Advance Directives for Health Care Decisions

It is important to choose someone to make health care decisions for you when you cannot. Tell the person (agent) you choose what you would want. The person you choose has the right to make any decision to ensure that your wishes are honored.

DURABLE POWER OF ATTORNEY FOR HEALTH CARE DECISIONS

K.S.A. 58-625 through 632

This form is sometimes called the Health Care Power of Attorney. It is a signed and notarized or witnessed legal paper. It allows a person to name someone to make health care decisions for him/her during a time of disability or incapacity. (The person who has the power of attorney is called the health care agent, proxy or surrogate.)

- The terms of the form may be fairly general or very specific, as desired. The powers granted usually include:
  - decisions about going to the hospital - choice of doctors - long term care
- The terms of this **paper** may include:
  - Refusing or withdrawing consent for the use of life sustaining procedures (even when the person is in a coma or persistent vegetative sate) - Consent for organ donation and autopsy
- The form is allowed by Kansas law.
- The person signing the DPOA for Health Care must be an adult (at least 18 years old) and competent when the document is signed. A person is usually assumed to be competent and does not need to prove it in the absence of actual notice of the opposite.
- Witnesses must be at least 18 years of age. They cannot be the agent or related to the person by blood, marriage or adoption. They cannot have a financial interest in the person's medical care or estate.
- The Health Care Power of Attorney may be effective immediately, or may be made effective only when the person lacks the capacity (as determined by a physician) to make or communicate decisions.
- The health care agent may not cancel a person's Living Will.

LIVING WILL

K.S.A. 65-28, 101 ET.SEQ.

A Living Will is a signed and notarized or witnessed form that allows a person to state in advance that his/her dying should not be artificially prolonged in cases of terminal illness. This decision may be made only by the patient or by a person the patient has designated as Durable Power of Attorney for Health Care. Relatives and even the patient's legal guardian do not have the authority to make this decision.

- The form is authorized by Kansas Law.
- The person must be an adult (at least 18 years old) and competent when the Living Will is signed.
- Witnesses must be at least 18 years of age. They cannot be the agent or related to the person by blood, marriage or adoption. They cannot have a financial interest in the person's medical care or estate.
- The Living Will applies only when the person has been diagnosed and certified as terminally ill by two doctors. One of the doctors is the patient's attending physician. (Terminally ill usually means that death will probably occur within six months regardless of whether life-sustaining treatments are used.)
- The Living Will does not apply to a person in a coma or persistent vegetative state unless the person is also diagnosed as terminally ill.
- Pain relief or other comfort care may be given with the Living Will.

STATE OF KANSAS DURABLE POWER OF ATTORNEY FOR HEALTH CARE DECISIONS
GENERAL STATEMENT OF AUTHORITY GRANTED

I, _____, designate and appoint:

Name: _____

Address: _____

_____

Telephone: _____

First Alternate Agent:

Name: _____

Address: _____

_____

Telephone: _____

Second Alternate Agent:

Name: _____

Address: _____

_____

Telephone: _____

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

(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.)

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 shall not include the power to revoke or invalidate any previously existing declaration made in accordance with the natural death act.

This is a Durable Power of Attorney and the authority of my attorney in fact, when effective, shall not terminate or be void or voidable if I am or become disabled.

My agent shall consider the following special instructions: (You may choose to write NONE.)

_____

_____

_____

_____

EFFECTIVE TIME
This power of attorney for health care decisions shall become effective immediately and shall not be affected by my subsequent disability or incapacity or upon the occurrence of my disability or incapacity).

REVOCATION
Any durable power of attorney for health care decisions I have precviously made is hereby revoked.
(This durable power of attorney for health care decisions shall be revoked by an instrument in writing executed, witnessed or acknowledged in the same manner as required herein or set out another manner of recovation, if desired.)

EXECUTION
Executed this _____, at _____, Kansas.

_____
Principal

This document must be: (1) witnessed by two individuals of lawful age who are not the agent, not related to the principal by blood, marriage, or adoption, not entitled to any portion of principal's estate and not financially responsible for principal's health care; OR (2) acknowledged by a notary public.

_____ _____

Witness **Witness**

_____ _____

Address **Address**

(OR)

STATE OF _____

COUNTY OF _____

This instrument was acknowledged before me on _____ by _____.
date **name of person**

_____

Signature of notary public

(Seal, if any)

My appointment expires: _____