SURVIVORS AND LEGAL PLANNING

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M 51 — New York Statutory Power of Attorney: durable unless modified, with affidavit of attorney, GOL § 5-1513: 12 pt. type, 9-10

POWER OF ATTORNEY
NEW YORK STATUTORY SHORT FORM

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(a) CAUTION TO THE PRINCIPAL: Your Power of Attorney is an important document. As the "principal," you give the person whom you choose (your "agent") authority to spend your money and sell or dispose of your property during your lifetime without telling you. You do not lose your authority to act even though you have given your agent similar authority.

When your agent exercises this authority, he or she must act according to any instructions you have provided or, where there are no specific instructions, in your best interest. "Important Information for the Agent" at the end of this document describes your agent's responsibilities.

Your agent can act on your behalf only after signing the Power of Attorney before a notary public.

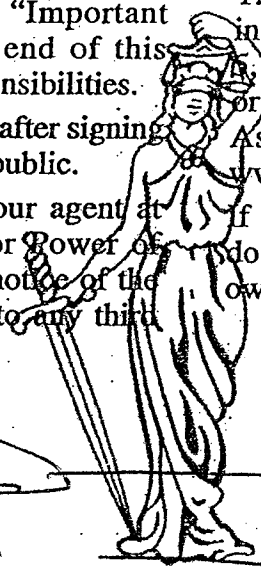
You can request information from your agent at any time. If you are revoking a prior Power of Attorney, you should provide written notice of the revocation to your prior agent(s) and to any third parties who may have acted upon it, including the financial institutions where your accounts are located.

You can revoke or terminate your Power of Attorney at any time for any reason as long as you are of sound mind. If you are no longer of sound mind, a court can remove an agent for acting improperly.

Your agent cannot make health care decisions for you. You may execute a "Health Care Proxy" to do this.

The law governing Powers of Attorney is contained in the New York General Obligations Law, Article 5, Title 15. This law is available at a law library, or online through the New York State Senate or Assembly websites, www.senate.state.ny.us or www.assembly.state.ny.us.

If there is anything about this document that you do not understand, you should ask a lawyer of your own choosing to explain it to you.



(b) DESIGNATION OF AGENT(S):

Name and address of principal

I, PRINCIPAL ADDRESS hereby appoint:

Name(s) and address(es) of agent(s)

AGENT(S) ADDRESSES as my agent(s)

If you designate more than one agent above, they must act together unless you initial the statement below.

X [ ] My agents may act SEPARATELY.

(c) ~~DESIGNATION~~ OF SUCCESSOR AGENT(S): (OPTIONAL)

Name(s) and address(es) of successor agent(s)

If any agent designated above is unable or unwilling to serve, I appoint as my successor agent(s):

"BACK-UP" AGENTS [NAMES/ADDRESSES]

Successor agents designated above must act together unless you initial the statement below.

[ ] My successor agents may act SEPARATELY.

You may provide for specific succession rules in this section. Insert specific succession provisions here:

(d) This POWER OF ATTORNEY shall not be affected by my subsequent incapacity unless I have stated otherwise below, under "Modifications."

(e) This POWER OF ATTORNEY DOES NOT REVOKE any Powers of Attorney previously executed by me unless I have stated otherwise below, under "Modifications."

If you do NOT intend to revoke your prior Powers of Attorney, and if you have granted the same authority in this Power of Attorney as you granted to another agent in a prior Power of Attorney, each agent can act separately unless you indicate under "Modifications" that the agents with the same authority are to act together.

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(f) GRANT OF AUTHORITY:

To grant your agent some or all of the authority below, either
(1) Initial the bracket at each authority you grant, or
(2) Write or type the letters for each authority you grant on the blank line at (P), and initial the bracket at (P). If you initial (P), you do not need to initial the other lines.

I grant authority to my agent(s) with respect to the following subjects as defined in sections 5-1502A through 5-1502N of the New York General Obligations Law:

[ ] (A) real estate transactions;
[ ] (B) chattel and goods transactions;
[ ] (C) bond, share, and commodity transactions;
[ ] (D) banking transactions;
[ ] (E) business operating transactions;
[ ] (F) insurance transactions;
[ ] (G) estate transactions;
[ ] (H) claims and litigation;
[ ] (I) personal and family maintenance.
If you grant your agent this authority, it will allow the agent to make gifts that you customarily have made to individuals, including the agent, and charitable organizations. The total amount of all such gifts in any one calendar year cannot exceed five hundred dollars;

[ ] (J) benefits from governmental programs or civil or military service;
[ ] (K) health care billing and payment matters; records, reports, and statements;
[ ] (L) retirement benefit transactions;
[ ] (M) tax matters;
[ ] (N) all other matters;
[ ] (O) full and unqualified authority to my agent(s) to delegate any or all of the foregoing powers to any person or persons whom my agent(s) select;
[ ] (P) EACH of the matters identified by the following letters ABCDEFGHIJKLMNO
You need not initial the other lines if you initial line (P).

(g) MODIFICATIONS: (OPTIONAL)

In this section, you may make additional provisions, including language to limit or supplement authority granted to your agent.

However, you cannot use this Modifications section to grant your agent authority to make gifts or changes to interests in your property. If you wish to grant your agent such authority, you MUST complete the Statutory Gifts Rider.

--My agent(s) under this Power of Attorney may qualify me for various entitlement programs such as Medicaid or SSI and includes the power to divest me of sufficient assets to qualify me for such entitlements.
--My agent(s) under this Power of Attorney shall have the authority to join a pooled income trust and/or pooled asset trust managedby a non-profit agency.

(h) CERTAIN GIFT TRANSACTIONS: STATUTORY GIFTS RIDER: (OPTIONAL)

In order to authorize your agent to make gifts in excess of an annual total of $500 for all gifts described in (I) of the grant of authority section of this document (under personal and family maintenance), you must initial the statement below and execute a Statutory Gifts Rider at the same time as this instrument. Initialing the statement below by itself does not authorize your agent to make gifts. The preparation of the Statutory Gifts Rider should be supervised by a lawyer.

[ ] (SGR) I grant my agent authority to make gifts in accordance with the terms and conditions of the Statutory Gifts Rider that supplements this Statutory Power of Attorney.

(i) DESIGNATION OF MONITOR(S): (OPTIONAL)

If you wish to appoint monitor(s), initial and fill in the section below:

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[ ] I wish to designate
whose address(es) is (are)

as monitor(s). Upon the request of the monitor(s), my agent(s) must provide the monitor(s) with a copy of the power of attorney and a record of all transactions done or made on my behalf. Third parties holding records of such transactions shall provide the records to the monitor(s) upon request.

(j) COMPENSATION OF AGENT(S): (OPTIONAL)

Your agent is entitled to be reimbursed from your assets for reasonable expenses incurred on your behalf. If you ALSO wish your agent(s) to be compensated from your assets for services rendered on your behalf, initial the statement below. If you wish to define "reasonable compensation," you may do so above, under "Modifications."

[ ] My agent(s) shall be entitled to reasonable compensation for services rendered.

(k) ACCEPTANCE BY THIRD PARTIES: I agree to indemnify the third party for any claims that may arise against the third party because of reliance on this Power of Attorney. I understand that any termination of this Power of Attorney, whether the result of my revocation of the Power of Attorney or otherwise, is not effective as to a third party until the third party has actual notice or knowledge of the termination.

(l) TERMINATION: This Power of Attorney continues until I revoke it or it is terminated by my death or other event described in section 5-1511 of the General Obligations Law.

Section 5-1511 of the General Obligations Law describes the manner in which you may revoke your Power of Attorney, and the events which terminate the Power of Attorney.

(m) SIGNATURE AND ACKNOWLEDGMENT:

In Witness Whereof I have hereunto signed my name on 20

PRINCIPAL signs here: → PRINCIPAL

ACKNOWLEDGMENT

STATE OF NEW YORK, COUNTY OF ss.:

On before me, the undersigned, personally appeared

personally known to me or proved to me on the basis of satisfactory evidence to be the individual(s) whose name(s) is (are) subscribed to the within instrument and acknowledged to me that he/she/they executed the same in his/her/their capacity(ies), and that by his/her/their signature(s) on the instrument, the individual(s), or the person upon behalf of which the individual(s) acted, executed the instrument.

(signature and office of person taking acknowledgment)

NOTARY

(n) IMPORTANT INFORMATION FOR THE AGENT:

When you accept the authority granted under this Power of Attorney, a special legal relationship is created between you and the principal. This relationship imposes on you legal responsibilities that continue until you resign or the Power of Attorney is terminated or revoked. You must:

(1) act according to any instructions from the principal, or, where there are no instructions, in the principal's best interest;

(2) avoid conflicts that would impair your ability to act in the principal's best interest;

(3) keep the principal's property separate and distinct from any assets you own or control, unless otherwise permitted by law;

(4) keep a record or all receipts, payments, and transactions conducted for the principal; and

(5) disclose your identity as an agent whenever you act for the principal by writing or printing the principal's name and signing your own name as "agent" in either of the following manners: (Principal's Name) by (Your Signature) as Agent, or (your signature) as Agent for (Principal's Name).

You may not use the principal's assets to benefit yourself or anyone else or make gifts to yourself or anyone else unless the principal has specifically granted you that authority in this document, which is either a Statutory Gifts Rider attached to a Statutory Short Form Power of Attorney or a Non-Statutory Power of Attorney. If you have that authority, you must act according to any instructions of the principal or, where there are no such instructions, in the principal's best interest. You may resign by giving written notice to the principal and to any co-agent, successor agent, monitor if one has been named in this document, or the principal's guardian if one has been appointed. If there is anything about this document or your responsibilities that you do not understand, you should seek legal advice.

Liability of agent:

The meaning of the authority given to you is defined in New York's General Obligations Law, Article 5, Title 15. If it is found that you have violated the law or acted outside the authority granted to you in the Power of Attorney, you may be liable under the law for your violation.

(o) AGENT'S SIGNATURE AND ACKNOWLEDGMENT OF APPOINTMENT:

It is not required that the principal and the agent(s) sign at the same time, nor that multiple agents sign at the same time.

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I/we,
have read the foregoing Power of Attorney. I am/we are the person(s) identified therein as agent(s) for the principal named therein.

I/we acknowledge my/our legal responsibilities.

Agent(s) sign(s) here: ➡ AGENT _____ AGENT _____

ACKNOWLEDGMENT

State of New York, County of **ss:**
On before me, the undersigned,
personally appeared

personally known to me or proved to me on the basis of satisfactory evidence to be the individual(s) whose name(s) is (are) subscribed to the within instrument and acknowledged to me that he/she/they executed the same in his/her/their capacity(ies), and that by his/her/their signature(s) on the instrument, the individual(s), or the person upon behalf of which the individual(s) acted, executed the instrument.

(signature and office of individual taking acknowledgment)

NOTARY

State of **County of** **ss:**
On before me, the undersigned,
personally appeared

personally known to me or proved to me on the basis of satisfactory evidence to be the individual(s) whose name(s) is (are) subscribed to the within instrument and acknowledged to me that he/she/they executed the same in his/her/their capacity(ies), and that by his/her/their signature(s) on the instrument, the individual(s), or the person upon behalf of which the individual(s) acted, executed the instrument.

(signature and office of individual taking acknowledgment)

NOTARY

(p) SUCCESSOR AGENT'S SIGNATURE AND ACKNOWLEDGMENT OF APPOINTMENT:

It is not required that the principal and the SUCCESSOR agent(s), if any, sign at the same time, nor that multiple SUCCESSOR agents sign at the same time. Furthermore, successor agents can not use this Power of Attorney unless the agent(s) designated above is/are unable or unwilling to serve.

I/we, BACK UP AGENTS have read the foregoing Power of Attorney. I am/we are the person(s) identified therein as SUCCESSOR agent(s) for the principal named therein.

Successor Agent(s) sign(s) here: ⟹ _____ _____

ACKNOWLEDGMENT

State of New York, County of ss:
On before me, the undersigned,
personally appeared

personally known to me or proved to me on the basis of satisfactory evidence to be the individual(s) whose name(s) is (are) subscribed to the within instrument and acknowledged to me that he/she/they executed the same in his/her/their capacity(ies), and that by his/her/their signature(s) on the instrument, the individual(s), or the person upon behalf of which the individual(s) acted, executed the instrument.

(signature and office of individual taking acknowledgment)

NOTARY

State of ss:
County of
On before me, the undersigned,
personally appeared

personally known to me or proved to me on the basis of satisfactory evidence to be the individual(s) whose name(s) is (are) subscribed to the within instrument and acknowledged to me that he/she/they executed the same in his/her/their capacity(ies), and that by his/her/their signature(s) on the instrument, the individual(s), or the person upon behalf of which the individual(s) acted, executed the instrument.

(signature and office of individual taking acknowledgment)

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AFFIDAVIT THAT POWER OF ATTORNEY IS IN FULL FORCE AND EFFECT

(Sign before a notary public)

STATE OF COUNTY OF ss.:
being duly sworn, deposes and says:

1. The Principal appointed me as the Principal's true and lawful agent in the within Power of Attorney.
2. I do not have, at the time of this transaction, actual notice of the termination or revocation of the Power of Attorney, or notice of any facts indicating that the Power of Attorney has been terminated or revoked;
3. I do not have, at the time of this transaction, actual notice that the Power of Attorney has been modified in any way that would affect my ability as the agent to authorize or engage in the transaction, or notice of any facts indicating that the Power of Attorney has been so modified; and
4. I make this affidavit for the purpose of inducing

to accept delivery of the following Instrument(s), as executed by me in my capacity as the agent, with full knowledge that this affidavit will be relied upon in accepting the execution and delivery of the Instrument(s) and in paying good and valuable consideration therefor:

☐ *I am the successor agent; the prior agent is no longer able or willing to serve.*

Sworn to before me on _____

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POWER OF ATTORNEY—NEW YORK STATUTORY SHORT FORM

Principal

Agent(s)

Record and Return To:

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POWER OF ATTORNEY—NEW YORK STATUTORY GIFTS RIDER

AUTHORIZATION FOR CERTAIN GIFT TRANSACTIONS

CAUTION TO THE PRINCIPAL: This OPTIONAL rider allows you to authorize your agent to make gifts in excess of an annual total of $500 for all gifts described in (I) of the Grant of Authority section of the statutory short form Power of Attorney (under personal and family maintenance), or certain other gift transactions during your lifetime. You do not have to execute this rider if you only want your agent to make gifts described in (I) of the Grant of Authority section of the statutory short form Power of Attorney and you initialed "(I)" on that section of that form.

Granting any of the following authority to your agent gives your agent the authority to take actions which could significantly reduce your property or change how your property is distributed at your death. "Certain gift transactions" are described in section 5-1514 of the General Obligations Law. This Gifts Rider does not require your agent to exercise granted authority, but when he or she exercises this authority, he or she must act according to any instructions you provide, or otherwise in your best interest.

This Gifts Rider and the Power of Attorney it supplements must be read together as a single instrument.

Before signing this document authorizing your agent to make gifts, you should seek legal advice to ensure that your intentions are clearly and properly expressed.

#13,000 for 2017

(a) GRANT OF LIMITED AUTHORITY TO MAKE GIFTS:

Granting gifting authority to your agent gives your agent the authority to take actions which could significantly reduce your property.

If you wish to allow your agent to make gifts to himself or herself, you must separately grant that authority in subdivision (c) below.

To grant your agent the gifting authority provided below, initial the bracket to the left of the authority.

[ ] I grant authority to my agent to make gifts to my spouse, children and more remote descendants, and parents, not to exceed, for each donee, the annual federal gift tax exclusion amount pursuant to the Internal Revenue Code. For gifts to my children and more remote descendants, and parents, the maximum amount of the gift to each donee shall not exceed twice the gift tax exclusion amount, if my spouse agrees to split gift treatment pursuant to the Internal Revenue Code.

This authority must be exercised pursuant to my instructions, or otherwise for purposes which the agent reasonably deems to be in my best interest.

(b) MODIFICATIONS:

Use this section if you wish to authorize gifts in amounts smaller than the gift tax exclusion amount, in amounts in excess of the gift tax exclusion amount, gifts to other beneficiaries or other gift transactions.

Granting such authority to your agent gives your agent the authority to take actions which could significantly reduce your property and/or change how your property is distributed at your death. If you wish to authorize your agent to make gifts to himself or herself, you must separately grant that authority in subdivision (c) below.

[ ] I grant the following authority to my agent to make gifts pursuant to my instructions, or otherwise for purposes which the agent reasonably deems to be in my best interest.

USE THIS FOR MEDICAID SURPLUS INCOME TRUST

(c) GRANT OF SPECIFIC AUTHORITY FOR AN AGENT TO MAKE GIFTS TO HIMSELF OR HERSELF: (OPTIONAL)

If you wish to authorize your agent to make gifts to himself or herself, you must grant that authority in this section, indicating to which agent(s) the authorization is granted, and any limitations and guidelines.

[ ] I grant specific authority for the following agent(s) to make the following gifts to himself or herself:

? BLANK ?

This authority must be exercised pursuant to my instructions, or otherwise for purposes which the agent reasonably deems to be in my best interest.

(d) ACCEPTANCE BY THIRD PARTIES:

I agree to indemnify the third party for any claims that may arise against the third party because of reliance on this Statutory Gifts Rider.

(e) SIGNATURE OF PRINCIPAL AND ACKNOWLEDGMENT:

In Witness Whereof I have hereunto signed my name on ^20

PRINCIPAL signs here: ➡ X PRINCIPAL

ACKNOWLEDGMENT

STATE OF NEW YORK, COUNTY OF ss.:

On before me, the undersigned, personally appeared

personally known to me or proved to me on the basis of satisfactory evidence to be the individual(s) whose name(s) is (are) subscribed to the within instrument and acknowledged to me that he/she/they executed the same in his/her/their capacity(ies), and that by his/her/their signature(s) on the instrument, the individual(s), or the person upon behalf of which the individual(s) acted, executed the instrument.

(signature and office of person taking acknowledgment)

(f) SIGNATURES OF WITNESSES:

By signing as a witness, I acknowledge that the principal signed the Statutory Gifts Rider in my presence and the presence of the other witness, or that the principal acknowledged to me that the principal's signature was affixed by him or her or at his or her direction. I also acknowledge that the principal has stated that this Statutory Gifts Rider reflects his or her wishes and that he or she has signed it voluntarily. I am not named herein as a permissible recipient of gifts.

Signature of witness 1	*Date*	*Signature of witness 2*	*Date*
Print name			
Address			
City, State, Zip code			

(g) This document prepared by:

NOTE: PREPARER CAN BE A WITNESS

MUST BE ENTERED

Health Care Proxy

(1) I, —NAME OF CLIENT—

hereby appoint 1ST AGENT
(name, home address and telephone number) ALL PHONE #S
ADDRESS
home/cell/work etc

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 2ND AGENT
(name, home address and telephone number)
—ADDRESS— ALL PHONE #S

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 this 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)*:

X I authorize my agent and substitute agent (if any) to make decisions concerning the provision or withdrawal of artificial nutrition and hydration and also organ donation as I have discussed my wishes with him/her/them. X

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 NAME OF CLIENT

X Your Signature CLIENT TO SIGN Date client to DA

Your Address CLIENT'S 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)* _____	Name of Witness 2 *(print)* _____
Signature _____	Signature _____
Address _____	Address _____

Home address preferred But, if staff use OK

State of New York
Eliot Spitzer, Governor

Department of Health
Richard F. Daines, M.D., Commissioner

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7/07

About the Health Care Proxy Form

This is an important legal document.
Before signing, 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, including the decision to remove or provide life-sustaining treatment, unless 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 your agent reasonably knows your wishes about artificial nutrition and hydration (nourishment and water provided by a feeding tube or intravenous line), he or she will not be allowed to refuse or consent to those measures for you.

3. Your agent will start making decisions for you when your doctor determines that you are not able to make health care decisions for yourself.

4. You may write on this form examples of the types of treatments that you would not desire and/or those treatments that you want to make sure you receive. The instructions may be used to limit the decision-making power of the agent. Your agent must follow your instructions when making decisions for you.

5. You do not need a lawyer to fill out this form.

6. You may choose any adult (18 years of age or older), including a family member or close friend, to be your agent. If you select a doctor as your agent, he or she will have to choose between acting as your agent or as your attending doctor because a doctor 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. Ask staff at the facility to explain those restrictions.

7. Before appointing someone as your health care agent, discuss it with him or her to make sure that he or she is willing to act as your agent. Tell the person you choose that he or she will be your health care agent. 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.

8. If you have named your spouse as your health care agent and you later become divorced or legally separated, your former spouse can no longer be your agent by law, unless you state otherwise. If you would like your former spouse to remain your agent, you may note this on your current form and date it or complete a new form naming your former spouse.

9. Even though 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, nor will your agent have any power to object.

10. You may cancel the authority given to your agent by telling him or her or your health care provider orally or in writing.

11. Appointing a health care agent is voluntary. No one can require you to appoint one.

12. You may express your wishes or instructions regarding organ and/or tissue donation on this form.

Frequently Asked Questions

Why should I choose a health care agent?

If you become unable, even temporarily, to make health care decisions, someone else must decide for you. Health care providers often look to family members for guidance. Family members may express what they think your wishes are related to a particular treatment. Appointing an agent lets you control your medical treatment by:

- allowing your agent to make health care decisions on your behalf as you would want them decided;
- choosing one person to make health care decisions because you think that person would make the best decisions;
- choosing one person to avoid conflict or confusion among family members and/or significant others.

You may also appoint an alternate agent to take over if your first choice cannot make decisions for you.

Who can be a health care agent?

Anyone 18 years of age or older can be a health care agent. The person you are appointing as your agent or your alternate agent cannot sign as a witness on your Health Care Proxy form.

How do I appoint a health care agent?

All competent adults, 18 years of age or older, can appoint a health care agent by signing a form called a Health Care Proxy. You don't need a lawyer or a notary, just two adult witnesses. Your agent cannot sign as a witness. You can use the form printed here, but you don't have to use this form.

When would my health care agent begin to make health care decisions for me?

Your health care agent would begin to make health care decisions after your doctor decides that you are not able to make your own health care decisions. As long as you are able to make health care decisions for yourself, you will have the right to do so.

What decisions can my health care agent make?

Unless you limit your health care agent's authority, your agent will be able to make any health care decision that you could have made if you were able to decide for yourself. Your agent can agree that you should receive treatment, choose among different treatments and decide that treatments should not be provided, in accordance with your wishes and interests. However, your agent can only make decisions about artificial nutrition and hydration (nourishment and water provided by feeding tube or intravenous line) if he or she knows your wishes from what you have said or what you have written. The Health Care Proxy form does not give your agent the power to make non-health care decisions for you, such as financial decisions.

Why do I need to appoint a health care agent if I'm young and healthy?

Appointing a health care agent is a good idea even though you are not elderly or terminally ill. A health care agent can act on your behalf if you become even temporarily unable to make your own health care decisions (such as might occur if you are under general anesthesia or have become comatose because of an accident). When you again become able to make your own health care decisions, your health care agent will no longer be authorized to act.

How will my health care agent make decisions?

Your agent must follow your wishes, as well as your moral and religious beliefs. You may write instructions on your Health Care Proxy form or simply discuss them with your agent.

How will my health care agent know my wishes?

Having an open and frank discussion about your wishes with your health care agent will put him or her in a better position to serve your interests. If your agent does not know your wishes or beliefs, your agent is legally required to act in your best interest. Because this is a major responsibility for the person you appoint as your health care

agent, you should have a discussion with the person about what types of treatments you would or would not want under different types of circumstances, such as:

- whether you would want life support initiated/continued/removed if you are in a permanent coma;
- whether you would want treatments initiated/continued/removed if you have a terminal illness;
- whether you would want artificial nutrition and hydration initiated/withheld or continued or withdrawn and under what types of circumstances.

Can my health care agent overrule my wishes or prior treatment instructions?

No. Your agent is obligated to make decisions based on your wishes. If you clearly expressed particular wishes, or gave particular treatment instructions, your agent has a duty to follow those wishes or instructions unless he or she has a good faith basis for believing that your wishes changed or do not apply to the circumstances.

Who will pay attention to my agent?

All hospitals, nursing homes, doctors and other health care providers are legally required to provide your health care agent with the same information that would be provided to you and to honor the decisions by your agent as if they were made by you. If a hospital or nursing home objects to some treatment options (such as removing certain treatment) they must tell you or your agent BEFORE or upon admission, if reasonably possible.

What if my health care agent is not available when decisions must be made?

You may appoint an alternate agent to decide for you if your health care agent is unavailable, unable or unwilling to act when decisions must be made. Otherwise, health care providers will make health care decisions for you that follow instructions you gave while you were still able to do so. Any instructions that you write on your Health Care Proxy form will guide health care providers under these circumstances.

What if I change my mind?

It is easy to cancel your Health Care Proxy, to change the person you have chosen as your health care agent or to change any instructions or limitations you have included on the form. Simply fill out a new form. In addition, you may indicate that your Health Care Proxy expires on a specified date or if certain events occur. Otherwise, the Health Care Proxy will be valid indefinitely. If you choose your spouse as your health care agent or as your alternate, and you get divorced or legally separated, the appointment is automatically cancelled. However, if you would like your former spouse to remain your agent, you may note this on your current form and date it or complete a new form naming your former spouse.

Can my health care agent be legally liable for decisions made on my behalf?

No. Your health care agent will not be liable for health care decisions made in good faith on your behalf. Also, he or she cannot be held liable for costs of your care, just because he or she is your agent.

Is a Health Care Proxy the same as a living will?

No. A living will is a document that provides specific instructions about health care decisions. You may put such instructions on your Health Care Proxy form. The Health Care Proxy allows you to choose someone you trust to make health care decisions on your behalf. Unlike a living will, a Health Care Proxy does not require that you know in advance all the decisions that may arise. Instead, your health care agent can interpret your wishes as medical circumstances change and can make decisions you could not have known would have to be made.

Where should I keep my Health Care Proxy form after it is signed?

Give a copy to your agent, your doctor, your attorney and any other family members or close friends you want. Keep a copy in your wallet or purse or with other important papers, but not in a location where no one can access it, like a safe

deposit box. Bring a copy if you are admitted to the hospital, even for minor surgery, or if you undergo outpatient surgery.

May I use the Health Care Proxy form to express my wishes about organ and/or tissue donation?

Yes. Use the optional organ and tissue donation section on the Health Care Proxy form and be sure to have the section witnessed by two people. You may specify that your organs and/or tissues be used for transplantation, research or educational purposes. Any limitation(s) associated with your wishes should be noted in this section of the proxy. **Failure to include your wishes and instructions on your Health Care Proxy form will not be taken to mean that you do not want to be an organ and/or tissue donor.**

Can my health care agent make decisions for me about organ and/or tissue donation?

Yes. As of August 26, 2009, your health care agent is authorized to make decisions after your death, but only those regarding organ and/or tissue donation. Your health care agent must make such decisions as noted on your Health Care Proxy form.

Who can consent to a donation if I choose not to state my wishes at this time?

It is important to note your wishes about organ and/or tissue donation to your health care agent, the person designated as your decedent's agent, if one has been appointed, and your family members. New York Law provides a list of individuals who are authorized to consent to organ and/or tissue donation on your behalf. They are listed in order of priority: 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; or a guardian appointed by a court prior to the donor's death.

NEW YORK
state department of
HEALTH

Nirav R. Shah, M.D., M.P.H.
Commissioner

Sue Kelly
Executive Deputy Commissioner

New York State Health Care Proxy
ORDER FORM

To order copies of the New York State Health Care Proxy, please mail this form to:

Health Care Proxy
NYS Department of Health Distribution Center
21 Simmons Lane
Menands, NY 12204

These materials are available free of charge to New York State residents and organizations. Please allow at least **three weeks** for delivery.

Health Care Proxy		**Circle Quantity**
English	#1430	1 25 50 100 200
Spanish	#1431	1 25 50 100 200
Chinese	#1402	1 25 50 100 200
Russian	#1401	1 25 50 100 200

Name:_____

Organization:_____

Street Address*:_____

City/State/Zip:_____ Date:_____

***Bulk orders cannot be shipped to Post Office boxes.**

NEW YORK LIVING WILL

This Living Will has been prepared to conform to the 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 that case the Court established the need for "clear and convincing" evidence of a patient's wishes and stated 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,** 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.**

I direct that my 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 artificial nutrition and hydration. I do not want antibiotics.

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

Other directions:

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

Signed _____ Date_____

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_____

Address_____

Witness 2_____

Address_____

Jewish Law - Halachic Forms

Jewish Law has compiled various legal forms which comply with the dictates of Halacha. These are freely available to be downloaded and filled out. Instructions describing the use of each form are included with each form. *Please click on the FORM TYPE of your choice.*

Note & Disclaimer: As with all Halachic and legal matters, the reader is advised to consult with competent Rabbinic authorities and one's own attorney. No reliance should be placed for definitive Halachic or legal purposes on any materials contained within this website, including the forms in this "Halachic Forms" section.

I. Halachic Living Will -- *Prepared by Agudath Israel of America*

For more information regarding living wills, see The "Halachic Health Care Proxy": An Insurance Policy With Unique Benefits by Chaim Dovid Zwiebel, Esq. Director of Government Affairs and General Counsel of Agudath Israel of America.

Register Your Halachic Living Will with the U.S. Living Will Registry:

Agudath Israel of America now recommends that everyone register their Halachic Living Wills with a national registry. *Agudath Israel* has made an arrangement with the *New York Legal Assistance Group* to register Halachic Living Wills for our constituents with the *U.S. Living Will Registry* at no charge. Please see the registry letter and complete the registry form as explained. This service is available to residents of all 50 states.

- Sample General Form (doc) (pdf)
- Brochure and Wallet Card
- Forms for Specific States
  - California (doc) (pdf)
  - Colorado (doc) (pdf)
  - Connecticut (doc) (pdf)
  - District of Columbia*
  - Delaware*
  - Florida (doc) (pdf)
  - Georgia (doc) (pdf)

What's New

- Illinois (doc) (pdf)
- Louisiana*
- Maryland (doc) (pdf)
- Massachusetts (doc) (pdf)
- Michigan (doc) (pdf)
- Minnesota (doc) (pdf)
- Missouri*
- Nebraska*
- Nevada*
- New Hampshire*
- New Jersey (doc) (pdf)
- New Mexico*
- New York (doc) (pdf)
- North Carolina*
- Ohio (doc) (pdf)
- Oregon*
- Pennsylvania (doc) (pdf)
- South Carolina*
- South Dakota*
- Tennessee*
- Texas*
- Virginia (doc) (pdf)
- Wisconsin (doc) (pdf)

* The text of the documents for these states was prepared more than ten years ago.
We therefore recommend you consult with a local estates and trusts attorney before executing this document to ensure that it conforms to current state law.
Agudath Israel is in the process of updating the Halachic Living Wills for most states.

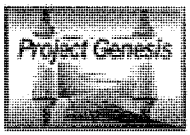
II. Heter Iska Forms -- *Reprinted with permission of ArtScroll/Mesorah Publications, Ltd. from "The Laws of Ribbis: The Laws of Interest and their Application to Everyday Life and Business" by Rabbi Yisroel Reisman*

- Iska A: When Merchandise is for Business Use
- Iska B: When Merchandise is for Personal Use
- Iska C: Standard Iska Calling for Monthly Payments
- Iska D: Kulo Pikadon Form - Where Money is Advanced for Business Use
- Iska E: Kulo Pikadon Form - Where Money is Advanced for Personal Use

III. Prenuptial and Postnuptial Agreement Forms

- A Legal Guide to the Prenuptial Agreement for Couples about to Be Married by Marc D. Stern
- Prenuptial Agreement (PDF) -- *created by Rabbi Mordechi Willig, Rabbi Michael Broyde, and the members of the legal Task Force of the Orthodox Caucus in association with the Beth Din Of America*
- Postnuptial Agreement -- *drafted by Rabbi Mordechi Willig*

Jewish Law Home Page



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The Halachic Living Will

PROXY AND DIRECTIVE WITH RESPECT TO HEALTH CARE
AND POST-MORTEM DECISIONS
FOR USE IN NEW YORK STATE

The "Halachic Living Will" is designed to help ensure that all medical and post-death decisions made by others on your behalf will be made in accordance with Jewish law and custom (*halacha*). The text of this Halachic Living Will has been approved by attorneys for use in your state as of November, 2003. While we do not expect that any future change in federal or state laws would materially affect the validity of this document, you may wish to show it to your own attorney to confirm its effectiveness in subsequent years.

INSTRUCTIONS

(a) **Please print your name on the first line of the form.**

(b) **In Section 1, print the name, address, and telephone numbers of the person you wish to designate as your *agent*** to make medical decisions on your behalf if, G-d forbid, you ever become incapable of making them on your own. Be sure to include all numbers (including cell phone and pager) where your agent can be reached in the event of an emergency. If the contact information for your agent changes, you should provide that updated information to everyone whom you have provided with a copy of your Halachic Living Will.

You may also insert the name, address, and telephone numbers of an *alternate agent* to make such decisions if your main agent is unable, unwilling, or unavailable to make such decisions.

It is recommended that before appointing anyone to serve as your agent or alternate agent you should ascertain that person's willingness to serve in such capacity. In addition, if you have made arrangements with a burial society (*Chevra Kadisha*) for the handling and disposition of your body after death, you may wish to advise your agents of such arrangements.

Note: *New York law allows virtually any competent adult* (an adult is a person 18 years of age or older, or anyone who has married) *to serve as a health care agent.* Thus, you may appoint as your agent (or alternate agent) your spouse, adult child, parent or other adult relative.

You may also appoint a non-relative to serve as your agent (or alternate agent), unless that individual has already been appointed by 10 other persons to serve as a health care agent; or unless that individual is a non-physician employee of a health care facility in which you are a patient or resident.

(c) **In section 3, please print the name, address, and telephone numbers of the Orthodox Rabbi whose guidance you want your agent to follow**, should any questions arise as to the requirements of *halacha.*

You should then print the name, address, and telephone numbers of the Orthodox Jewish institution or organization you want your agent to contact for a referral to *another* Orthodox Rabbi *if* the rabbi you have identified is unable, unwilling or unavailable to provide the appropriate consultation and guidance.

You are, of course, free to insert the name of any Orthodox Rabbi or institution/organization you would like, but before doing so it is advisable to discuss the matter with the rabbi or institution/organization to ascertain their competency and willingness to serve in such capacity.

(d) **In Section 8, sign and print your name, address, phone numbers, and the date.** If you are not physically able to do these things, New York law allows another person to sign and date the form on your behalf, as long as he or she does so *at your direction, in your presence,* and *in the presence of two adult witnesses.*

(e) **In the DECLARATION OF WITNESSES Section, two witnesses should sign their names and insert their addresses beneath your signature.** These two witnesses must be competent adults. *Neither of them should be the person you have appointed as your health care agent (or alternate agent).* They may, however, be your relatives.

If you reside in a mental health facility, at least one witness must be an individual who is not affiliated with the facility. In addition, if the mental health facility is also a hospital, at least one witness must be a qualified psychiatrist.

(f) It is recommended that you keep the original of this form among your valuable papers in a location that is readily accessible in the event of an emergency; and that you **distribute copies to the health care agent (and alternate agent)** you have designated in section 1, **to the rabbi and institution/organization** you have designated in section 3, as well as to **your doctors, your lawyer**, and anyone else who is likely to be contacted in times of emergency. We also recommend that you register a copy of this form with a national living will registry, so that it can be accessed by any health care facility via computer. Agudath Israel has made an arrangement with the New York Legal Assistance Group to register Halachic Living Wills for our constituents with the U.S. Living Will Registry at no charge. Contact our office (212-797-9000 ext. 267) for the forms that will enable you to do this.

(g) If at any time you wish to revoke this Proxy and Directive, you may do so by executing a new one; or by notifying your agent or health care provider, orally or in writing, of your intent to revoke it. To avoid possible confusion, it would be wise to try to obtain all originals and copies of the old Proxy and Directive and destroy them.

If you do not revoke the Proxy and Directive, New York law provides that it remains in effect indefinitely. Obviously, if any of the persons whose names you have inserted in the Proxy and Directive dies or becomes otherwise incapable of serving in the role you have assigned, you should execute a new Proxy and Directive.

(h) It is recommended that you also complete the **Emergency Instructions Card** contained in the Halachic Living Will brochure, and carry it with you in your wallet or purse.

(i) If, upon consultation with your rabbi, you would like to add to this standardized Proxy and Directive any additional expression of your wishes with respect to medical and/or post-mortem decisions, you may do so by attaching a "rider" to the standardized form. If you choose to do so, or if you have any other questions concerning this form, please consult an attorney.

These instructions are not part of the Halachic Living Will and need not be kept attached to the executed document.

Developed and published by: Agudath Israel of America • 42 Broadway, 14th Floor • New York, NY 10004 • 212-797-9000

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PROXY AND DIRECTIVE WITH RESPECT TO HEALTH CARE DECISIONS AND POST-MORTEM DECISIONS FOR USE IN NEW YORK STATE

I, _____, hereby declare as follows:

1. Appointment of Agent: In recognition of the fact that there may come a time when I will become unable to make my own health care decisions because of illness, injury or other circumstances, I hereby appoint

Agent

Name of Agent:

_____

Address:

_____

Telephone: Day: _____ Evening: _____

Cell: _____ Pager/beeper: _____

as my health care agent to make any and all health care decisions for me, consistent with my wishes as set forth in this directive.

If the person named above is unable, unwilling or unavailable to act as my agent, I hereby appoint

Alternate Agent

Name of Alternate Agent:

_____

Address:

_____

Telephone: Day: _____ Evening: _____

Cell: _____ Pager/beeper: _____

to serve in such capacity.

This appointment shall take effect in the event I become unable, because of illness, injury or other circumstances, to make my own health care decisions.

2. Jewish Law to Govern Health Care Decisions: I am Jewish. It is my desire, and I hereby direct, that all health care decisions made for me (whether made by my agent, a guardian appointed for me, or any other person) be made pursuant to Jewish law and custom as determined in accordance with strict Orthodox interpretation and tradition. Without limiting in any way the generality of the foregoing, it is my wish that Jewish law and custom should dictate the course of my health care with respect to such matters as the performance of cardio-pulmonary resuscitation if I suffer cardiac or respiratory arrest; the performance of life-sustaining surgical procedures and the initiation or maintenance of any particular course of life-sustaining medical treatment or other form of life-support maintenance, including the provision of nutrition and hydration; and the criteria by which death shall be determined, including the method by which such criteria shall be medically ascertained or confirmed.

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3. Ascertaining the Requirements of Jewish Law: In determining the requirements of Jewish law and custom in connection with this declaration, I direct my agent to consult with the following Orthodox Rabbi and I ask my agent to follow his guidance:

Rabbi Name of Rabbi:

_____

Address:

_____

Telephone: Day: Evening:

_____ _____

Cell: Pager/beeper:

_____ _____

If such Orthodox Rabbi is unable, unwilling or unavailable to provide such consultation and guidance, then I direct my agent to consult with, and I ask my agent to follow the guidance of, the following Orthodox Rabbi:

Rabbi Name of Rabbi:

_____

Address:

_____

Telephone: Day: Evening:

_____ _____

Cell: Pager/beeper:

_____ _____

If both of these Orthodox Rabbis are unable, unwilling or unavailable to provide such consultation and guidance, then I direct my agent to consult with, and I ask my agent to follow the guidance of, an Orthodox Rabbi referred by the following Orthodox Jewish institution or organization:

Organization Name of Institution/Organization:

_____

Address:

_____

Telephone: Day: Evening:

_____ _____

If such institution or organization is unable, unwilling or unavailable to make such a reference, or if the Orthodox Rabbi referred by such institution or organization is unable, unwilling or unavailable to provide such guidance, then I direct my agent to consult with, and I ask my agent to follow the guidance of, an Orthodox Rabbi whose guidance on issues of Jewish law and custom my agent in good faith believes I would respect and follow.

4. Direction to Health Care Providers: Any health care provider shall rely upon and carry out the decisions of my agent, and may assume that such decisions reflect my wishes and were arrived at in accordance with the procedures set forth in this directive, unless such health care provider shall have good cause to believe that my agent has not acted in good faith in accordance with my wishes as expressed in this directive.

If the persons designated in section 1 above as my agent and alternate agent are unable, unwilling or unavailable to serve in such capacity, it is my desire, and I hereby direct, that any health care provider or other person who will be making health care decisions on my behalf follow the procedures outlined in section 3 above in determining the requirements of Jewish law and custom.

Pending contact with the agent and/or Orthodox Rabbi described above, it is my desire, and I hereby direct, that all health care providers undertake all essential emergency and/or life sustaining measures on my behalf.

5. Access to Medical Records and Information; HIPAA: I direct that all of my protected health information (as such term is defined under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA")) and other medical records shall be made available to my agent upon request in the same manner as such information and records would be released and disclosed to me, and my agent shall have and may exercise all of the rights I would have regarding the use and disclosure of such information and records. In the event that the authority of my agent has not yet been established, I authorize each of my health care providers to release and disclose all my protected health information and other medical records to the individual nominated hereunder as my agent for the purpose of determining my capacity to make my own health care decisions, including, without limitation, the issuance and release of any written opinion relating to my capacity that such person may have requested.

The foregoing direction and authorization shall supersede any prior agreement that I may have made with any of my health care providers to restrict access to or disclosure of my protected health information or other medical records, and shall expire with respect to any health care provider upon being revoked by me in a writing delivered to such health care provider.

6. Post-Mortem Decisions: It is also my desire, and I hereby direct, that after my death, all decisions concerning the handling and disposition of my body be made pursuant to Jewish law and custom as determined in accordance with strict Orthodox interpretation and tradition. For example, Jewish law generally requires expeditious burial and imposes special requirements with regard to the preparation of the body for burial. It is my wish that Jewish law and custom be followed with respect to these matters.

Further, subject to certain limited exceptions, Jewish law generally prohibits the performance of any autopsy or dissection. It is my wish that Jewish law and custom be followed with respect to such procedures, and with respect to all other post-mortem matters including the removal and usage of any of my body organs or tissue for transplantation or any other purposes. I direct that any health care provider in attendance at my death notify the agent and/or Orthodox Rabbi described above immediately upon my death, in addition to any other person whose consent by law must be solicited and obtained, prior to the use of any part of my body as an anatomical gift, so that appropriate decisions and arrangements can be made in accordance with my wishes. Pending such notification, and unless there is specific authorization by the Orthodox Rabbi consulted in accordance with the procedures outlined in section 3 above, it is my desire, and I hereby direct, that no post-mortem procedure be performed on my body.

7. Incontrovertible Evidence of My Wishes: If, for any reason, this document is deemed not legally effective as a health care proxy, or if the persons designated in section 1 above as my agent and alternate agent are unable, unwilling or unavailable to serve in such capacity, I declare to my family, my doctor and anyone else whom it may concern that the wishes I have expressed herein with regard to compliance with Jewish law and custom should be treated as incontrovertible evidence of my intent and desire with respect to

all health care measures and post-mortem procedures; and that it is my wish that the procedure outlined in section 3 above should be followed in determining the requirements of Jewish law and custom.

8. Duration and Revocation: It is my understanding and intention that unless I revoke this proxy and directive, it will remain in effect indefinitely. My signature on this document shall be deemed to constitute a revocation of any prior health care proxy, directive or other similar document I may have executed prior to today's date.

My Signature

Signature:

_____

(If you are not physically capable of signing, please ask another person to sign your name on your behalf.)

Print Name:

_____

Date:

_____

Address:

_____

Telephone: Day: _____ Evening: _____

Cell: _____ Pager/beeper: _____

DECLARATION OF WITNESSES

I, on this _____ day of _____, 200__, 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/She signed (or asked another to sign for him/her) this document in my presence (and that person signed in my presence). I am not the person appointed as agent by this document.

Witnesses

Witness 1:

_____

Print Name:

_____

Residing at:

_____

Witness 2:

_____

Print Name:

_____

Residing at:

_____

Developed and published by: Agudath Israel of America • 42 Broadway, 14th Floor • New York, NY 10004 • 212-797-9000

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State of New York
Department of Health

Nonhospital Order Not to Resuscitate
(DNR Order)

Person's Name_____

Date of Birth __ / __ / __

Do not resuscitate the person named above.

Physician's Signature_____

Print Name _____

License Number _____

Date __ / __ / __

It is the responsibility of the physician to determine, at least every 90 days, whether this order continues to be appropriate, and to indicate this by a note in the person's medical chart. The issuance of a new form is NOT required, and under the law this order should be considered valid unless it is known that it has been revoked. This order remains valid and must be followed, even if it has not been reviewed within the 90-day period.

DOH-3474 (04/09)

MEDICAL ORDERS FOR LIFE SUSTAINING TREATMENT (MOLST)

On July 8, 2008 Governor Paterson signed into law new legislation making permanent and statewide a pilot program called Medical Orders for Life Sustaining Treatment (MOLST). These forms are approved for use in both healthcare facilities and for community use. A copy of the MOLST forms can be found in the appendix, attached.

What is MOLST?

MOLST is a form for Medical Orders for Life Sustaining Treatment. It is filled out by the patient (or proxy) and medical personnel and signed by a physician. The MOLST forms offer an opportunity for patients to discuss their end of life wishes with a health care professional and then to have those preferences turned into Medical Orders that can be followed across the health care delivery system. It is recommended that the MOLST forms be copied onto bright pink paper making them clearly visibly to medical personnel including EMS workers.

Who may complete a MOLST form?

MOLST forms are intended for patients with serious health conditions. This form is not intended for minors or those patients with Developmental Disabilities who lack health care decision making capacity.

It is recommended that physicians discuss the MOLST form with patients who: want to avoid or receive life sustaining treatment; patients who reside in a long term care facility or who are receiving long term care services; or, patients who might die within the next year.

How is a MOLST form completed?

Only a qualified health care professional may complete or change the MOLST form. The form must be completed based on the patient's current medical conditions, values and wishes in accordance with MOLST instructions. Only a licensed physician can sign the orders.

What does the MOLST form look like?

A copy of the MOLST form is in the appendix. It is recommended that the form be printed on bright pink heavy cardstock. White forms and photocopies of the original, signed version are legal and valid.

How is the MOLST different from a DNR?

MOLST forms may be used statewide as an alternative to both hospital and non hospital DNRs and/or DNIs. EMS workers must still honor a standard 1 page non hospital DNR or bracelet.

What if the patient lacks capacity?

At this time minor patients and patients with developmental disabilities who lack medical decision making capacity or their surrogates cannot fill out the MOLST forms. However other adult patients, including those without decision making capacity can have a MOLST form. An individual designated in an existing health care proxy or an individual appointed pursuant to the Family Health Care Decision Making Act may complete the form on the incapacitated individual's behalf.

How is the MOLST different than other advanced directives?

The MOLST form does not replace any existing health care proxies or living wills filled out by the patient. Section D of the form asks if any of these forms exist. The MOLST form reinforces patient wishes by turning those wishes into medical orders.

What happens if a patient with a MOLST form is transferred?

The MOLST forms are transferable and should go with the patient. Any specific medical orders in their record, including a DNR or other information on life sustaining treatment can be transcribed directly into the MOLST forms.

NEW YORK STATE DEPARTMENT OF HEALTH

Medical Orders for Life-Sustaining Treatment (MOLST)

THE PATIENT KEEPS THE ORIGINAL MOLST FORM DURING TRAVEL TO DIFFERENT CARE SETTINGS. THE PHYSICIAN KEEPS A COPY.

LAST NAME/FIRST NAME/MIDDLE INITIAL OF PATIENT

ADDRESS

CITY/STATE/ZIP

DATE OF BIRTH (MM/DD/YYYY) ☐ Male ☐ Female

eMOLST NUMBER **(THIS IS NOT AN eMOLST FORM)**

Do-Not-Resuscitate (DNR) and Other Life-Sustaining Treatment (LST)

This is a medical order form that tells others the patient's wishes for life-sustaining treatment. A health care professional must complete or change the MOLST form, based on the patient's current medical condition, values, wishes and MOLST Instructions. If the patient is unable to make medical decisions, the orders should reflect patient wishes, as best understood by the health care agent or surrogate. A physician must sign the MOLST form. All health care professionals must follow these medical orders as the patient moves from one location to another, unless a physician examines the patient, reviews the orders and changes them.

MOLST is generally for patients with serious health conditions. The patient or other decision-maker should work with the physician and consider asking the physician to fill out a MOLST form if the patient:

- Wants to avoid or receive any or all life-sustaining treatment.
- Resides in a long-term care facility or requires long-term care services.
- Might die within the next year.

If the patient has a developmental disability and does not have ability to decide, the doctor must follow special procedures and attach the appropriate legal requirements checklist.

SECTION A Resuscitation Instructions: When the Patient Has No Pulse and/or is Not Breathing

Check one:

☐ **CPR Order: Attempt Cardio-Pulmonary Resuscitation**
CPR involves artificial breathing and forceful pressure on the chest to try to restart the heart. It usually involves electric shock (defibrillation) and a plastic tube down the throat into the windpipe to assist breathing (intubation). It means that all medical treatments will be done to prolong life when the heart stops or breathing stops, including being placed on a breathing machine and being transferred to the hospital.

☐ **DNR Order: Do Not Attempt Resuscitation (Allow Natural Death)**
This means do not begin CPR, as defined above, to make the heart or breathing start again if either stops.

SECTION B Consent for Resuscitation Instructions (Section A)

The patient can make a decision about resuscitation if he or she has the ability to decide about resuscitation. If the patient does NOT have the ability to decide about resuscitation and has a health care proxy, the health care agent makes this decision. If there is no health care proxy, another person will decide, chosen from a list based on NYS law.

SIGNATURE ☐ Check if verbal consent (Leave signature line blank) DATE/TIME

PRINT NAME OF DECISION-MAKER

PRINT FIRST WITNESS NAME PRINT SECOND WITNESS NAME

Who made the decision? ☐ Patient ☐ Health Care Agent ☐ Public Health Law Surrogate ☐ Minor's Parent/Guardian ☐ §1750-b Surrogate

SECTION C Physician Signature for Sections A and B

PHYSICIAN SIGNATURE PRINT PHYSICIAN NAME DATE/TIME

PHYSICIAN LICENSE NUMBER PHYSICIAN PHONE/PAGER NUMBER

SECTION D Advance Directives

Check all advance directives known to have been completed:

☐ Health Care Proxy ☐ Living Will ☐ Organ Donation ☐ Documentation of Oral Advance Directive

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HIPAA permits disclosure of MOLST to other health care professionals & electronic registry as necessary for treatment

THE PATIENT KEEPS THE ORIGINAL MOLST FORM DURING TRAVEL TO DIFFERENT CARE SETTINGS. THE PHYSICIAN KEEPS A COPY.

LAST NAME/FIRST NAME/MIDDLE INITIAL OF PATIENT

DATE OF BIRTH (MM/DD/YYYY)

SECTION E — Orders for Other Life-Sustaining Treatment and Future Hospitalization When the Patient has a Pulse and the Patient is Breathing

Life-sustaining treatment may be ordered for a trial period to determine if there is benefit to the patient. If a life-sustaining treatment is started, but turns out not to be helpful, the treatment can be stopped.

Treatment Guidelines No matter what else is chosen, the patient will be treated with dignity and respect, and health care providers will offer comfort measures. *Check one:*

- ☐ **Comfort measures only** Comfort measures are medical care and treatment provided with the primary goal of relieving pain and other symptoms and reducing suffering. Reasonable measures will be made to offer food and fluids by mouth. Medication, turning in bed, wound care and other measures will be used to relieve pain and suffering. Oxygen, suctioning and manual treatment of airway obstruction will be used as needed for comfort.
- ☐ **Limited medical interventions** The patient will receive medication by mouth or through a vein, heart monitoring and all other necessary treatment, based on MOLST orders.
- ☐ **No limitations on medical interventions** The patient will receive all needed treatments.

Instructions for Intubation and Mechanical Ventilation *Check one:*

- ☐ **Do not intubate (DNI)** Do not place a tube down the patient's throat or connect to a breathing machine that pumps air into and out of lungs. Treatments are available for symptoms of shortness of breath, such as oxygen and morphine. (This box should ***not*** be checked if full CPR is checked in Section A.)
- ☐ **A trial period** *Check one or both:*
  - ☐ **Intubation and mechanical ventilation**
  - ☐ **Noninvasive ventilation (e.g. BIPAP), if the health care professional agrees that it is appropriate**
- ☐ **Intubation and long-term mechanical ventilation, if needed** Place a tube down the patient's throat and connect to a breathing machine as long as it is medically needed.

Future Hospitalization/Transfer *Check one:*

- ☐ **Do not send to the hospital unless pain or severe symptoms cannot be otherwise controlled.**
- ☐ **Send to the hospital, if necessary, based on MOLST orders.**

Artificially Administered Fluids and Nutrition When a patient can no longer eat or drink, liquid food or fluids can be given by a tube inserted in the stomach or fluids can be given by a small plastic tube (catheter) inserted directly into the vein. If a patient chooses not to have either a feeding tube or IV fluids, food and fluids are offered as tolerated using careful hand feeding. *Check one each for feeding tube and IV fluids:*

- ☐ **No feeding tube**
- ☐ **A trial period of feeding tube**
- ☐ **Long-term feeding tube, if needed**
- ☐ **No IV fluids**
- ☐ **A trial period of IV fluids**

Antibiotics *Check one:*

- ☐ **Do not use antibiotics.** Use other comfort measures to relieve symptoms.
- ☐ **Determine use or limitation of antibiotics when infection occurs.**
- ☐ **Use antibiotics** to treat infections, if medically indicated.

Other Instructions about starting or stopping treatments discussed with the doctor or about other treatments not listed above (dialysis, transfusions, etc.).

Consent for Life-Sustaining Treatment Orders (Section E) (Same as Section B, which is the consent for Section A)

SIGNATURE ☐ Check if verbal consent (Leave signature line blank) DATE/TIME

PRINT NAME OF DECISION-MAKER

PRINT FIRST WITNESS NAME PRINT SECOND WITNESS NAME

Who made the decision? ☐ Patient ☐ Health Care Agent ☐ Based on clear and convincing evidence of patient's wishes ☐ Public Health Law Surrogate ☐ Minor's Parent/Guardian ☐ §1750-b Surrogate

Physician Signature for Section E

PHYSICIAN SIGNATURE PRINT PHYSICIAN NAME DATE/TIME

This MOLST form has been approved by the NYSDOH for use in all settings.

THE PATIENT KEEPS THE ORIGINAL MOLST FORM DURING TRAVEL TO DIFFERENT CARE SETTINGS. THE PHYSICIAN KEEPS A COPY.

LAST NAME/FIRST NAME/MIDDLE INITIAL OF PATIENT ____________________ DATE OF BIRTH (MM/DD/YYYY) ____________

SECTION F Review and Renewal of MOLST Orders on This MOLST Form

The physician must review the form from time to time as the law requires, and also:

- If the patient moves from one location to another to receive care; or
- If the patient has a major change in health status (for better or worse); or
- If the patient or other decision-maker changes his or her mind about treatment.

Date/Time	Reviewer's Name and Signature	Location of Review (e.g., Hospital, NH, Physician's Office)	Outcome of Review
			☐ No change ☐ Form voided, new form completed ☐ Form voided, ***no*** new form
			☐ No change ☐ Form voided, new form completed ☐ Form voided, ***no*** new form
			☐ No change ☐ Form voided, new form completed ☐ Form voided, ***no*** new form
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			☐ No change ☐ Form voided, new form completed ☐ Form voided, ***no*** new form
			☐ No change ☐ Form voided, new form completed ☐ Form voided, ***no*** new form

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THE PATIENT KEEPS THE ORIGINAL MOLST FORM DURING TRAVEL TO DIFFERENT CARE SETTINGS. THE PHYSICIAN KEEPS A COPY.

LAST NAME/FIRST NAME/MIDDLE INITIAL OF PATIENT ______________________ DATE OF BIRTH (MM/DD/YYYY) ______________

SECTION F | Review and Renewal of MOLST Orders on This MOLST Form *Continued from Page 2*

Date/Time	Reviewer's Name and Signature	Location of Review (e.g., Hospital, NH, Physician's Office)	Outcome of Review
			☐ No change ☐ Form voided, new form completed ☐ Form voided, ***no*** new form
			☐ No change ☐ Form voided, new form completed ☐ Form voided, ***no*** new form
			☐ No change ☐ Form voided, new form completed ☐ Form voided, ***no*** new form
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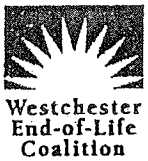

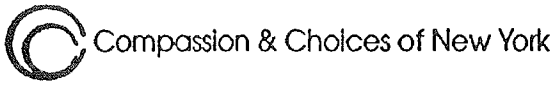

Family Health Care Decisions Act Summary

The Family Health Care Decisions Act establishes the authority of a patient's family member or close friend to make health care decisions for the patient in cases where a patient lacks decisional capacity and did not leave prior instructions or appoint a health care agent. The family member or close friend's decision making authority includes the authority to direct the withdrawal or withholding of life-sustaining treatment when standards set forth in the statute are satisfied.

Until this law became effective in June, 2010, in general, unless there was a health care agent appointed pursuant to a completed health care proxy form, there was no legal basis for a family member or friend to make health or end-of-life decisions on behalf of the patient who lacked decision making capacity. Instead, decisions to withdraw or withhold treatment could be made only where there was "clear and convincing evidence" of the patient's wish to refuse such treatment. Moreover, when a patient lacked capacity, family members lacked clear authority even to consent to beneficial, desired treatment. While health care providers routinely, and out of necessity, accepted treatment consent from a family member or close friend for beneficial treatment, there was only thin legal support for that practice.

Summary of Key Provisions of the FHCDA

1. Applicability

☐ Applies to decisions in general hospitals, residential health care facilities and hospices.

☐ Does not apply to decisions for patients:
– who have a health care agent or who have left prior treatment instructions.
– who have a court-appointed guardian pursuant to Section 1750-a of the Surrogate's Court Procedure Act (SCPA) or for whom decisions are governed by Section 1750-b of the SPCA.
– for whom decisions about life-sustaining treatment may be made pursuant to OMH or OPWDD surrogate decision making regulations.

2. Determining Incapacity

☐ Sets forth a hospital-based process to determine that a patient lacks decisional capacity. In general, the process requires an initial determination by the attending physician, and may require a concurring determination by a "health or social services practitioner," a broader category of professionals.

☐ Requires special credentials for professionals when determining that the patient lacks capacity as a result of mental retardation or mental illness.

☐ Provides that if the patient objects to the determination of incapacity, or to the choice of a surrogate, or to a surrogate's decisions, the patient's decisions prevails unless a court finds that the patient lacks capacity, or another legal basis exists for overriding the patient's decision.

3. Decisions for Patients who Lack Capacity

• Sets forth, in order of priority, the persons who may act as a surrogate decision maker for the incapable patient, i.e.:

- an MHL Article 81 court-appointed guardian (if there is one);
- the spouse or domestic partner
- an adult son or daughter
- a parent
- a brother or sister
- a close friend (who could be another relative)

☐ Grants the surrogate the right to receive medical information and medical records necessary to make informed decisions about the patient's health care, including diagnosis, prognosis and risks and benefits of alternative treatment options.

☐ Grants the surrogate authority to make all health care decisions for the patient that the adult patient could make for himself or herself, subject to certain standards and limitations.

☐ States that health care providers do not need a surrogate's consent for a health care decision if the patient previously made the decision, either orally or in writing.

☐ Requires the surrogate to decide about treatment based on the patient's wishes, including the patient's religious and moral beliefs, or, if the patient's wishes are not reasonably known and cannot with reasonable diligence be ascertained, based on the best interests.

☐ Authorizes decisions to withhold or withdraw life-sustaining treatment if treatment would be an extraordinary burden to the patient and the patient is terminally ill or permanently unconscious, or if the patient has an irreversible or incurable condition and the treatment would involve such pain, suffering or other burden that it would reasonably be deemed inhumane or an extraordinary burden under the circumstances. Certain such decisions require ethics committee review.

☐ Authorizes the parent or guardian of a minor patient to decide about life-sustaining treatment, in accord with the same standards that apply to surrogate decisions for adults. In addition, if a minor has the capacity to decide about life-sustaining treatment, the minor's consent is required to withhold or to stop treatment.

☐ Establishes a procedure for making health care decisions, other than life-sustaining treatment decisions, for adult patients who have lost decision-making capacity and have no available family member or friend to act as a surrogate.

Medical Decisions by a Surrogate:

- The surrogate has all the powers an individual has to make their own medical decisions, including the decision to withhold or withdraw life-sustaining treatment.
- The FHCDA directs the surrogate to make decisions in accordance with the patient's wishes, including the patient's religious and moral beliefs.
- If the patient's wishes are not reasonably known and cannot be ascertained, the FHCDA directs the surrogate to make decisions in accordance with the patient's best interests.

Decisions to Withhold or Withdraw Life-Sustaining Treatment:

- Decisions to withhold or withdraw life-sustaining treatment are governed by additional standards under the FHCDA.
- A surrogate may withhold or withdraw life-sustaining treatment for an individual if that individual will die within six months with or without treatment, as determined by two independent physicians, and treatment would be an extraordinary burden to the patient.
- A surrogate may also withhold or withdraw life-sustaining treatment if the patient has an irreversible condition, as determined by two independent physicians, and treatment would involves such pain, suffering, or other burden that it would be inhumane or extraordinarily burdensome to provide treatment under the circumstances.
- Decisions to withhold or withdraw life-sustaining treatment for minors are made by the minor's parents.

Medical Decisions for Individuals Without a Surrogate:

- The FHCDA authorizes the attending physician to act as surrogate for routine medical treatment.
- For major medical treatment, a physician may act only upon the concurrence of another physician that such major medical treatment is necessary.
- A physician may withhold or withdraw life-sustaining treatment for individuals without a surrogate only upon

the independent concurrence of another physician that life-sustaining treatment offers no medical benefit to the patient because the patient will die imminently and the provision of life-sustaining treatment would violate accepted medical standards.

Individuals with Mental Retardation/Developmental Disability:

- Under the FHCDA, individuals with mental retardation or developmental disabilities are within the class of individuals for whom health care surrogates may be appointed.

The Family Healthcare Decisions Act will give New Yorkers peace of mind by allowing all parents, all guardians, all partners and all families the ability to make important medical decisions. This law establishes a standard of care for incapacitated persons which has been long overdue.

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August 24, 2010

PERSONAL HEALTH; Frank Talk About Care At Life's End

By JANE E. BRODY

Legislators have begun to recognize the medical, humanitarian and economic value of helping terminally ill patients and their families navigate treatment options as they approach the end of life.

Last week, over the objections of New York State's medical society, Gov. David A. Paterson signed into law a bill -- the New York Palliative Care Information Act -- requiring physicians who treat patients with a terminal illness or condition to offer them or their representatives information about prognosis and options for end-of-life care, including aggressive pain management and hospice care as well as the possibilities for further life-sustaining treatment.

The Medical Society of the State of New York objected, saying that the new law would intrude "unnecessarily upon the physician-patient relationship" and mandate "a legislatively designed standard of care."

A similar provision in the original federal health care overhaul proposal, which would have reimbursed doctors for the time it takes to have such conversations, was withdrawn when it was erroneously labeled by conservatives as a "death panel" option.

Also last week, a study in The New England Journal of Medicine reported that among 151 patients with newly diagnosed metastatic lung cancer, those who received palliative care, which is care focused on symptoms, along with standard cancer therapy had a better quality of life, experienced less depression, were less likely to receive aggressive end-of-life care and lived nearly three months longer than those who received cancer treatment alone.

The New York law was sponsored by Assemblyman Richard N. Gottfried and Senator Thomas K. Duane, both Democrats of Manhattan, at the request of Compassion and Choices of New York, an organization that seeks to improve end-of-life comfort care and reduce the agony often associated with dying in this era of costly can-do medicine.

The organization said the law addresses "a major concern for terminally ill patients and their families, who often face the most important decision of their lives -- how to live their final days -- without being informed of their legal rights and medical options." The law obligates health

care providers to volunteer information on a complete menu of care options -- if patients want to know about the options.

Tough Conversations

While some patients, especially those who are young or are the parents of young children, choose to pursue aggressive treatment for their diseases until their dying days, studies have shown that most terminally ill patients opt for comfort care after receiving honest information about their survival prospects and the benefits and risks of further disease-directed therapy.

For example, in a study published in the Journal of the American Medical Association in October 2008, Boston researchers found that patients who had end-of-life discussions with their physicians "were more likely to accept that their illness was terminal, prefer medical treatment focused on relieving pain and discomfort over life-extending therapies, and have completed a do-not-resuscitate order."

When compared with patients who had no such discussion, they were also more likely to be enrolled in outpatient hospice for more than a week and less likely to be placed on mechanical ventilators, or to be resuscitated if their hearts stopped, or to be admitted to intensive care units.

Contrary to fears that such discussions cause emotional harm to patients, the researchers reported that there was no increase in serious depression or worry and that the worst psychological distress occurred in patients and family members when end-of-life talks had not taken place. The poorest quality of life and worst bereavement adjustment resulted when patients received aggressive care during the last week of life, the researchers found.

The team, led by Dr. Alexi A. Wright, a palliative care specialist at the Dana-Farber Cancer Institute, concluded that there was "a need to increase the frequency" of end-of-life conversations.The new law in New York, like a similar one in California, seeks to overcome physician resistance to talking frankly with terminally ill patients. Many studies have shown that such discussions can reduce costly aggressive yet futile treatments, improve the quality of remaining life for patients and their families and result in more dignified deaths unencumbered by medical technology.In a study published last year in the Archives of Internal Medicine, terminally ill patients who talked about hospice with their doctors were nearly three times as likely to take advantage of this service, which is covered by Medicare and is far less costly than aggressive hospital-based care.

More Yet to Be Done

Still, according to one palliative care expert, the law is not enough. Dr. Diane E. Meier, director of the Hertzberg Palliative Care Institute at Mount Sinai School of Medicine in New York, said in an interview that the law does not help doctors and nurses acquire the expertise they need to hold meaningful end-of-life discussions with their patients. To increase competency in palliative

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care, she said, courses in medical and nursing schools and a continuing-education requirement for practicing physicians are essential.

"Doctors need to know how to identify when patients are on the decline, be able to initiate conversations with patients and/or family members, discuss what to expect in the future and the pros and cons of alternative care options, and know how to provide support as a patient's illness progresses," Dr. Meier said.

Another problem is the admittedly poor ability of physicians to determine a patient's remaining life expectancy, except perhaps when death is but a week or two away. Even with advanced cancer, when death may be most predictable, doctors are often wrong either because the disease follows an unexpected course or because doctors are reluctant to acknowledge their inability to delay death.

For any number of diseases that are considered terminal, like Alzheimer's disease or emphysema, patients can survive many years. Dr. Meier maintains that all patients, regardless of how near or far death may be, should be told about and receive palliative care whether or not they are treated for their underlying disease.

In an editorial accompanying the new report in The New England Journal of Medicine, Dr. Meier and Dr. Amy S. Kelley wrote, "Physicians tend to perceive palliative care as the alternative to life-prolonging or curative care -- what we do when there is nothing more that we can do -- rather than as a simultaneously delivered adjunct to disease-focused treatment."

Palliative care should not be limited to terminally ill patients, Dr. Meier insists. "Life-threatening illness, whether it can be cured or controlled, carries with it significant burdens of suffering for patients and their families and this suffering can be effectively addressed by modern palliative care teams. Perhaps unsurprisingly, reducing patients' misery may help them live longer."

PHOTO (PHOTOGRAPH BY GETTY IMAGES) (D7)

APPOINTMENT OF AGENT TO CONTROL DISPOSITION OF REMAINS

I, _____, being of sound mind, willfully and voluntarily make known my desire that, upon my death, the disposition of my remains shall be controlled by _____.
With respect to that subject only, I hereby appoint such person as my agent with respect to the disposition of my remains.

SPECIAL DIRECTIONS:
Set forth below are my special directions limiting the power granted to my agent as well as any instructions or wishes desired to be followed in the disposition of my remains:

_____

_____

Indicate below if you have entered into a pre-funded pre-need funeral agreement subject to §453 of the General Business Law for funeral merchandise or service in advance of need:

{_} No, I have not entered into a pre-funded pre-need agreement subject to section four hundred fifty-three of the General Business Law.

{_} Yes, I have entered into a pre-funded pre-need agreement subject to section four hundred fifty-three of the General Business Law.

_____
(Name of funeral firm with which you entered into a pre-funded pre-need funeral agreement to provide merchandise and/or services)

AGENT:
Name:_____
Address:_____
Telephone Number: _____

SUCCESSORS:
If my agent dies, resigns, or is unable to act, I hereby appoint the following persons (each to act alone and successively, in the order named) to serve as my agent to control the disposition of my remains as authorized by this document:

First Successor:
Name:_____
Address:_____
Telephone Number: _____

Second Successor:
Name:_____
Address:_____
Telephone Number: _____

DURATION
This appointment becomes effective upon my death.

PRIOR APPOINTMENT REVOKED:
I hereby revoke any prior appointment of any person to control the disposition of my remains.

Signed this _____ day of _____, ____

_____
(Signature of person making appointment)

Statement by witness (must be 18 or older)
I declare that the person who executed this document is personally known to me and appears to be of sound mind and acting of his or her free will. He or she signed (or asked another to sign for him or her) this document in my presence.

Witness 1:_____
(Signature)
Address:_____
_____

Witness 2:_____
(Signature)
Address:_____
_____

ACCEPTANCE AND ASSUMPTION BY AGENT

1. I have no reason to believe that there have been any revocations of this appointment to control disposition of remains.
2. I hereby accept this appointment.

Signed this _____day of _____, _____

_____
(Signature of agent)

Volunteers of Legal Service, Inc.

PPOSSIBLE ASSISTANCE WITH WILL PREPARATION

FROM: WWW.LAWHELP.ORG/NY

AGENCY	FINANCIAL CRITERIA	RESTRICTIONS	AREAS SERVED
AIDS Center of Queens (718) 896-2500		HIV-positive	Queens residents
BedStuy Legal Services (718) 636-1155	Up to 125% of poverty level		Brooklyn -Zip Codes Served;11213/16/21/25/ 33
Bronx AIDS Services, Inc. (718) 295-5598		HIV-positive	Bronx residents
Brooklyn Bar Association, Volunteer Lawyers Project (718) 624-3894	Up to 125% of poverty level		Brooklyn residents
Cardozo Bet Tzedek Legal Service (212) 790-0240		60+ or disabled	Manhattan residents
City Bar Justice Center, Cancer Advocacy Project (212) 382-4785	Call for info	Must have cancer, a survivor, or caregiver.	All 5 boroughs
City Bar Justice Center ElderLaw Project (212) 382-6658	Up to 200% of poverty level.	60+	All 5 boroughs. Will do home visits.
CUNY Elder Law Clinic (Main Street Legal Services) (718) 340-4300	Up to 150% of poverty level	60+ (August to September)	Queens residents
DC 37 Municipal Employees' Legal Services (MELS) (212) 815-1111	Must be a DC 37 member or retiree		All 5 boroughs
FACES NY (212) 283-9180		HIV positive	All 5 boroughs
Family Center, Inc. (212) 766-4522	Must be ill parent with minor child or caring for minor child	Also serves families coping with HIV/AIDS	All 5 boroughs
Family Circle of Support (Council on Adoptable Children - AIDS Orphans Adoption Program) (212) 475-0222		HIV-positive	All 5 boroughs
Gay Men's Health Crisis Legal Department (212) 367-1134		HIV-positive	All 5 boroughs
HIV Law Project, Inc. (212) 577-3001	Up to 125% of poverty level	HIV-positive or related to one who is	Bronx or Manhattan residents
Legal Action Center & City of New York HIV Legal Services (212) 243-1313		HIV positive or related to someone who is	All 5 boroughs
The Legal Aid Society: Bronx (718) 991-4400	Up to 125% of poverty level		Bronx residents

The Legal Aid Society: Brooklyn (718) 852-8888	Up to 125% of poverty level		Brooklyn residents Zipcodes: 11203 / 04 / 11/ 13/ 19/ 35
The Legal Aid Society: Brooklyn AIDS Office (718) 722-3100	Up to 125% of poverty level	HIV positive	Brooklyn residents
The Legal Aid Society: Brooklyn Office for the Aging (718) 645-3111	Assets under $20,000 excluding the primary residence	60+	Brooklyn residents
The Legal Aid Society: Harlem Office (212) 426-3000	Up to 125% of poverty level		Manhattan: East Side above 96th St; West Side above 110th St
The Legal Aid Society: Queens (718) 286-2450			Queens residents
Legal Services for the Elderly in Queens [JASA] (718) 286-1500		60+	Queens residents
Lenox Hill Neighborhood House (212) 744-5022 xtn 1392	Up to 200% of poverty level	60+	Manhattan-East Side between 59th & 96th Street & Roosevelt Island
LSNY-Bronx (718) 928-3700	Up to 125 % of poverty level	60+	Bronx residents
Manhattan Legal Services HIV/AIDS Project (646) 442-3100	Up to 200% of poverty level	HIV positive or related to someone who is	Manhattan residents
New York Legal Assistance Group (NYLAG) (212) 613-5000	Assets under $40,000 ($60,000 for couples), excluding residence.		All 5 boroughs
NYC Dept. for Aging (212) 442-1100		60+ Referrals to other agencies only	All 5 boroughs
Project Hospitality (718) 720-8172		HIV positive	Staten Island residents
South Brooklyn HIV Project (718) 237-5546	Up to 125% of poverty level	HIV positive or related to someone who is	Brooklyn residents
Queens Legal Services HIV/AIDS Advocacy Project (347) 592-2177		HIV positive or related to someone who is	Queens residents
Volunteers of Legal Services (212) 966-4400	Fixed income.	60+	Manhattan only (all referrals must come from a social worker or VOLS walk-in legal clinic)

LIFE-TIME PLANNING DOCUMENTS

HOW MANY & WHAT TO DO WITH THEM

LAST WILL & TESTAMENT- One original & as many copies as the client desires.
-Preparer should keep a copy.

POWER OF ATTORNEY- One original for each agent & back-up agent.
-Preparer should keep a copy.

HEALTH CARE PROXY- One original for each agent. Also 8 copies to the client for the following distribution:
-One copy on the client's refrigerator with a magnet (this is for the EMT's if they come).
-One copy for each of the client's main physicians to be placed in their file.
-One copy for the social worker.
-Preparer should keep a copy.

LIVING WILL- The same number of copies and distribution as the Health Care Proxy.

CONTROL OF THE BODY FORM- One original for each agent.
-One copy for the client.
-One copy for the social worker.
-Preparer should keep a copy.