

KANSAS

Advance Directive

Planning for Important Healthcare Decisions

Caring Connections
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www.caringinfo.org
800/658-8898

CARING CONNECTIONS

Caring Connections, a program of the National Hospice and Palliative Care Organization (NHPCO), is a national consumer engagement initiative to improve care at the end of life.

Caring Connections tracks and monitors all state and federal legislation and significant court cases related to end-of-life care to ensure that our advance directives are up to date.

It's About How You LIVE

It's About How You LIVE is a national community engagement campaign encouraging individuals to make informed decisions about end-of-life care and services. The campaign encourages people to:

- L**earn about options for end-of-life services and care
- I**mplement plans to ensure wishes are honored
- V**oice decisions to family, friends and healthcare providers
- E**ngage in personal or community efforts to improve end-of-life care

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Using these Materials

BEFORE YOU BEGIN

Check to be sure that you have the materials for each state in which you may receive healthcare.

1. These materials include:
 - Instructions for preparing your advance directive, please read all the instructions.
 - Your state-specific advance directive forms, which are the pages with the gray instruction bar on the left side.

ACTION STEPS

2. You may want to photocopy these forms before you start so you will have a clean copy if you need to start over.
3. When you begin to fill out the forms, refer to the gray instruction bars - they will guide you through the process.
4. Talk with your family, friends, and physicians about your advance directive. Be sure the person you appoint to make decisions on your behalf understands your wishes.
5. Once the form is completed and signed, photocopy the form and give it to the person you have appointed to make decisions on your behalf, your family, friends, healthcare providers and/or faith leaders so that the form is available in the event of an emergency.

Introduction to Your Advance Directive

This packet contains the *Advance Directive for Healthcare* which protects your right to refuse medical treatment you do not want or to request treatment you do want in the event you lose the ability to make decisions yourself.

The first part of this document is your state's *Living Will*. It lets you discuss your wishes about medical care in the event that you develop a terminal condition or are permanently unconscious and can no longer make your own medical decisions. The Living Will becomes effective when your doctor and one other physician document in your medical record that you are in a terminal condition or permanently unconscious.

The second part of this document permits the appointment of a *Healthcare Proxy*. This section lets you name someone to make decisions about your medical care, including decisions about life-sustaining treatment, if you can no longer speak for yourself. It goes into effect when your doctor determines that you are unable to communicate your healthcare decisions.

Note: This document will be legally binding only if the person completing the document is a competent adult.

Completing Your Kansas Declaration - Advance Directive for Healthcare

How do I make my *Advance Directive for Healthcare* legal?

The law requires that you sign your document, or direct another to sign it, in the presence of two witnesses who must be at least 18 years of age. These witnesses must also sign the document to show that they personally know you, believe you to be of sound mind, that they did not sign the document on your behalf and that they do not fall into any of the categories of people who cannot be witnesses. The law also requires that your appointed healthcare proxy and alternate healthcare proxy sign and date the document.

Note: You do not need to notarize your Advance Directive.

Your witnesses **cannot** be:

- your appointed healthcare proxy,
- related to you by blood, adoption or marriage,
- entitled to any portion of your estate upon your death, either through your will or any codicil to your will or under the laws of interstate succession, or
- someone directly financially responsible for your medical care.

Can I add personal instructions to my *Living Will*?

Yes. You can add personal instructions to your living will. For example, if there are any specific forms of treatment that you wish to refuse that are not already listed in the document, you may list them here.

You may also want to emphasize pain control by adding specific instructions such as, "I want to receive as much pain medication as necessary to ensure my comfort."

What if I change my mind?

You may revoke your Advance Directive for Healthcare at any time by:

- obliterating, burning, tearing or otherwise destroying or defacing the document,
- executing, or directing another person to execute, a dated written revocation (formal statement that you have changed your mind), or
- orally expressing your intent to revoke the Advance Directive for Healthcare in the presence of a witness, 18 years of age or older, who must sign and date a written confirmation that you made an oral revocation. An oral revocation becomes effective once the signed and dated confirmation is given to your doctor or healthcare provider, who will then make it a part of your medical record.

What other important facts should I know?

The directions of a pregnant patient's Kansas Advance Directive for Healthcare authorizing the providing, withdrawal or withholding of life-sustaining treatments and artificially provided nutrition and hydration will not be honored due to restrictions in the state law.

Completing Your Kansas Durable Power of Attorney for Healthcare

How do I make my Kansas Durable Power of Attorney for Healthcare legal?

The law requires that you have your Durable Power of Attorney for Healthcare witnessed. You can do this in either of two ways:

1. Have your signature witnessed by a notary public,

OR

2. Sign your document in the presence of two witnesses, at least 18 years of age.

These witnesses **cannot** be:

- the person you appointed as your healthcare proxy,
- entitled to any portion of your estate,
- directly financially responsible for your healthcare, or
- related to you by blood, marriage or adoption.

Whom should I appoint as my proxy?

Your proxy is the person you appoint to make decisions about your medical care if you become unable to make those decisions yourself. (A proxy may also be called an "agent"). Your proxy can be a family member or a close friend whom you trust to make serious decisions. The person you name as your proxy should clearly understand your wishes and be willing to accept the responsibility of making medical decisions for you.

The person you appoint as your proxy cannot be any of the following individuals, unless he or she is a member of a religious community to which you both are bound by vows, or is related to you by blood, marriage or adoption:

- your doctor or other treating healthcare provider, or
- an employee of your treating healthcare provider, or
- an employee of any hospital, psychiatric hospital or psychiatric treatment facility, hospice, nursing home or similar institution.

You can appoint a second person as your alternate proxy. The alternate will step in if the first person you name as proxy is unable, unwilling or unavailable to act for you.

Completing Your Kansas Durable Power of Attorney for Healthcare (continued)

Instructions for my healthcare proxy.

One of the strongest reasons for naming a proxy is to have someone who can respond flexibly as your medical situation changes and deal with situations that you did not foresee.

Talk with your proxy about your future medical care and describe what you consider to be an acceptable "quality of life."

What if I change my mind?

You may revoke your Durable Power of Attorney for Healthcare at any time by executing a new Durable Power of Attorney for Healthcare, or by executing a written revocation that must be witnessed in the same way that your Durable Power of Attorney for Healthcare was witnessed.

**KANSAS DURABLE POWER OF ATTORNEY FOR HEALTH CARE
DECISIONS GENERAL STATEMENT OF AUTHORITY GRANTED
– PAGE 1 OF 4**

INSTRUCTIONS

PRINT YOUR NAME

I, _____,
(name)

PRINT THE NAME,
ADDRESS AND
TELEPHONE
NUMBERS OF YOUR
PROXY

designate and appoint: _____
(name of proxy)

(address)

(home telephone number) (work telephone number)

or, in the event the person I appoint above is unable, unwilling or unavailable to serve, I appoint:

PRINT THE NAME,
ADDRESS AND
TELEPHONE
NUMBERS OF YOUR
ALTERNATE
PROXY

(name of alternate proxy)

(address)

(home telephone number) (work telephone number)

to be my proxy for health care decisions and pursuant to the language stated below, on my behalf to:

(1) Consent, refuse consent, or withdraw consent to any care, treatment, service or procedure to maintain, diagnose or treat a physical or mental condition, and to make decisions about organ donation, autopsy and disposition of the body;

(2) make all necessary arrangements at any hospital, psychiatric hospital or psychiatric treatment facility, hospice, nursing home or similar institution; to employ or discharge health care personnel, to include physicians, psychiatrists, psychologists, dentists, nurses, therapists or any other person who is licensed, certified or otherwise authorized or permitted by the laws of this state to administer health care, as the proxy shall deem necessary for my physical, mental and emotional well being; and

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**KANSAS DURABLE POWER OF ATTORNEY FOR HEALTH CARE
DECISIONS - PAGE 2 OF 4**

(3) request, receive and review any information, verbal or written, regarding my personal affairs or physical or mental health, including medical and hospital records, and to execute any releases of other documents that may be required in order to obtain such information.

In exercising the grant of authority set forth above my proxy for health care decisions shall: (Here may be inserted any special instructions or statement of the principal's desires to be followed by the proxy in exercising the authority granted)

ADD PERSONAL
INSTRUCTIONS
(IF ANY)

LIST LIMITATIONS
ON YOUR PROXY'S
POWER TO
CONSENT TO
MEDICAL
TREATMENT
(IF ANY)

LIMITATIONS OF AUTHORITY

- (1) The powers of the proxy herein shall be limited to the extent set out in writing in this durable power of attorney for health care decisions, and shall not include the power to revoke or invalidate any previously existing declaration made in accordance with the natural death act.
- (2) The proxy shall be prohibited from authorizing consent for the following items:

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**KANSAS DURABLE POWER OF ATTORNEY FOR HEALTH CARE
DECISIONS - PAGE 3 OF 4**

(3) This durable power of attorney for health care decisions shall be subject to the additional following limitations:

LIST FURTHER
LIMITATIONS TO
YOUR PROXY'S
POWER (IF ANY)

EFFECTIVE TIME

This power of attorney for health care decisions shall become effective upon my disability or incapacity.

REVOCATION

Any durable power of attorney for health care decisions I have previously made is hereby revoked.

EXECUTION

Executed this _____, at _____, Kansas.
(date) (county)

PRINT THE DATE
AND COUNTY OF
EXECUTION

SIGN THE
DOCUMENT

(principal)

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KANSAS DECLARATION – PAGE 1 OF 3

INSTRUCTIONS

PRINT THE DATE

Declaration made this _____ day of _____
(day) (month) (year)

PRINT YOUR NAME

I, _____,
(name)

being of sound mind, willfully and voluntarily make known my desire that my dying shall not be artificially prolonged under the circumstances set forth below, and do hereby declare:

If at any time I should have an incurable injury, disease, or illness certified to be a terminal condition by two physicians who have personally examined me, one of whom shall be my attending physician, and the physicians have determined that my death will occur whether or not life-sustaining procedures are utilized and where the application of life-sustaining procedures would serve only to artificially prolong the dying process, I direct that such procedures be withheld or withdrawn, and that I be permitted to die naturally with only the administration of medication or the performance of any medical procedure deemed necessary to provide me with comfort care.

In the absence of my ability to give directions regarding the use of such life-sustaining procedures, it is my intention that this declaration shall be honored by my family and physician(s) as the final expression of my legal right to refuse medical or surgical treatment and accept the consequences from such refusal.

KANSAS DECLARATION – PAGE 2 OF 3

ORGAN DONATION
(OPTIONAL)

ORGAN DONATION (OPTIONAL)

Under Kansas law, you may make a gift of all or part of your body to a bank or storage facility or a hospital, physician or medical or dental school for transplantation, therapy, medical or dental evaluation or research or for the advancement of medical or dental science. You may also authorize your agent to do so or a member of your family may make a gift unless you give them notice orally or in writing that you do not want a gift made.

You may revoke or amend an anatomical gift by: (1) the execution of a signed statement; (2) an oral statement that is made in the presence of two persons, at least one of whom is a disinterested witness, and communicated to your family or attorney or to the donee; (3) a statement during a terminal illness or injury addressed to an attending physician; (4) a signed card or document found on you or in your personal effects; or (5) by destruction, cancellation, or mutilation of the document providing for the anatomical gift and all executed copies thereof.

In the space below you may make a gift yourself or state that you do not want to make a gift. If you do not complete this section, your agent will have the authority to make a gift of all or a part of your body pursuant to law. The donation elections you make below survive your death.

Initial the line next to the statement below that best reflects your wishes. You do not have to initial any of the statements. If you do not initial any of the statements, your agent and your family will have the authority to make a gift of all or part of your body under Kansas law.

_____ I do not want to make an organ or tissue donation and I do not want my agent or family to do so.

_____ I have already signed a written agreement or donor card regarding organ and tissue donation with the following individual or institution:

Name of individual/organization: _____

_____ Pursuant to Kansas law, I hereby give, effective on my death:

_____ Any needed organ or parts.

_____ The following part or organs listed below:

For (initial one):

_____ Any legally authorized purpose.

_____ Transplant or therapeutic purposes only.

INITIAL THE
OPTION THAT
REFLECTS YOUR
WISHES

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KANSAS DECLARATION — PAGE 3 OF 3

ADD ANY PERSONAL
INSTRUCTIONS
REGARDING ORGAN
DONATION HERE

Other directions:

I understand the full importance of this declaration and I am emotionally and mentally competent to make this declaration.

Signed _____

City, County and State of Residence _____

The declarant has been personally known to me and I believe him or her to be of sound mind. I did not sign the declarant's signature above for or at the direction of the declarant. I am not related to the declarant by blood or marriage, entitled to any portion of the estate of the declarant according to the laws of interstate succession or under any will of declarant or codicil thereto, or directly financially responsible for the declarant's medical care.

Witness _____

Witness _____

OR

STATE OF KANSAS)

SS.

COUNTY OF)

This instrument was acknowledged before me on _____
(date)

by _____
(name of principal)

(signature of notary public)

(Seal, if any)

My appointment expires: _____

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

SIGN THE
DOCUMENT AND
PRINT YOUR PLACE
OF RESIDENCE

WITNESSING
PROCEDURE

WITNESSES MUST
SIGN BELOW

WITNESS #1

WITNESS #2

OR

A NOTARY PUBLIC
MUST COMPLETE
THIS SECTION OF
YOUR DOCUMENT

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You Have Filled Out Your Advance Directive, Now What?

1. Your Kansas Advance Directive for Healthcare decisions is an important legal document. Keep the original signed document in a secure but accessible place. Do not put the original document in a safe deposit box or any other security box that would keep others from having access to it.
2. Give photocopies of the signed original to your proxy and alternate proxy, doctor(s), family, close friends, clergy and anyone else who might become involved in your healthcare. If you enter a nursing home or hospital, have photocopies of your document placed in your medical records.
3. Be sure to talk to your proxy(s), doctor(s), clergy, family and friends about your wishes concerning medical treatment. Discuss your wishes with them often, particularly if your medical condition changes.
4. If you want to make changes to your documents after they have been signed and witnessed, you must complete a new document.
5. Remember, you can always revoke your document.
6. Be aware that your document will not be effective in the event of a medical emergency. Ambulance personnel are required to provide cardiopulmonary resuscitation (CPR) unless they are given a separate order that states otherwise. These orders, commonly called "non-hospital do-not-resuscitate orders," are designed for people whose poor health gives them little chance of benefiting from CPR. These orders must be signed by your physician and instruct ambulance personnel not to attempt CPR if your heart or breathing should stop.

Currently not all states have laws authorizing non-hospital do-not-resuscitate orders. We suggest you speak to your physician for more information. **Caring Connections does not distribute these forms.**