

# **KANSAS**

## **Advance Directive**

### **Planning for Important Health Care Decisions**

*Caring Connections*  
1731 King St., Suite 100, Alexandria, VA 22314

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800/658-XXXX

#### **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.

#### **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 health care providers
- E**ngage in personal or community efforts to improve end-of-life care

**Note:** The following is not a substitute for legal advice. While Caring Connections updates the following information and form to keep them up-to-date, changes in the underlying law can affect how the form will operate in the event you lose the ability to make decisions for yourself. If you have any questions about how the form will help ensure your wishes are carried out, or if your wishes do not seem to fit with the form, you may wish to talk to your health care provider or an attorney with experience in drafting advance directives.

## Using these Materials

### BEFORE YOU BEGIN

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

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

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 the form and give it to the person you have appointed to make decisions on your behalf, your family, friends, health care 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 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 Kansas Advance Directive

This packet contains a legal document that 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. You may complete Part One, Part Two, or both, depending on your advance planning needs.

**Part One.** The **Kansas Durable Power of Attorney for Health Care Decisions** 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. The Durable Power of Attorney for Health Care Decisions is especially useful because it appoints someone to speak for you any time you are unable to make your own health care decisions, not only at the end of life. The person you choose is called your “agent.”

Your agent may also make decisions about organ donation and the final disposition of your remains.

Your Kansas Durable Power of Attorney for Health Care Decisions goes into effect when your doctor determines that you are no longer able to make or communicate your health care decisions.

**Part Two.** The **Kansas Declaration** is your state’s living will. It lets you state your wish to have life-sustaining procedures withheld or withdrawn in the event that you develop a terminal condition and can no longer make your own health care decisions. If this is not your wish, you should not fill out Part Two.

Your Kansas Declaration goes into effect when your doctor determines that you have a terminal condition and can no longer make your own health care decisions.

**Part Three** contains the signature and witness provisions so that your document will be effective.

Following the advance directive form is a **Kansas Organ Donation Form**. This is especially helpful to communicate your organ donation wishes if you have not appointed an agent to communicate your wishes for you in Part One of the Kansas Advance Directive.

This form does not expressly address mental illness. If you would like to make advance care plans involving mental illness, you should talk to your physician and an attorney about a durable power of attorney tailored to your needs.

*Note: These documents will be legally binding only if the person completing them is a competent adult (at least 18 years old).*

## Completing Your Kansas Advance Directive

### **How do I make my Advance Directive care legal?**

The law requires that you sign and date your advance directive. You must also have it witnessed in one of two ways:

1. Have your signature witnessed by a notary public, **OR**
2. Sign your document, or direct another to sign it, in the presence of two witnesses. These witnesses **cannot** be:
  - the person signing your form for you,
  - the person you appoint as your health care agent,
  - entitled to any portion of your estate,
  - directly financially responsible for your health care, or
  - related to you by blood, marriage, or adoption.

### **Whom should I appoint as my agent?**

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

Unless your agent is related to you or is a co-member of a religious order to which you belong — for instance, if you and your agent are monks, priests, or nuns — your agent cannot be:

- your doctor or other treating health care provider,
- an employee of your treating health care 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 agent. The alternate will step in if the first person you name as an agent is unable, unwilling, or unavailable to act for you.

### **Can I add personal instructions to my Advance Directive?**

One of the strongest reasons for naming an agent is to have someone who can respond flexibly as your medical situation changes and deal with situations that you did not foresee. If you add instructions to this document it may help your agent carry out your wishes, but be careful that you do not unintentionally restrict your agent's power to act in your best interest. In any event, be sure to talk with your agent about your future medical care and describe what you consider to be an acceptable "quality of life."

## Completing Your Kansas Advance Directive (Continued)

### **What if I change my mind?**

You may revoke your agent's authority under Part One, the Durable Power of Attorney for Health Care Decisions, by giving notice to your agent orally or in writing. This revocation is only effective if you also inform your physician.

You may revoke your Declaration under Part Two 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 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 when your doctor or health care provider receives a copy of this document.

### **What other important facts should I know?**

Part Two, the Kansas Declaration, is not effective at any time you are pregnant.

INSTRUCTIONS

**KANSAS ADVANCE DIRECTIVE**

**Part One: Durable Power of Attorney for Health Care Decisions**

GRANT OF AUTHORITY TO AGENT

PRINT YOUR NAME

I, \_\_\_\_\_,  
(name)

PRINT THE NAME,  
ADDRESS, AND  
TELEPHONE  
NUMBERS OF YOUR  
AGENT

designate and appoint: \_\_\_\_\_  
(name of agent)

\_\_\_\_\_  
(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  
AGENT

\_\_\_\_\_  
(name of alternate agent)

\_\_\_\_\_  
(address)

\_\_\_\_\_  
(home telephone number) (work telephone number)

to be my agent 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 agent shall deem necessary for my physical, mental, and emotional well being; and

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Organization  
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LIMITATIONS OF AUTHORITY

(1) The powers of the agent herein shall be limited to the extent set out in writing in this durable power of attorney for health care decisions, and by my wishes set out in Part Two (if I have filled out Part Two), and shall not include the power to revoke or invalidate any previously existing declaration made in accordance with the Natural Death Act.

(2) The agent shall be prohibited from authorizing consent for the following items:

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

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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.

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

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

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INSTRUCTIONS

**Part Two: Declaration**

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.

I further direct that:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

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 agent (if any), 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.

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

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

ATTACH ADDITIONAL PAGES IF NEEDED

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**Part Three: Execution.**

I understand the full importance of this document and I am emotionally and mentally competent to appoint an agent and/or make this declaration.

Signed \_\_\_\_\_ Date \_\_\_\_\_

City, County and State of Residence \_\_\_\_\_

**Alternative No. 1, Witnesses:**

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 appointed above as the declarant's agent. 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 intestate succession or under any will of declarant or codicil thereto, or directly financially responsible for the declarant's medical care.

Witness \_\_\_\_\_  
Address \_\_\_\_\_

Witness \_\_\_\_\_  
Address \_\_\_\_\_

**OR**

**Alternative No. 2, Acknowledged by a Notary Public:**

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: \_\_\_\_\_

Copies: \_\_\_\_\_

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

SIGN AND DATE  
THE DOCUMENT  
AND PRINT YOUR  
PLACE OF  
RESIDENCE

YOUR SIGNATURE  
MUST BE EITHER  
WITNESSED OR  
NOTARIZED

WITNESS #1

WITNESS #2

OR

A NOTARY PUBLIC  
MUST COMPLETE  
THIS SECTION OF  
YOUR DOCUMENT

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ORGAN DONATION  
(OPTIONAL)

## KANSAS ORGAN DONATION FORM — PAGE 1 OF 1

INITIAL THE  
OPTION THAT  
REFLECTS YOUR  
WISHES

ADD NAME OR  
INSTITUTION (IF  
ANY)

PRINT YOUR NAME,  
SIGN, AND DATE  
THE DOCUMENT

YOUR  
WITNESSES  
MUST SIGN AND  
PRINT THEIR  
ADDRESSES

AT LEAST ONE  
WITNESS MUST BE  
A DISINTERESTED  
PARTY

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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, guardian, or your family may 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, guardian, 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/institution: \_\_\_\_\_

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.

Declarant name: \_\_\_\_\_

Declarant signature: \_\_\_\_\_, Date: \_\_\_\_\_

The declarant voluntarily signed or directed another person to sign this writing in my presence.

Witness \_\_\_\_\_ Date \_\_\_\_\_

Address \_\_\_\_\_

I am a disinterested party with regard to the declarant and his or her donation and estate. The declarant voluntarily signed or directed another person to sign this writing in my presence.

Witness \_\_\_\_\_ Date \_\_\_\_\_

Address \_\_\_\_\_

*Courtesy of Caring Connections*  
1731 King St., Suite 100, Alexandria, VA 22314  
[www.caringinfo.org](http://www.caringinfo.org), 800/658-8898

## **You Have Filled Out Your Health Care Directive, Now What?**

1. Your Advance Directive 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 agent and alternate agent, doctor(s), family, close friends, clergy, and anyone else who might become involved in your health care. 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 agent(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. You may also want to save a copy of your form in 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.
5. If you want to make changes to your documents after they have been signed and witnessed, you must complete a new document.
6. Remember, you can always revoke your Kansas document.
7. Be aware that your Kansas document will not be effective in the event of a medical emergency. Ambulance and hospital emergency department personnel are required to provide cardiopulmonary resuscitation (CPR) unless they are given a separate directive that states otherwise. These directives called "prehospital medical care directives" or "do not resuscitate orders" are designed for people whose poor health gives them little chance of benefiting from CPR. These directives instruct ambulance and hospital emergency 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 if you are interested in obtaining one. **Caring Connections does not distribute these forms.**