name, home address and telephone number of alternate agent) as my health care agent. I understand that, unless I revoke it, this proxy will remain in effect indefinitely or until the date or occurrence of the condition I have stated below:

(*Please complete the following only if you do NOT want this health care proxy to remain in effect indefinitely*):

This proxy shall expire upon (*specify date or condition*): _____

_____

Your Signature: _____

Address: _____

Date: _____

Statement of Witnesses

I declare that the person who signed (or asked another to sign) this document is personally known to me and appears to be of sound mind and acting willingly and free from duress. He or she signed (or asked another to sign for him or her) this document in my presence and that person did sign in my presence. I am not the person appointed as agent by this document.

1st Witness: _____

Printed Name: _____

Address: _____

2nd Witness: _____

Printed Name: _____

Address: _____