HILLSIDE MEDICAL

Introduction to your Advance Directives

This packet contains legal documents that protect your right to request medical treatment you want, or refuse medical treatment you do not want, in the event you lose the ability to make those decisions yourself. You may complete Part One (Durable Power of Attorney for Health Care Decisions), Part Two (Declaration and Living Will), and/or Part Three (Patient Self Determination) depending on your advance planning needs.

Part One: Durable Power of Attorney for Health Care Decisions. This document 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" and may also make decisions about organ donation and the final disposition of your remains.

Part Two: Declaration and Living Will. This document lets you state your wish(es) to have life-sustaining procedures withheld or withdrawn in the event you develop a terminal condition and can no longer make your own health care decisions.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. The Declaration and Living Will goes into effect if you are unable to make your own health care decisions and only when your doctor determines you have a terminal condition.

Part Three: Patient Self Determination. This document reviews specific life-prolonging procedures and when you might want to have them withheld. You may choose to complete it instead of Part Two, in addition to Part Two, or not at all.

Execution. This page contains spaces for signatures and witness provisions so your document(s) will be valid. The execution page should be filled out and signed if any of the documents above are completed.

NOTE: THESE DOCUMENTS WILL BE LEGALLY BINDING ONLY IF THE PERSON COMPLETING THEM IS A COMPETENT ADULT (AT LEAST 18 YEARS OLD).

Questions and Answers about Advance Directives

How do I make my Advance Directive legal?

The law requires you to sign and date your advance directives. You must also have it witnessed by a notary public. You can meet both of these requirements by completing the "Execution" portion of this document.

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 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 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 you did not foresee. If you add instructions to this document it may help your agent carry out your wishes, but be careful 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.

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 you 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 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?

In Kansas, Part Two (Declaration and Living Will) is not effective at any time you are pregnant.

KANSAS ADVANCE DIRECTIVE
GRANT OF AUTHORITY TO AGENT

I, _____, designate and appoint:
[your name]

Name: _____
Address: _____
Phone: _____

or, in the event the person I appoint above is unable, unwilling or unavailable to serve, I appoint:

Name: _____
Address: _____
Phone: _____

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, physical or mental health, including medical and hospital records, and to execute any releases of other documents that maybe required in order to obtain such information.

In exercising the grant of authority set forth above, my agent for health care decisions shall:
[List any special instructions or statement of your wishes 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 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:

_____

_____

_____

_____

_____

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 immediately upon my disability or incapacity.

REVOCATION

Any durable power of attorney for health care decisions I have previously made is hereby revoked.

Part Two: Declaration and Living Will

Declaration made this _____ day of _____, 20_____;

I,_____, being of sound mind, willfully and voluntarily
[your name]
make known by 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 by my attending physician, and the physicians have determined 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 such procedures be withheld or withdrawn, and I be permitted to die naturally with only the administration of medication or the performance of any medical procedures deemed necessary to provide me with comfort care.

I further direct that:

☐ I have indicated my detailed wishes in "Part Three: Patient Self Determination."

☐ I elect to write my own detailed wishes below.

Part Three: Patient Self Determination

Name: _____

The following is a statement of my treatment wishes if I lack the capacity to make or communicate decisions regarding my health care treatment. I place much importance on my ability to live a meaningful life, to interact with others, to care for myself, and to engage in intellectual activity. I do not desire to live life in any condition in which I have little or no chance of regaining sufficient mental faculties to interact with others in a meaningful manner.

I direct all life-prolonging procedures be withheld or withdrawn when there is no hope of significant recovery and I have:

- A terminal condition, or
- A condition, disease, or injury without reasonable expectation I will regain an acceptable quality of life, or
- Substantial brain damage or brain disease which cannot be significantly reversed.

When any of the above conditions exist, the following life-prolonging procedures withheld unless directed by me in "Part Two: Declaration and Living Will":

- Surgery
- Dialysis
- Heart-Lung Resuscitation ("CPR")
- Antibiotics
- Mechanical Ventilator (Respirator)
- Tube Feeding (food or water delivered through a tube in the veins, nose, or stomach)
- Other: _____

If my physician believes a certain life-prolonging procedure or other health care treatment may provide me with comfort, relieve pain or lead to a significant recovery, I direct my physician to try the treatment for a reasonable period of time not to exceed _____. However, if it does not significantly improve my conditions, provide comfort, or relieve pain, I direct the procedure or treatment be withdrawn, even if doing so shortens my life.

I direct I be given health care treatment to relieve pain or to provide comfort, even if such treatment might shorten my life, suppress my appetite or my breathing, or be habit-forming.

I have read these instructions and have given them careful consideration, and they are in accordance with my wishes. It is my intention that this declaration shall be honored by my agent (if any), family, and physicians as the final expression of my legal right to refuse medial or surgical treatment and accept the consequences from such refusal.

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. I have read these instructions and have given them careful consideration, and they are in accordance with my wishes.

I have chosen to not complete the following sections at this time and those pages have been left blank intentionally (Check the appropriate box, initial and date):

- ☐ **Part One: Durable Power of Attorney** *Date* _____ *Initials* _____
- ☐ **Part Two: Declaration and Living Will** *Date* _____ *Initials* _____
- ☐ **Part Three: Patient Self Determination** *Date* _____ *Initials* _____

_____ _____

Signature Date

Name: _____

City/State: _____

County: _____

Acknowledged by a Notary Public:

STATE OF KANSAS

County of _____

This instrument was acknowledged before me on _____

by _____.

_____

Signature of Notary Public

My appointment expires: _____