

KENTUCKY

Advance Directive

Planning for Important Healthcare Decisions

Courtesy of CaringInfo

www.caringinfo.org

800-658-8898

CaringInfo, a program of the National Hospice and Palliative Care Organization (NHPCO), is a national consumer engagement initiative to improve care and the experience of caregiving during serious illness and at the end of life. As part of that effort, CaringInfo provides detailed guidance for completing advance directive forms in all 50 states, the District of Columbia, and Puerto Rico.

This package includes:

- 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.

BEFORE YOU BEGIN

Check to be sure that you have the materials for each state in which you may receive healthcare. Because documents are state-specific, having a state-specific document for each state where you may spend significant time can be beneficial. A new advance directive is not necessary for ordinary travel into other states. The advance directives in this package will be legally binding only if the person completing them is a competent adult who is 18 years of age or older, or an emancipated minor.

ACTION STEPS

1. You may want to photocopy or print a second set of these forms before you start so you will have a clean copy if you need to start over.
2. When you begin to fill out the forms, refer to the gray instruction bars — they will guide you through the process.
3. 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.
4. Once the form is completed and signed, photocopy, scan, or take a photo of 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.

5. You may also want to save a copy of your form in your electronic healthcare record, or an online personal health records application, program, or service that allows you to share your medical documents with your physicians, family, and others who you want to take an active role in your advance care planning.

INTRODUCTION TO YOUR KENTUCKY ADVANCE HEALTH CARE DIRECTIVE

This packet contains a Kentucky Living Will Directive (or "Advance Directive"), 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.

Part I is an **Appointment of a Surrogate**. This part lets you name someone to make decisions about your health care, including decisions about life-sustaining procedures, if you can no longer speak for yourself.

Part II allows you to provide **Instructions** regarding your wishes about health care. Part II also allows you to choose whether or not to donate your organs.

Part III contains the witnessing and signature provisions to make your document effective.

You may complete Part I, Part II, or both, depending on your advance planning needs. **You must complete Part III.**

How do I make my Kentucky Advance Health Care Directive legal?

In order to make your document effective, you have two options.

Option 1: Sign in the presence of two witnesses, who must be at least 18 years of age. Your witnesses **cannot** be:

- A blood relative,
- Entitled to any portion of your estate,
- Your attending physician,
- An employee of a health care 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.

OR

Option 2: Sign in the presence of a notary public. The notary public is subject to the same restrictions as your witnesses.

Whom should I appoint as my surrogate?

Your surrogate is the person you appoint to make decisions about your healthcare if you become unable to make those decisions yourself. Your surrogate may be a family member or a close friend whom you trust to make serious decisions. The person you name as your surrogate should clearly understand your wishes and be willing to accept the responsibility of making healthcare 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 a surrogate is unable, unwilling, or unavailable to act for you.

You cannot appoint as your surrogate or alternate surrogate, an employee, owner, director, or officer of a health care facility in which you are a resident or patient, unless he or she is related to you by blood or marriage or is a member of the same religious order (for example, if you are both priests, monks, or nuns in the same order).

Should I add personal instructions to my advance directive?

Yes! One of the most important reasons to execute an advance directive is to have your voice heard. When you name an agent and clearly communicate to them what you want and don't want, they are in the strongest position to advocate for you. Because the future is unpredictable, be careful that you do not unintentionally restrict your agent's power to act in your best interest. Be especially careful with the words "always" and "never." In any event, be sure to talk with your agent and others about your future healthcare and describe what you consider to be an acceptable "quality of life."

When does my surrogate's authority become effective?

Part I, **Appointment of a Surrogate**, goes into effect when your doctor determines that you cannot make your own health care decisions.

Part II, **Instructions**, becomes effective when your doctor determines that you cannot make your own healthcare decisions and that you are in a terminal condition or permanently unconscious.

You retain the primary authority for your healthcare decisions as long as you are able to make your wishes known.

Surrogate Limitations

Despite any directions you or your surrogate gives, life-prolonging treatments and artificially provided nutrition and hydration will not be withheld while you are pregnant unless it is reasonably medically certain that such procedures will not allow the baby to be born, will be physically harmful to you, or will prolong severe pain that cannot be alleviated through medication.

Your surrogate will be bound by the current laws of Kentucky as they regard pregnancy and termination of pregnancies.

What if I change my mind?

You may revoke all or part of your living will directive, including the designation of your surrogate, at any time that you have the capacity to make your own decisions. You may revoke your living will directive at any time by:

- A signed and dated written revocation,
- An oral revocation made in the presence of two adults, one of whom must be a health care provider; or
- Destruction of the document by you or someone acting at your direction.

Mental Health Issues

These forms do not *expressly* address mental illness, although you can state your wishes and grant authority to your agent regarding mental health issues. The National Resource Center on Psychiatric Advance Directives maintains a website (<https://nrc-pad.org/>) with links to each state's psychiatric advance directive forms. If you would like to make more detailed advance care plans regarding mental illness, you could talk to your physician and an attorney about a durable power of attorney tailored to your needs.

What other important facts should I know?

Be aware that your advance directive will not be effective in the event of a medical emergency, except to identify your agent. Ambulance and hospital emergency department personnel are required to provide cardiopulmonary resuscitation (CPR) unless you have a separate physician's order, which are typically called "prehospital medical care directives" or "do not resuscitate orders." DNR forms may be obtained from your state health department or department of aging (<https://www.hhs.gov/aging/state-resources/index.html>). Another form of orders regarding CPR and other treatments are state-specific POLST (portable orders for life sustaining treatment) (<https://polst.org/form-patients/>). Both a POLST and a DNR form **MUST** be signed by a healthcare provider and **MUST** be presented to the emergency responders when they arrive. These directives instruct ambulance and hospital emergency personnel not to attempt CPR (or to stop it if it has begun) if your heart or breathing should stop.

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

PART I. DESIGNATION OF HEALTH CARE SURROGATE

PRINT YOUR NAME

I, _____ (print name),

PRINT YOUR SURROGATE'S NAME

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 the person I name above refuses or is not able to act for me, I

PRINT YOUR ALTERNATE SURROGATE'S NAME

designate _____ (name of alternate surrogate)

as my health care surrogate.

ADD OTHER INSTRUCTIONS, IF ANY, REGARDING YOUR ADVANCE CARE PLANS

When making health-care decisions for me, my surrogate should think about what action would be consistent with past conversations we have had, my treatment preferences as expressed in this or any other document where I have recorded my wishes, my religious and other beliefs and values, and how I have handled medical and other important issues in the past. If what I would decide is still unclear, then my surrogate should make decisions for me that my surrogate believes are in my best interest, considering the benefits, burdens, and risks of my current circumstances and treatment options.

THESE INSTRUCTIONS CAN FURTHER ADDRESS YOUR HEALTH CARE PLANS, SUCH AS YOUR WISHES REGARDING HOSPICE TREATMENT, BUT CAN ALSO ADDRESS OTHER ADVANCE PLANNING ISSUES, SUCH AS YOUR BURIAL WISHES

I give the following instructions as further guidance to my surrogate:

ATTACH ADDITIONAL PAGES IF NEEDED

Any prior designation is revoked.

PART II. HEALTH CARE INSTRUCTIONS

My wishes regarding healthcare, 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, or if my surrogate is not reasonably available, 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:

A. Surrogate Decision-Maker

_____ I authorize my surrogate, designated above, to withhold or withdraw artificially provided nourishment or fluids, or other life-prolonging treatment, if the surrogate determines that withholding or withdrawing is in my best interest; but I do not mandate that withholding or withdrawing. **(Do not complete B or C, below, if you initial this choice).**

B. Life-Prolonging Treatment

_____ I direct that life-prolonging 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.

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

C. Artificially-Provided Nutrition and Hydration

_____ I authorize the withholding or withdrawal of artificially provided food, water, or other artificially provided nourishment or fluids.

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

D. Organ and Tissue Donation

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

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

INITIAL THIS DECISION IF YOU WANT YOUR SURROGATE TO MAKE DECISIONS REGARDING ARTIFICIAL NUTRITION AND HYDRATION AND OTHER LIFE-PROLONGING TREATMENTS. IF YOU INITIAL THE CHOICE IN PART A, DO NOT COMPLETE PARTS B OR C

INITIAL ONLY ONE. DO NOT COMPLETE PART B IF YOU INITIALED THE CHOICE IN PART A

INITIAL ONLY ONE. DO NOT COMPLETE PART C IF YOU INITIALED THE CHOICE IN PART A

INITIAL ONLY ONE

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Part II. Execution

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

Signature of the grantor: _____

Printed Name: _____

Address of the grantor: _____

WITNESSES

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: _____

Date: _____

Address of witness: _____

Printed Name: _____

Signature of witness: _____

Date: _____

Address of witness: _____

Printed Name: _____

-OR-

NOTARY

STATE OF KENTUCKY)
) ss
County of _____)

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: _____

*Courtesy of CaringInfo
www.caringinfo.org*

SIGN AND DATE THE DOCUMENT AND PRINT YOUR NAME AND ADDRESS

TO BE VALID YOU MUST EITHER

HAVE YOUR WITNESSES AND SIGN AND DATE HERE AND PRINT THEIR ADDRESSES AND NAMES

OR

HAVE A NOTARY PUBLIC COMPLETE THIS SECTION