

KENTUCKY Advance Directive Planning for Important Healthcare Decisions

Caring Connections
1731 King St., Alexandria, VA 22314
www.caringinfo.org
800/658-8898

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, supported by a grant from The Robert Wood Johnson Foundation.

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.
 - Your state-specific advance directive forms, which are the pages with the gray instruction bar on the left side.

PREPARING TO COMPLETE YOUR ADVANCE DIRECTIVE

2. Read all the instructions, as they will give you specific information about the requirements in your state.

ACTION STEPS

3. You may want to photocopy these forms before you start so you will have a clean copy if you need to start over.
4. When you begin to fill out the forms, refer to the gray instruction bars - they will guide you through the process.
5. 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.
6. 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 *Living Will* 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 permits the appointment of a *Healthcare Surrogate*. 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.

The second 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.

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

Instructions for Completing Your Living Will

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 19 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. *Note: You may also have your Advance Directive notarized.*

Your witnesses cannot be:

- A blood relative,
- Entitled to any portion of your estate, either through your will, under Kentucky descent and distribution statutes or under the laws of interstate succession,
- your attending physician,
- an employee of a healthcare facility in which you are a patient or resident, unless the employee serves as a notary public, 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.

Whom should I appoint as my Surrogate?

A proxy is the person you appoint to make decisions about your medical care if you become unable to make those decisions yourself. (A surrogate may also be called an "agent" or "proxy.") Your surrogate may be a family member or a close friend whom you trust to make serious decisions. You cannot appoint as your surrogate or alternate surrogate, an employee, owner, director or officer of a healthcare facility in which you are a resident or patient, unless he or she is related to you by blood or marriage or a member of the same religious order.

The person you name as your surrogate should clearly understand your wishes and be willing to accept the responsibility of making medical decisions for you. You can appoint a second person as your alternate surrogate. The alternate will step in if the first person you name as your proxy is unable, unwilling, or unavailable to act for you.

Instructions for Completing Your Living Will (continued)

Instructions for my healthcare surrogate.

One of the strongest reasons for naming a surrogate 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 surrogate 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 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, or
- orally expressing your intent to revoke the Advance Directive for Healthcare in the presence of two adults, one of whom is a healthcare provider, 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 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.

INSTRUCTIONS

PRINT THE NAME
OF YOUR
SURROGATE

PRINT THE NAME
OF YOUR
ALTERNATE
SURROGATE

CHECK AND INITIAL
THE STATEMENTS
THAT REFLECT
YOUR WISHES
(CONTINUED ON
PAGE 2)

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1. DESIGNATION OF HEALTH CARE SURROGATE

I designate _____
(name of surrogate)

as my health care surrogate to make health care decisions for me in accordance with this directive when I no longer have decisional capacity.

If _____
(name of surrogate)

refuses or is not able to act for me, I designate

(name of alternate surrogate)

as my health care surrogate.

Any prior designation is revoked.

2. LIVING WILL DIRECTIVE

My wishes regarding life-prolonging treatment and artificially provided nutrition and hydration to be provided to me if I no longer have decisional capacity, have a terminal condition, or become permanently unconscious have been indicated by checking and initialing the appropriate lines below. If I do not designate a surrogate, the following are my directions to my attending physician. If I have designated a surrogate, my surrogate shall comply with my wishes as indicated below:

___ Direct that treatment be withheld or withdrawn, and that I be permitted to die naturally with only the administration of medication or the performance of any medical treatment deemed necessary to alleviate pain.

___ DO NOT authorize that life-prolonging treatment be withheld or withdrawn.

___ Authorize the withholding or withdrawal of artificially provided food, water, or other artificially provided nourishment or fluids.

CHECK AND INITIAL
THE STATEMENTS
THAT REFLECT
YOUR WISHES

_____ DO NOT authorize the withholding or withdrawal of artificially provided food, water, or other artificially provided nourishment or fluids.

_____ Authorize my surrogate, designated above, to withhold or withdraw artificially provided nourishment or fluids, or other treatment if the surrogate determines that withholding or withdrawing is in my best interest; but I do not mandate that withholding or withdrawing.

3. ANATOMICAL GIFT

CHECK AND INITIAL
THE STATEMENTS
THAT REFLECT
YOUR WISHES

_____ Authorize the giving of all or any part of my body upon death for any purpose specified in KRS 311.185.

_____ DO NOT authorize the giving of all or any part of my body upon my death.

ADD PERSONAL
INSTRUCTIONS
(IF ANY)

Other directions:

In the absence of my ability to give directions regarding the use of life-prolonging treatment and artificially provided nutrition and hydration, it is my intention that this directive shall be honored by my attending physician, my family, and any surrogate designated pursuant to this directive as the final expression of my legal right to refuse medical or surgical treatment and I accept the consequences of the refusal.

If I have been diagnosed as pregnant and that diagnosis is known to my attending physician, this directive shall have no force or effect during the course of my pregnancy.

I understand the full meaning and significance of this directive and I am emotionally and mentally competent to make this directive.

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KENTUCKY LIVING WILL — PAGE 3 OF 3

SIGN AND DATE
THE DOCUMENT
AND PRINT
YOUR ADDRESS

Signed this _____ day of _____, 20_____.
(date) (month) (year)

Signature of the grantor: _____

Address of the grantor: _____

WITNESSING
PROCEDURE

3. Witnessing Procedure

In our joint presence, the grantor, who is of sound mind and
eighteen years of age, or older, voluntarily dated and signed this
writing or directed it to be dated and signed for the grantor.

Signature of witness: _____

Address of witness: _____

Signature of witness: _____

Address of witness: _____

-OR-

STATE OF KENTUCKY)
) ss
County of _____)

TWO WITNESSES
MUST SIGN HERE
AND PRINT THEIR
ADDRESSES

OR

A NOTARY PUBLIC
MUST COMPLETE
THIS SECTION

Before me, the undersigned authority, came the grantor who is of
sound mind and eighteen (18) years of age, or older, and
acknowledged that he voluntarily dated and signed this writing or
directed it to be dated and signed as above.

Done this _____ day of _____, 20_____.

(signature of notary public or other person authorized to administer
oaths)

Date commission expires: _____

**NOTE: Execution of this document restricts withholding
and withdrawing of some medical procedures. Consult
Kentucky Revised Statutes or your attorney.**

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You Have Filled Out Your Advance Directive, Now What?

1. Your *Advance Directive for Healthcare* 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 there.
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.