DURABLE POWER OF ATTORNEY
FOR HEALTH CARE DECISIONS

CREATION OF DURABLE POWER OF ATTORNEY

I, _____, date of birth _____, of _____ (city), _____ (county), and _____ (state), designate and appoint

Name _____

Address _____

_____

Telephone _____

as my agent to make health care decisions for me as authorized in this document. The decision of my agent shall be honored. In the event the above-named agent is unwilling or unable to act as my agent, I hereby appoint the following person(s) to so serve, in the order listed below. (If more than one agent is appointed to serve jointly, I understand that they must be in agreement on the health care decisions made on my behalf.)

First alternate agent:

Name _____

Address _____

_____

Telephone _____

Second alternate agent:

Name _____

Address _____

_____

Telephone _____

GENERAL STATEMENT OF AUTHORITY GRANTED

Pursuant to the language stated below, on my behalf my agent may:

(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 my 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;

(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 or other documents that may be required in order to obtain such information; and

(4) Execute any appropriate authorizations for the use or disclosure of my protected health information.

In exercising this grant of authority, my agent shall be guided by my expressed desires, including the following:

(Insert any special instructions to be followed by the agent, such as a living will declaration, statements relating to the principal's meaningful quality of life, or other guidance.)

_____

_____

_____

LIMITATIONS OF AUTHORITY

The powers of my agent 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 or subsequent declaration made in accordance with the Natural Death Act or any common law living will declaration.

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

_____

_____

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

_____

_____

WHEN EFFECTIVE

This durable power of attorney for health care decisions shall become effective (initial one):

_____ Immediately and shall not be affected by my subsequent disability, incapacity, or death; or

_____ Upon the occurrence of my disability or incapacity.

REVOCATION

Any durable power of attorney for health care decisions which I have previously made is hereby revoked. This durable power of attorney for health care decisions may be revoked by any instrument in writing executed, witnessed, or acknowledged in the same manner as this document.

EXECUTION

Executed this _____ day of _____, 20____, at _____, Kansas.

_____
Principal

This document must be dated and signed in the presence of two witnesses **OR** acknowledged by a notary public.

(1) Witnesses – 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 the principal's estate; and not financially responsible for principal's health care.

Witness _____ Witness _____

Address _____ Address _____

OR

(2) STATE OF KANSAS)
) ss:
COUNTY OF _____)

This instrument was acknowledged before me on this _____ day of _____, 20___.

Signature of Notary Public _____

My appointment expires: _____

Discuss this document and your treatment preferences with your physician(s), family members, and designated agent, and provide them with a signed copy or photocopy.

STATUTORY LIVING WILL DECLARATION

Declaration made this _____ day of _____, 20___.

I, _____, date of birth _____, of _____ (city), _____ (county), and _____ (state), 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, subject to later revocation, 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 only serve to 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 agent, 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.

I understand the full significance of this declaration, and I am emotionally and mentally competent to make this declaration.

❒ I do not wish to make additional instructions.

❒ My additional instructions are listed on the reverse side (or page 2) of this form.

Signature of Declarant _____
(May be signed by another person in the declarant's presence and by the declarant's expressed direction.)

This document must be signed in the presence of two witnesses **OR** acknowledged by a notary public.

By signing below, I certify the following: The declarant has been personally known to me and I believe the declarant to be of sound mind and 18 years or older. The declarant voluntarily signed this document in my presence. 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, am not entitled to any portion of the estate of the declarant either as a legal heir or under any Will of declarant or any addition thereto, and am not directly financially responsible for declarant's medical care.

(1) Witnesses – 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 the principal's estate; and not financially responsible for principal's health care.

Witness _____ Witness _____

Address _____ Address _____

OR

(2) STATE OF KANSAS)
) ss:
COUNTY OF _____)

This instrument was acknowledged before me on this _____ day of _____, 20___.

Signature of Notary Public _____

My appointment expires: _____

Discuss this document with your physician(s), family members, designated agent(s), and clergy, and provide them with a signed copy or photocopy.

OPTIONAL ADDITIONAL INSTRUCTIONS

In addition to the above and foregoing, all persons involved in decisions regarding my medical treatment shall consider the following as clear and convincing evidence of my treatment wishes in the event I lack the capacity to make or communicate decisions regarding my health care treatment and there is no realistic hope that I will regain such capacity:

If there is no reasonable hope that I will regain a meaningful quality of life and I have:

- a terminal condition;
- a condition, disease, or injury without reasonable expectation of significant recovery;
- substantial brain damage or brain disease, or extreme mental deterioration including dementia; or
- other _____, then I direct that life-saving or life-prolonging measures or procedures be administered or withheld/withdrawn in accordance with my instructions marked below:

When any of the conditions described in the preceding paragraph exist, I request that I be provided all of the following measures or interventions ***EXCEPT*** those that I have marked "**No**."

Yes	**No**	SURGERY	**Yes**	**No**	DIALYSIS
Yes	**No**	HEART-LUNG RESUSCITATION (CPR)	**Yes**	**No**	ANTIBIOTICS
Yes	**No**	MECHANICAL VENTILATOR (respirator requiring intubation)	**Yes**	**No**	TUBE FEEDING (food and water delivered through tube in the veins, nose, or stomach)
Yes	**No**	OTHER _____	**Yes**	**No**	OTHER _____

Yes **No** If my physician believes that any life-saving or life-prolonging measure or intervention may lead to a significant recovery (even those marked "No" above), I direct my physician to try the treatment for a reasonable period of time. If it does not significantly improve my condition, I direct the treatment be withdrawn, even if so doing shortens my life.

Yes **No** I direct that in all circumstances, I be given health care treatment to relieve pain or provide comfort, even if such treatment might shorten my life, suppress my appetite or my breathing, or be habit-forming.

I consider a "meaningful quality of life" to include the following, which shall be taken into consideration by any caregivers and/or surrogate decision makers in determining my course of medical treatment: _____
_____
_____
_____

I make other instructions as follows: _____
_____
_____

Signature of Declarant _____
(May be signed by another person in the declarant's presence and by the declarant's expressed direction.)

(1) Witness _____ Witness _____

Address _____ Address _____

OR

(2) STATE OF KANSAS)
) ss:
COUNTY OF _____)

This instrument was acknowledged before me on this _____ day of _____, 20___.

Signature of Notary Public _____

My appointment expires: _____

Discuss this document with your physician(s), family members, designated agent(s), and clergy, and provide them with a signed copy or photocopy.

Health Care Decision Making – Living Will and Durable Power of Attorney

Who controls your health if you are unable to make decisions yourself? Would you like to maintain control? Kansas Laws make two legal documents available to you to make sure your wishes are followed. One is known as a "living will" or natural death act declaration. The second is the durable power of attorney for health care decisions.

What is a living will?
A living will is a written statement of your wishes regarding your medical treatment if you are in a terminal condition. It is only effective if two physicians have determined you are terminally ill.

What is a durable power of attorney for health care decisions?
A durable power of attorney for health care decisions is a written document in which you authorize someone (your "agent") to make health care decisions for you in the event you are unable to speak for yourself. In the document you can give specific instructions which will require the agent to make decisions following your wishes.

What is the difference between a durable power of attorney for health care decisions and a living will?
Power of Attorney Can Cover All Medical Decisions. Living wills only apply to decisions regarding "life sustaining treatment" in the event of a "terminal illness." A durable power of attorney for health care decisions can be effective any time or, if you want, at anytime you are unable to make or communicate a decision. The agent you appoint can make any decision you allow, including decisions about health care other than those covered by your living will. For example, the agent under a durable power of attorney can make decisions about care if you are in a persistent vegetative state or coma, but are not terminally ill.

Power of Attorney Appoints an Agent. Through a durable power of attorney, you appoint someone to act on your behalf. That person can weigh the pros and cons of treatment decisions, in accordance with your wishes. Unless you limit the powers, the agent can hire physicians and other health care providers, decide where you will receive treatment, and make decisions about the full range of medical decisions from routine care to decisions about life-sustaining treatment.

Do I lose control by appointing an agent?
You can write your living will and your durable power of attorney to include specific limitations about anything you want to have done or want to avoid. You can express your wishes about what you care most about. You can terminate your durable power of attorney at any time by notifying your agent and health care provider. You should revoke your durable power of attorney in writing and have it witnessed or notarized.

Do I need a living will or durable power of attorney for health care decisions?
Without these documents, your wishes may not be followed. In some situations a guardian will be appointed to you, but the guardian may be limited in making some decisions, especially those regarding life-sustaining treatment if you are in a vegetative state or coma, but not terminally ill. In addition, the guardian appointed by the court may have no idea what your wishes are. The existence of the document can relieve some of the stress or conflict that otherwise might arise if family or friends have to decide on their own what you would want done when you cannot speak for yourself.

Do I need both a living will and durable power of attorney for health care decisions?
It is recommended you have both documents. The living will provides clear evidence of your wishes and will help ensure that the agent and physicians carry out your wishes. The durable power of attorney for health care allows immediate action without the delays of court proceedings in cases where the living will does not apply. If you do not have a durable power of attorney, health care decision making may be made by someone other than the person you have chosen.

How do I make a living will and durable power of attorney for health care decisions?
The legislature has adopted statutory forms for both the living will and durable power of attorney. These can be found in the Kansas Statutes which are available in many public libraries. The living will is at K.S.A. 65-18, 103 (Volume 5, pages 264-65 of the Kansas Statutes Annotated). The durable power of attorney for health care decisions is at K.S.A. 58-632 (Volume 4-4A Supplement to Kansas Statutes Annotated). Copies are also available in kiosks throughout the hospital. In addition, an attorney can draft a document which specifically incorporates your wishes. Take time to consider all the possibilities and seek competent advice so the documents you develop meet your special needs.

Once I have the documents, what do I do?
Even as you draft the documents you should talk about your values and wishes with your physician(s), anyone you will appoint as an agent or alternate agent, and those who are close to you. You should give a copy of the documents to all of your physicians, your agent, and your family or friends. If you retain the originals, tell someone where the papers can be found. Place the original in a secure place which someone can access without court intervention.

What are Stormont Vail Health's policies regarding living wills and durable power of attorney for health care?
If Stormont Vail Health is aware of a living will or durable power of attorney, steps will be taken to alert your physician. You should discuss your treatment concerns with your physician so that he/she is aware of your wishes. If you have ethical concerns about the treatment course, information is available about the hospital's Ethics Committee. Stormont Vail Health does not discriminate because a person does or does not have a living will or durable power of attorney for health care.

Remember, a living will and durable power of attorney for health care decisions provide you a way to maintain control of your health care.

If you have further questions, or would like more information about health care decision making, please refer to the list below for additional resources.

- Stormont Vail HealthWise
  2252 S.W. 10th Ave.
  Topeka, Kansas 66604
  (785) 354-6787

- Kansas Legal Services
  712 S. Kansas Ave.
  Topeka, Kansas 66603
  (785) 354-8531

- Kansas Bar Association
  1200 S.W. Harrison
  Topeka, Kansas 66612
  (785) 234-5696

Health Care Decision Making

Living Will
Durable Power of Attorney

Stormont Vail Health