NEW YORK STATE HEALTH CARE PROXY WALLET CARD

NY–RAH

In case of an emergency, the NY–RAH Health Care Proxy Wallet Card will alert medical personnel that you have identified a Health Care Agent to make health care decisions on your behalf when you are unable to.

Instructions:

1. Before completing the Wallet Card, please review New York State Department of Health Publication 1430 (request a copy from your Social Work Department or download one here: https://www.health.ny.gov/publications/1430.pdf), which provides important information about who can be your Health Care Agent, what decisions your Agent can make, and how you can ensure that your Agent makes the same decisions you would if able.
2. The link above also contains a Health Care Proxy Form. Nursing facility residents can obtain this form from your Social Work Department. While you may complete either the Health Care Proxy Form or the Health Care Proxy Wallet Card, NY–RAH recommends completing both and sharing the form with your medical provider(s). This will ensure that all of your providers—especially in case of an emergency—will be able to ask someone you trust (your Agent) to make health care decisions for you if you are unable to. Make sure you write the same information on both your Health Care Proxy Form and your Wallet Card.
3. After you fill out the card, you will need two witnesses to watch while you sign it, and then the witnesses will need to sign it. Your Health Care Agent cannot also be a witness.
4. Store the card in your wallet or purse where you keep other important documents that you normally carry with you such as your state-issued ID and your money or credit cards. Give your Health Care Proxy Form to your medical providers.

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HEALTH CARE PROXY WALLET CARD

I, _____ (Principal),

of _____
STREET CITY STATE

_____ _____
CELL PHONE ALTERNATE PHONE

hereby appoint _____ (Agent),

of _____
STREET CITY STATE

_____ _____
CELL PHONE ALTERNATE PHONE

as my Health Care Agent to make any and all health care decisions for me, except to the extent that I state otherwise (see special instructions). My Agent will be able to make health care decisions for me if a doctor or other authorized person determines that I am unable to make my own health care decisions.

This document will remain in effect indefinitely, unless I revoke it or state an expiration date or expiration circumstances.

_____ _____
PRINCIPAL SIGNATURE DATE

I declare that the person who signed this document is personally known to me and appears to be of sound mind and acting of their own free will. They signed (or asked another to sign for them) this document in my presence. I am not the Agent and I am 18 years of age or older.

_____ _____
WITNESS 1 DATE

_____ _____
WITNESS 2 DATE

Fold here →

Fold here →

NY–RAH

HEALTH CARE PROXY WALLET CARD

for

_____

NAME

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 nor will it prevent your Agent (or another person who is otherwise authorized by law) from consenting to a donation on your behalf.

SPECIAL INSTRUCTIONS (for example, any limitations you may wish to impose on your Agent's decision-making powers here):

_____

Your Agent can only make decisions about artificial nutrition and hydration (nourishment and water provided via feeding tube or intravenous line) if they knows your wishes from what you have said or written. You may write those wishes here:

_____