TOTAL LIFE CHOICES

Advance Directives Project

FORMS PACKET

Including:

- New York Health Care Proxy
- New York Living Will
- U.S. Living Will Registry® Online Registration
- Frequently Asked Questions

NYLAG
NEW YORK
LEGAL ASSISTANCE GROUP

The Jewish Healing and Hospice Alliance
an initiative of UJA Federation of New York

NYLAG
NEW YORK

Total Life Choices

A Project of

The New York Legal Assistance Group
450 W. 33rd Street, 11th Floor
New York, New York 10001

Phone: 212.371.6873
Fax: 212.750.0820
E-mail: tlc@nylag.org
Website: www.nylag.org

How to Register

To submit advance directives for registration, you or your social service provider may send the documents along with the U.S. Living Will Registration Form by either of the following methods:

- FAX to **212.750.0820**
- Mail to:

  Total Life Choices
  New York Legal Assistance Group
  450 W. 33rd Street, 11th Floor
  New York, New York 10001

*Additional advance directive forms and registration materials can be obtained online at **www.nylag.org** or by calling **212.371.6873**.*

TOTAL LIFE CHOICES

ADVANCE DIRECTIVES FORMS PACKET

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New York State Health Care Proxy: Instructions

Appointing Your Health Care Agent in New York State

Item (1)
Write the name, home address and telephone number of the person you are selecting as your agent. You may not choose your attending doctor to serve as your health care proxy unless he/she is related to you by blood, marriage or adoption. You may also not choose an employee of a hospital if you are a patient or resident of such hospital.

Item (2)
If you want to appoint an alternate agent, write the name, home address and telephone number of the person you are selecting as your alternate agent.

Item (3)
Your Health Care Proxy will remain valid indefinitely unless you set an expiration date or condition for its expiration. This section is optional and should be filled in only if you want your Health Care Proxy to expire.

Item (4)
If you have special instructions for your agent, write them here. Also, if you wish to limit your agent's authority in any way, you may say so here or discuss them with your health care agent. If you do not state any limitations, your agent will be allowed to make all health care decisions that you could have made, including the decision to consent to or refuse life-sustaining treatment. However, an alternative to listing specific instructions as exampled below would be to complete a Living Will, which would guide your health care agent in making decisions.

If you wish to give your agent authority over artificial nutrition and hydration, you must tell this to him/her, or preferably state it in writing on this form. Simply write:

I have discussed my wishes with my health care agent and alternate and they know my wishes including those about artificial nutrition and hydration.

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

If I become terminally ill, I do/don't want to receive the following types of treatments....
If I am in a coma or have little conscious understanding, with no hope of recovery, then I do/don't want the following types of treatments:....
If I have brain damage or a brain disease that makes me unable to recognize people or speak and there is no hope that my condition will improve, I do/don't want the following types of treatments:....
I have discussed with my agent my wishes about_____ and I want my agent to make all decisions about these measures.

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

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

Item (5)
This paragraph authorizes your health care agent to act as your representative in respect to the Health Insurance Portability and Accountability Act (HIPAA), authorizing your agent to obtain all medical records and information about you.

Item (6)
You must date and sign this Health Care Proxy form. If you are unable to sign yourself, you may direct someone else to sign in your presence. Be sure your address is included.

Item (7)
Two witnesses 18 years of age or older must sign this Health Care Proxy form. The witnesses are only required to witness the registrant's signing of the document and do not have to read/review the document itself. Be sure both witnesses write the date, print and sign their names and include their addresses. If you have appointed a person to be your health care agent or alternate agent, s/he cannot sign as a witness.

New York Health Care Proxy

(1) I, _____

hereby appoint _____
(*name, home address and telephone number*)

_____

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

(2) Optional: Alternate Agent
If the person I appoint is unable, unwilling or unavailable to act as my health care agent, I hereby appoint

_____
(name, home address and telephone number)

_____

_____

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

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

_____

_____

(4) 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*):

_____

_____

_____

_____

Please note that 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 the above 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) I also grant authority and power to my agent(s) to serve as my personal representative for purposes of the Health Insurance Portability and Accountability Act (HIPAA). My agent is authorized to execute any and all releases and other documents necessary in order to obtain disclosure of my patient records and other medical information subject to and protected by HIPAA.

(6) Your Identification ***(please print)***

Name _____

Signature _____ Date _____

Address_____

(7) Witnesses: Two 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 appeared to execute the Health Care Proxy 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:	***Witness 2:***
Signature:_____	Signature: _____
Print Name: _____	Print Name: _____
Address: _____	Address: _____
Tel. No.: _____	Tel. No.: _____

Optional: Organ and/or Tissue Donation

You may state wishes or instructions about organ and/or tissue donation on this form. A health care agent cannot make a decision about organ and/or tissue donation because the agent's authority ends upon your death. The law does provide for certain individuals in order of priority to consent to an organ and/or tissue donation on your behalf: your spouse, a son or daughter 18 years of age or older, either of your parents, a brother or sister 18 years of age or older, a guardian appointed by a court prior to the donor's death, or any other legally authorized person.

I hereby make an anatomical gift, to be effective upon my death, of (*write your initials next to the statement of your choice*):

☐ Any organs and/or tissues

☐ The following organs and/or tissues:

_____

_____

☐ Limitations:

_____

_____

If you do not state your wishes or instructions regarding organ and/or tissue donation on this form, it will not 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.

Signed _____ Date: _____

Address: _____

New York Living Will: Description and Instructions

(NYLAG General and Specific Versions)

What is the purpose of a Living Will?

When a person is in the final stages of life, or is in an incurable or irreversible mental or physical condition with no chance of recovery, the medical community, under most circumstances, will make every reasonable effort to prolong or save the life of that person.

Some persons, however, would prefer that some or all of these medical efforts not be made during this critical and difficult period - and New York law permits you to make that choice. A Living Will enables you, at a time when you are still able to think about this important decision, to make your wishes clearly known. Once you become unconscious or unable to communicate, you lose this opportunity and the matter is left to doctors and hospital staff, who may feel obliged to continue life saving procedures.

A Living Will is a legally recognized means of stating exactly what kind of medical treatment you want and do not want in the final stages of your life.

NYLAG offers you a choice of Living Wills, depending on how you want to state your preferences about end of life medical treatment.

These living wills, which we have named a **General** Living Will and a **Specific** Living Will, are very similar in overall content. The **General** Living Will is a person's statement that, in the final stages of life, he or she does not want any life saving efforts to be made but that maximum pain relief should be provided. The **Specific** Living Will permits a person to specifically choose those life sustaining procedures he or she does not want administered or maintained in the final stages of life. By not initialing a box in the **Specific** Living Will you will be indicating you want that particular procedure to be administered.

The listing of medical procedures in each living will is not intended to be all-inclusive. New procedures are being developed every day. The purpose of the listing is to inform your health care team of the general type of life saving efforts you do not want administered. Both living wills also provide space for giving additional instructions that may relate to your specific medical condition.

In all cases, it is advisable to speak to a medical professional about your desires at the end of life.

How Does NYLAG's Living Will Form Operate?

First: The living will is a clear and explicit statement of your medical wishes, signed by you before two witnesses.

Second: The living will operates only if you are permanently unable to participate in decisions regarding your medical care. Further, the will comes into effect only in certain circumstances – specifically, the

treatment would only prolong your dying and you are 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 you are permanently unable to make decisions or express your wishes**.

Third: The living will also has a section captioned "Other Directions", where you can add any further instructions about your medical care during this end of life time.

How do I complete a Living Will?

Type or print your name at the top of the living will. If you are signing a **General** Living Will, you can add any further instructions about your care in the area captioned 'Other directions'. You should then sign and date the living will in the space indicated, before two witnesses, and print your address below your signature. The witnesses should then sign in the space indicated and their names and addresses printed below. Note that your health care agent, if you have one, cannot be a witness to the will.

If you choose to sign a **Specific** Living Will the procedures are the same as for a **General** Living Will except for one important difference. You must initial the treatment choice boxes that you want withheld. If you also want the option to receive maximum pain relief, even if it may hasten your demise, you should initial that choice as well. Any choice box that is not initialed will result in the administration of that particular treatment if the terms of the **Specific** Living Will become effective as a result of your incapacity.

If you have any questions about your Living Will you should ask your medical advisor or a NYLAG representative.

New York Living Will

(NYLAG General Form)

This is an important legal document. Read it carefully and talk about it with your doctor and family. It directs the medical treatment you are to receive in the event you are unable to participate in your own medical decisions and are terminally ill, in a permanently unconscious condition, or in a minimally conscious condition in which you are permanently unable to make decisions or express your wishes.

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 Cardiopulmonary Resuscitation (CPR), and I want my health care provider to issue a Do Not Resuscitate (DNR) order (an order written in my medical records that CPR is not to be administered to me).
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_____

Witnesses: Two 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 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:	***Witness 2:***
Signature: _____	Signature: _____
Print Name: _____	Print Name: _____
Address: _____	Address: _____
Tel. No.: _____	Tel. No.: _____

New York Living Will

(NYLAG Specific Form)

This is an important legal document. Read it carefully and talk about it with your doctor and family. It directs the medical treatment you are to receive in the event you are unable to participate in your own medical decisions and are terminally ill, in a permanently unconscious condition, or in a minimally conscious condition in which you are permanently unable to make decisions or express your wishes.

I, _____, being of sound mind, make this statement as a directive to be followed if I become unable to make my own health care decisions, as determined by the physician who has primary responsibility for my care. These instructions reflect my firm and settled commitment to decline medical treatment under the circumstances indicated below.

Health Care:
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, it is my wish that the following directions be followed by my health care provider.

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:**

WRITE YOUR INITIALS NEXT TO ANY STATEMENT WITH WHICH YOU AGREE:

☐ I do not want Cardiopulmonary Resuscitation (CPR), and I want my health care provider to issue a Do Not Resuscitate (DNR) order (an order written in my medical records that CPR is not to be administered to me).

☐ I do not want mechanical respiration.

☐ I do not want artificial nutrition and/or hydration (provision of foods and fluids through tubes).

☐ I do not want antibiotics.

☐ I do not want any other painful or invasive treatment that will result in prolonging my life.

☐ I want maximum pain relief, even if it may hasten my demise.

Other Instructions or Comments about My Care:

_____

_____

_____

_____

_____

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_____

Witnesses: Two 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 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:	***Witness 2:***
Signature: _____	Signature: _____
Print Name: _____	Print Name: _____
Address: _____	Address: _____
Tel. No.: _____	Tel. No.: _____

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NEW YORK
LEGAL ASSISTANCE GROUP

U.S. Living Will Registry: Description and Instructions

What is the U.S. Living Will Registry?

The mission of the U.S. Living Will Registry is to promote the use of advance directives through educational programs, and to make people's health care choices available to their caregivers and families whenever and wherever they are needed, while maintaining the confidentiality of their information and documents.

Founded in 1996, the U.S. Living Will Registry is a privately held organization that electronically stores advance directives, organ donor information and emergency contact information, and makes them available to health care providers across the country 24 hours a day through an automated system. The policies and procedures of the U.S. Living Will Registry were developed in consultation with attorneys who represent hospitals. All health care providers have access to the documents and information, and privacy and confidentiality are always maintained. In a written agreement with each registrant, the U.S. Living Will Registry agrees not to release their documents or information to any party other than health care providers (hospitals, doctors, skilled nursing facilities, nursing facilities, home health agencies, providers of home health care, ambulatory surgery facilities, and hospices).

Why should I register with the U.S. Living Will Registry?

- Completely free, lifetime registration of your advance directives in secure online registry.
- Confidential, 24-hour access to your advance directives by health care providers across the country.
- Easy modification of your documents if you wish to change your directives.
- Receive annual update letters to confirm that your information is current and up-to-date.
- Peace of mind in knowing that your choices are secure and will be available to your family and doctors even if you become ill away from home.

How to Register:

Once you have completed your advance directives and a U.S. Living Will Registration Form, you or a TLC partner can submit your documents for registration. A TLC attorney will then review your completed advance directives and have them stored in the online registry.

To submit advance directives for registration, you may send the documents along with the U.S. Living Will Registration Form by either of the following methods:

FAX to 212.750.0820

Mail to:

Total Life Choices
New York Legal Assistance Group
450 W. 33rd Street, 11th Floor
New York, New York 10001

U.S. Living Will Registry®
Registration Agreement

Source Code
37125901

Registrant's Identifying Information (Please type or print clearly)

Name: First_____ Middle_____Last _____ Suffix _____

Social Security Number:_____ _____ _____Date of Birth: Month ___Day____Year_____(4 digits, please)

Address - Primary Residence: Street Address _____ Apt #_____

City _____ State _____ Zip Code _____

Secondary Residence (if any): Street Address_____Apt #_____

City _____ State_____ Zip Code _____

Phone- Home: ( )_____ Work: ( )_____Secondary Res: ( )_____

Emergency Contact #1: Name:_____Relationship:_____

Address:_____

Telephone Number: Home: ( )_____Work/Other: ( )_____

Emergency Contact #2: Name:_____Relationship:_____

Telephone Number: Home: ( )_____Work/Other: ( )_____

I,_____ ("Registrant" or "I"), request that the *U.S. Living Will Registry®*, with offices at 523 Westfield Ave., PO Box 2789 Westfield, New Jersey 07091-2789 ("Registry"), electronically store a copy of my attached advance directive (collectively, including but not limited to my: living will, health care proxy, or similar document[s], including organ donor information, provided to the Registry), and provide a copy of the stored advance directive image to any health care provider who requests it in conjunction with my care. A "health care provider" is any hospital, doctor, skilled nursing facility, nursing facility, home health care agency/provider, ambulatory surgery facility, hospice, or any authorized employee, contractor or agent of any of the foregoing, or other person believed charged with giving effect to my advance directive or assisting in same. I voluntarily execute this registration on the date set forth below, without coercion, duress or undue influence from any party, and I warrant and represent that I have the legal capacity to offer my consent to such registration. My registration is not effective until I receive written confirmation from the Registry, at the above address. I can only register through a Registry member Health Care Provider or a Registry Community Partner. The Registry's member Health Care Providers and Community Partners are not owned or operated by the Registry, and they cannot change any terms of this Registration Agreement; any oral changes are not effective. Only the Registry can change the terms of the Registration Agreement, and only in writing (except in emergencies, in the Registry's sole discretion). I have provided my Social Security number to facilitate the identification, retrieval and provision of my stored advance directive images to health care providers, and for the Registry's recordkeeping purposes only.

I. Registration and Certification: I submit the information contained herein to confirm my identity, in the event that a health care provider requests a copy of my advance directive. I certify that this information is correct and that the attached advance directive is my currently effective advance directive, which was properly executed in accordance with the laws of the state where it was executed. If the attached advance directive is a copy, I certify that it is a true and correct copy of the

original document. I agree to immediately notify the Registry, in writing, at the Registry's address listed above, in the event of my revocation of the attached advance directive or of this registration, or if the attached advance directive or the identifying information herein are changed in any way. I agree immediately to provide the Registry with a copy of the new/changed documents. I will indemnify and hold the Registry harmless for any damages resulting from the Registry's reliance on these certifications, or on any inaccurate information I supplied. If I don't notify the Registry in writing and in a timely manner of any changes, or of the revocation of my advance directive or this registration, or if I don't provide a true copy of the changed documents to the Registry, the Registry will not be liable for any damages resulting from the production of the documents on file to any health care provider. If my information is accessed over the Internet utilizing my unique registration number, my social security number ("SSN") will not be revealed, and it will not be visible or disclosed on the Registry's web page. If the card containing my unique registration number is lost or otherwise unavailable, health care providers will be able to access my documents using my SSN. Since most health care providers have access to their patients' SSN, providing your SSN to the Registry ensures the widest availability of your advance directive images to health care providers in time of need, even when your card is not available. The Registry will take appropriate steps to safeguard the privacy and confidentiality of each Registrant's SSN, and the Registry will not use SSNs for any purposes not specifically permitted by this Registration agreement. If you do not provide your SSN, your documents will be identified only by the unique registration number assigned by the Registry, which will significantly limit the accessibility of your documents.

II. Authorization: I authorize the Registry to send a copy of my advance directive to any health care provider (as defined herein) that requests a copy of it, provided the request conforms to the Registry's policies and procedures (or as deemed advisable by the Registry in an emergency situation, or as required by law). The Registry is not otherwise authorized to share my personal information with parties other than health care providers (as defined herein). A copy of this Agreement may be used in place of the original document.

III. Limitations on Liability: I understand that I will not be charged a fee to register or to maintain my registration. Registry shall not be liable to me or any person or entity for any liability arising from the improper transmission/disclosure of my advance directive, from the transmission of inaccurate or incomplete materials, or from the loss/misplacement/destruction/unavailability of all or part of my advance directive. If I don't agree to these terms, I am free not to use the Registry's service.

IV. Term: This Agreement shall remain in effect until Registry receives reliable information that the Registrant is deceased, the Registrant requests, in writing, that the Agreement be terminated, or until registration is cancelled pursuant to the Registry's policies and procedures. When the Agreement is terminated, Registry will use best efforts to remove Registrant's advance directive from its files.

I hereby agree to the terms herein, and certify the accuracy of the information provided. I agree to safeguard my Registration ID card from unauthorized access. I understand that anyone who gains access to my card can use it to gain access to my documents and personal information (but not to my SSN), and I will not hold the Registry liable for such unauthorized access.

X_____ **DATED:** _____/_____/_____

Signature of Registrant

WITNESS STATEMENT

I declare that the Registrant who signed this document is personally known to me, that he/she signed or acknowledged this document in my presence, and that he/she appears to be of sound mind, and under no duress or undue influence.

Signature: _____Print Name: _____

(Witness #1) DATED: _____/_____/_____

Signature: _____Print Name: _____

(Witness #2) DATED: _____/_____/_____

NEW YORK
LEGAL ASSISTANCE GROUP

Total Life Choices
Frequently Asked Questions

Q. What is an advance directive?
A. An advance directive is a legal document that allows a person to make their health care choices known in advance of an incapacitating illness or injury. Although laws vary from state to state in America, there are two main types of directives:

- A **living will** is a legal document in which you state the kind of health care you want or don't want in the event you become very ill and there is no reasonable hope for recovery.

- A **health care proxy** (or durable health care power of attorney) is a legal document in which you name someone close to you to make decisions about your health care in the event you become incapacitated.

Q. Why do I need an advance directive?
A. Advance directives give you a voice in decisions about your medical care when you are unconscious or too ill to communicate. As long as you are able to express your own decisions, your advance directive will not be used and you can accept or refuse any medical treatment. But if you become seriously ill, you may lose the ability to participate in decisions about your own treatment. That's when your advance directive becomes important.

Q. Should an individual have both types of advance directives?
A. Ideally, yes. You can have a health care proxy that names a health care agent and a living will to help guide the agent in making the decisions. Some individuals, however, do not have anyone to name as their agent, so s/he should complete a living will and be as specific as possible. Others prefer to have just a health care proxy and discuss their wishes with their agent. We recommend that individuals complete a health care proxy if at all possible as there is currently no surrogate decision-making under New York state law.

Whatever you decide, your advance directive should be easily accessible. That's why we recommend registering both documents with the U.S. Living Will Registry®, so that they are included in a secure online database.

Q. When does an advance directive become effective?
A. A living will and health care proxy will become effective only when you are incapacitated and unable to make communicate your wishes regarding your care.

Q. How do I register my advance directive in the U.S. Living Will Registry®?
A. To submit advance directives for registration, you or your social service provider may send the documents along with the U.S. Living Will Registration Agreement by either of the following methods:

- **FAX** to 212.750.0820 to the attention of "**Total Life Choices"**
- **MAIL** to:

  Total Life Choices
  New York Legal Assistance Group
  450 W. 33rd Street, 11th Floor
  New York, New York 10001

Additional advance directive forms and registration materials can be obtained online at www.nylag.org or by calling 212.371.6873.

Q. How does Total Life Choices work?
A. A TLC attorney will first review your documents to ensure they are legally sufficient. Your advance directive(s) is then scanned into the U.S. Living Will Registry® so that an exact image of your document is stored. Once registered, you will be sent a confirmation letter in addition to labels for your driver's license and insurance card, stating that you are registered, and a wallet card listing your Registration #. Health care providers can contact the computer on the telephone or via a secure Internet web site, and request a copy of your advance directive. The computer sends a copy to the provider, and it is kept as part of your confidential medical record. If you don't have your card, the health care provider can still access your document using your social security number (health care providers almost always have your social security number because they use it for billing purposes).

Your document is stored and transmitted in the safest way possible to insure your privacy. You will have peace of mind knowing that your advance directive is safe, secure and available to your family and doctors whenever and wherever it is needed. And because health care providers can contact the Registry to see if any patient has an advance directive, they can retrieve your document even if they don't have your card.

Q. How much does it cost to register?
A. Registration is completely free. TLC provides this service without charge so that everyone can participate.

Q. What if I change my mind?
A. You can revoke your health care proxy and/or living will at any time while you are competent by informing your agent or physician that you have changed your mind. You must notify the Registry in writing if you change or revoke your advance directive in which case your old directive will be destroyed and your new document will be registered. Moreover, the U.S. Living Will Registry® automatically sends annual reminder letters to confirm that your information is up-to-date.

To change your advance directive(s): Simply fill out a new health care proxy and/or a new living will form and mail everything directly to the Registry. They will automatically replace the new documents with the existing ones. If you would like to revoke a document entirely, provide instructions in the form of a letter. All documents should be mailed to:

U.S. Living Will Registry
523 Westfield Ave., P.O. Box 2789
Westfield, NJ 07091-2789

Q. Will my advance directive be honored if I become ill in another state?
A. All 50 states and the District of Columbia have laws recognizing the use of advance directives (i.e., living wills, medical powers of attorney). The majority of states will recognize a New York State health care proxy and living will and most states also have reciprocity provisions. However, if you spend a great deal of time in more than one state you might want to consider executing an advance directive specifically worded to meet each state's requirements to best protect your interests.

Q. I am worried about my advance directives not remaining confidential. What safeguards are in place to protect my privacy?
A. Your advance directive is a legal document and its privacy and confidentiality must be protected. In the Registration Agreement, it is clearly stated "Registry is not authorized to share my personal information with parties other than health care providers." Health care providers (as defined by federal regulations on advance directives) are hospitals, doctors, skilled nursing facilities, nursing facilities, home health agencies, providers of home health care, ambulatory surgery facilities, and hospices. Once transmitted to a provider, your advance directive becomes part of your medical record. Law protects the privacy of medical records.

The Registry does not share or sell your personal information and no identifying information is collected from this web site.

Q. What if I already have an advance directive? Do I have to complete a new one to participate in Total Life Choices?
A. No. Just as long as a NYLAG attorney reviews the documents and finds them legally sufficient, your existing forms can be uploaded into the database after you fill out a registration form.

Q. How do I access my advance directives once they are stored in the Registry?
A. You can visit the website at www.uslwr.com and access the documents by entering the "Source" and the "Registration #," both of which are listed on the Registry ID card you receive in the mail. If you do not have the card with you and a hospital/medical facility needs to access the documents, they can do so by calling 1.800.LIV.WILL (548.9455).

Q. I don't have a U.S. Social Security Number. Can I still participate in the Registry service?
A. Yes. Individuals without a SSN can either leave this section of their Registration form blank or write that they do not have a SSN. An account number will be generated randomly and assigned to the individual.

Q. Can registered individuals have their directives accessed if they are admitted to a hospital outside of the U.S.?
A. Mostly yes. The Registry already has numerous Foreign Service employees registered who are regularly out of the country. In the event they are admitted to a hospital overseas, the Registry would use similar verification methods to ensure that person requesting the information is from a legitimate medical institution. This may be more difficult in countries with less developed information technology systems.

Q. What if I do not have access to a computer or am not comfortable using the internet, should I still store my advance directives electronically?
A. Individuals without internet access can make full use of this service. All advance directives must be mailed or faxed to us so there is no need for the internet. Doctors, health care facilities and anybody else with whom you share your registration number can download your documents from the internet, but there are also alternative methods of obtaining them from the Registry.

NYLAG & the U.S. Living Will Registry®

About NYLAG

Founded in 1990, the New York Legal Assistance Group (NYLAG) is a not-for-profit law office providing free civil legal services to low income New Yorkers. A full service agency, NYLAG offers comprehensive assistance to clients with more than one legal issue. NYLAG provides direct legal services, advocacy through impact litigation, consultation, and numerous volunteer and pro bono opportunities. Last year, NYLAG handled 19,993 cases and benefited additional thousands through successful impact litigation and community legal education. For more information on NYLAG, go to www.nylag.org.

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About the U.S. Living Will Registry®

Established in 1996, the U.S. Living Will Registry® electronically stores advance directives and organ donor information, and makes them available 24 hours a day to hospitals and health care providers. Information on advance directive and state-specific forms can be found on the Registry's website. For more information on the Registry, visit www.uslivingwillregistry.com, or call 1.800.LIV.WILL.