KANSAS
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.

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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 KANSAS ADVANCE HEALTH CARE 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.

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.

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.

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

You may complete Part One, Part Two, or both, depending on your advance planning needs. **You must complete Part Three**.

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.

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

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

Option 1: Have your signature witnessed by a notary public,

OR

Option 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 healthcare 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 healthcare decisions for you.

Unless your agent is related to you or is a co-member of a religious order to which you belong, 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.

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 agent's authority become effective?

Part One, 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, 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.

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

Agent Limitations

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

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.

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?

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

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.

INSTRUCTIONS

Part One: Durable Power of Attorney for Health Care Decisions

GRANT OF AUTHORITY TO AGENT

PRINT YOUR NAME

I ,____ ,
(name)

designate and appoint: ____
(name of agent)

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

____
(name of alternate agent)

PRINT THE NAME, ADDRESS, AND TELEPHONE NUMBERS OF YOUR 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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(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 agent for health care decisions shall: (Here may be inserted any special instructions or statement of the principal's desires to be followed by the agent in exercising the authority granted)

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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(attach additional pages if needed)

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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 setout 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.

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

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

____

____

____

____

____

____

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

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

____

____

____

____

____

____

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.

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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.

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

I further direct that:

____

____

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____

____

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.

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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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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: __________

ORGAN DONATION (OPTIONAL)

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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KANSAS ORGAN DONATION FORM — PAGE 1 OF 1

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 ____
____