DOWNLOAD COVERSHEET:

This is a standard advance directive for your state, made available to you as a courtesy by Lifecare Directives, LLC. You should be aware that extensive research has demonstrated that there are significant drawbacks to using a very brief state-standard document. As one researcher has noted, "the development of statutory forms occurs in the legislative arena, [so] their content is the result of a political rather than a 'scientific' process." Because of "political compromise, ...many of the forms ultimately passed by the legislatures are not optimal from a consumer perspective" (see: Hoffmann, Diane E; Zimmerman, S; Tompkins, C. The dangers of directives, or the false security of forms. *Journal of Law, Medicine & Ethics*. 1996;24(1) (Spring):5-17).

American Bar Association concurs, noting that "The statutory advance directive is not necessarily the exclusive, or even the best, pathway for individuals to follow," and suggesting that revised and enhanced documents "may be especially helpful as a...replacement for statutory forms where restrictions in a statutory directive prevents the individual from fully expressing his or her wishes" (see: American Bar Association. (1991). *Patient Self Determination Act State Law Guide*. Government printing office, Washington, DC).

Lifecare Directives staff have reviewed more than 6,000 medical, legal, academic, and news media articles on advance directives, as well as reviewing hundreds of document forms. They have also conducted formal research with scores of medical, legal, and academic processionals along with more than 1,000 lay public participants. From this process, more than 30 additional key living will and medical power of attorney enhancements have been identified that should be included in any living will (or "health care instruction" or "declaration") and medical power of attorney (or "proxy") forms that you may use.

Please consider obtaining the *Lifecare Advance Healthcare Directive* to obtain these important additions and benefits. To better understand the important enhancements available through this combined living will and medical power of attorney, you may wish to obtain the booklet, "*Should I Use a Shorter Standard Directive?*" available through Lifecare Directives, LLC.

If you have any other questions about this document or other Lifecare resources, please do not hesitate to contact our staff who will make every effort to fully respond your inquiries and address any questions you may have. We can be reached at the following:

Lifecare Directives, LLC
5348 Vegas Drive
Las Vegas, NV 89108
www.lifecaredirectives.com
Toll Free: (877) 559-0527

~ Lifecare Directives ~

Statutory Advance Directive

For

Kansas Residents

Statutory Compliant Advance Directive for Health Care Choices

~ Lifecare Directives ~

Statutory Advance Directive

For

Kansas Residents

Statutory Compliant
Advance Directive for
Health Care Choices

Important Notice:

An advance directive is not a substitute for medical, legal or other necessary advice or direction. This document should not be construed as offering counseling, medical, legal, financial, or estate planning or advice, nor any other similar guidance or direction. Such counsel should be obtained from qualified, certified, and licensed professionals in your locale who are experienced in the specific areas of concern. Completion of this document constitutes acceptance of its content both in whole and in part, as well as a determination of its utility for the purposes indicated. Lifecare Directives, LLC, and all involved in this document's design, publication, and distribution assume no liability for its use, including that which may arise from omissions, technical inaccuracies, and typographical errors. Diligent efforts notwithstanding, this document is not warrantied to be in compliance with state and local laws. All warranties, including those of merchantability, fitness for a particular purpose, and non-infringement are expressly disclaimed. The utilizer agrees to seek appropriate outside review prior to completion. The utilizer and all heirs, assigns, designees, devisees, representatives, and all others involved, agree to assume all liability for its use and any subsequent outcomes, and to release and hold harmless all involved in its design, publication, advertising and distribution. The utilizer also agrees that any physician, health care provider, agent, proxy, surrogate, representative, mediator, court officer, and all others relying on the document's content are similarly free of all liability, when they act in good faith and with due diligence to follow the recorded wishes and directions.

Statutory Advance Directive
For Kansas Residents

________________________________ ______________________________
Print Full Name *Date of Birth*

Your right *(when age 18 or older): To Document Your Personal Wishes,*
and to have these wishes followed ~~

The Kansas state legislature has provided both a living will Declaration and a Power of Attorney for Health Care for use by the public. Collectively, these documents are known as "advance directives." As the content of these documents was designed by your state government, each is in compliance with all applicable statutes and laws.

There is an introduction to each that summarizes the scope and purpose of the documents, as well as providing further directions for completion. Read each carefully to ensure that your advance directives are fully and properly filled out.

Understanding Your Directive

To make the *best* choices for your medical care, your physician needs to know your wishes. In fact, the law requires doctors to seek your permission before giving you *any* treatment. However, if you are ever unable to make decisions due to severe illness or injury, this may not be possible. Completing this Directive will help your family and physicians know who should speak for you, and understand what you want if you cannot make this known yourself.

You can **revoke** (cancel) this directive at ***any*** time by: **1**) writing "revoked" across the front of the directive, followed by your signature and date, and the signature of at least one witness aged 18 years or older ; or **2**) by completing a Notice of Revocation; or **3**) by *telling* an adult witness that you want it revoked (who must then sign and date a statement, which becomes effective only when given to your doctor or health care provider); or **4**) *by simply completing a new directive* in which you state that any prior directive is no longer valid (as is already stated in this directive).

You can **limit** your directive and the authority of anyone named in it, but *no changes are recommended after the document is witnessed*. Any scope-of-authority or content changes needed *after* your directive has been witnessed should be made by completing a new directive. First-time changes can be made by lining out anything in the directive and writing "deleted" beside that clause or section (or initialing above any word(s) you have lined out), followed by your signature, and the signature of at least one of the persons serving as a witness to this document, placed in the margin immediately beside the change.

If you are **unable to write**, you may tell your directive witnesses what you want to have excluded, limited, or added to this directive. They must then sign, date, witness and/or notarize

the statement of the limitations and exclusions as you have described them. Remember, unless you direct otherwise, this directive will **only** be used to guide your family and doctors if you are unable to make and communicate medical treatment decisions for yourself.

Instructions for Completing the Directive:

This directive is written in two parts. While it is best if you fill out the whole document, you may choose to complete only the living will Declaration in ***Section I***, leaving just a statement of your values and wishes. Or you may complete only health care power of attorney in ***Section II***, just naming someone to speak for you. However, this may leave your family and others without any evidence to support your wishes in the future, or leave them unsure who is to make decisions and speak for you. Thus, omitting either section may cause your loved ones difficulty if they must eventually make medical choices in your behalf. So, you are strongly encouraged to complete the entire directive.

SECTION I:
LIVING WILL DECLARATION

(*Pursuant to KS Statutes Chap.65; Art.28; §65-28,101 to §65-28, 109*)

1. INTRODUCTION: *Any adult person may execute a declaration directing the withholding or withdrawal of life-sustaining procedures in a terminal condition. Should any personal specific directions be held to be invalid, such invalidity shall not affect other directions of the declaration which can be given effect without the invalid direction, and to this end the directions in the declaration are severable.*

DECLARATION

2. Declaration made this ___________ day of ______________________________, 20______.

3. I, ____, 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, do hereby declare:

    4. 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.

       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 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.

5. I understand the full import of this declaration and I am emotionally and mentally competent to make this declaration.

6. Signed: ____
Date: ______________________
City: ______________________ County: ______________________
State: ______________________ ~~ of residence.

Statement of Witnesses

7. The declarant has been personally known to me and I believe the declarant 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 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, nor directly financially responsible for declarant's medical care.

8. Witness: ______________________________________
Printed Name:______________________________________
Address: ______________________________________

9. Witness: ______________________________________
Printed Name:______________________________________
Address: ______________________________________

(**OR**)
Certificate of Notary Public

10. STATE OF KANSAS)
SS.
COUNTY OF ____________________)

This instrument was acknowledged before me on (*date*) ________________________,
by (*name of person*) ____

______________________________________ **Notary Seal** (*if any*):
(Signature of notary public)

My appointment expires: ____________________

SECTION II:

DURABLE POWER OF ATTORNEY FOR HEALTH CARE

Designation of Health Care Agent

(*KS Statutes: Chapter 58; Art.6: §58-625 to §58-632*)

11. INTRODUCTION: *This section lets you name a person (called an "agent" or "attorney-in-fact") to make health care decisions for you, if you cannot make them for yourself. The person you name must be at least 18 years of age. Unless you indicate otherwise, the powers which you may grant through this document include the authority to make health care decisions, including life-sustaining treatment decisions, as well as other authorities regarding related affairs. If you have questions, you should seek further counsel and advice.*

DURABLE POWER OF ATTORNEY FOR HEALTH CARE DECISIONS

General Statement of Authority Granted

12. ***Be it known that I***:

Full Legal Name: ____

Date of Birth: ____

Street Address: ____

City: ______________________________ County: __________________________

State: ______________________________ Zip Code: ________________________

~~ do designate and appoint:

13. **Name of Agent**: ____

Address: ____

Telephone: Home:______________________ Work:______________________

Cell Phone or Pager: ___________________ E-mail: ____________________

~~ to be my agent for health care decisions and pursuant to the language stated below, on my behalf to:

14. 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;
15. 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

16. 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.

17. 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

18. 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.
19. The agent shall be prohibited from authorizing consent for the following items: __________
____
____
____
____

20. This durable power of attorney for health care decisions shall be subject to the additional following limitations: ____
____
____
____
____

EFFECTIVE TIME

21. 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

22. Any durable power of attorney for health care decisions I have previously 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 revocation, if desired.)

EXECUTION

23. Executed this ________________________, at ______________________________, Kansas.
(*Date*) (*City/County*)

24. ____
Signature of Principal.

Qualified Witnesses

25. 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) it shall be acknowledged by a notary public.

26. 1st Witness: ____
(Signature)

__________________________________ ____________________
(Name Printed) (Date)

____
(Residence Address)

27. 2nd Witness: ____
(Signature)

__________________________________ ____________________
(Name Printed) (Date)

____
(Residence Address)

(OR)

Certificate of Notary Public

28. STATE OF KANSAS)
SS.
COUNTY OF ________________________)

This instrument was acknowledged before me on (*date*) __________________________________,
by (*name of person*) ____

____ **Notary Seal** (*if any*):
(Signature of notary public)

My appointment expires: _________________________

For additional copies of this directive, or other related materials, please contact Lifecare Directives, LLC, at:

Lifecare Directives, LLC
5348 Vegas Drive
Las Vegas, NV 89108
(877) 559-0527
www.lifecaredirectives.com