~ Kansas ~

Durable Power of Attorney For Health Care Decisions Christian Version

NOTICE TO PERSON MAKING THIS DOCUMENT

You have the right to make decisions about your health care. No health care may be given to you over your objection, and necessary health care may not be stopped or withheld if you object.

Because your health care providers in some cases may not have had the opportunity to establish a long–term relationship with you, they are often unfamiliar with your beliefs and values and the details of your family relationships. This poses a problem if you become physically or mentally unable to make decisions about your health care.

In order to avoid this problem, you may sign this legal document to specify the person whom you want to make health care decisions for you if you are unable to participate in medical treatment decisions and make those decisions personally. That person is known as your health care agent. You should take some time to discuss your thoughts and beliefs about medical treatment with the person or persons whom you have specified. You may state in this document any types of health care that you do or do not desire, and you may limit the authority of your health care agent. If your health care agent is unaware of your desires with respect to a particular health care decision, he or she is required to determine what would be in your best interests in making the decision.

This is an important legal document. It gives your health care agent broad powers to make health care decisions for you. It revokes any prior durable power of attorney for health care decisions that you may have made. If you wish to change your Durable Power of Attorney for Health Care Decisions, you may revoke this document at any time by destroying it, by directing another person to destroy it in your presence, by signing a written and dated statement, or by stating that it is revoked in the presence of two witnesses. If you revoke, you should notify your health care agent, your health care provider(s), and any other person(s) to whom you have given a copy. If your health care agent is your spouse and your marriage is annulled or you are divorced after signing this document, the document is invalid.

Do not sign this document unless you clearly understand it. It is suggested that you keep the original of this document with your personal papers where it can be easily accessed by your health care agent, close family, or friends, if needed.

STATE OF KANSAS
DURABLE POWER OF ATTORNEY
FOR HEALTH CARE DECISIONS

Written in accordance with Kansas § 58-632

A durable power of attorney for health care in Kansas may not designate as an agent the treating health care provider, nor an employee of the treating health care provider, nor an employee, owner, director, or officer of a facility described in K.S.A. 1989 Supp. 58-629(a)(2).

GENERAL STATEMENT OF AUTHORITY GRANTED

I, ______________________________, designate and appoint ______________________________,
Name of Principal — Health Care Agent

____, (____) ________________, to be
Address — Phone

my health care agent 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.

STATEMENT OF DESIRES, SPECIAL PROVISIONS, OR LIMITATIONS

In exercising the grant of authority set forth above, my health care agent shall act consistently with my following stated desires, if any, and is subject to any special provisions or limitations that I specify. The following are any specific desires, provisions or limitations that I wish to state (add more items as appropriate):

1. I request that the attached Addendum (pages 6-11) be included as a valid part of this Durable Power of Attorney for Health Care Decisions document.

2. I request, but not as a requirement, that my health care agent consult my clergy regarding health care decisions.

3. ____

____

____

____

____

[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 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;

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

____

____

____

____

____

[Attach additional pages, if needed.]

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

____

____

____

____

____

[Attach additional pages, if needed.]

EFFECTIVE TIME

This Durable 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 previously made is hereby revoked.

(This Durable Power of Attorney for Health Care Decisions shall be revoked by any instrument in writing executed, witnessed or acknowledged in the same manner as required herein or set out another manner of revocation, if desired.)

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The principal and the witnesses or notary public must sign this document at the same time.

EXECUTION

Signature of Principal

Executed this ______________________________, at ______________________________________, Kansas.
Date City

Signature: ____ Date: ______________________

(The signing of this document by the principal revokes all previous Durable Power of Attorney for Health Care Decisions documents.)

WITNESSES

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 the principal's estate and not financially responsible for the principal's health care; **OR** (2) acknowledged by a notary public (found on page 5).

Witness #1

Print name: ____ Date: ______________________________

Address: ____

Signature: ____

Witness #2

Print name: ____ Date: ______________________________

Address: ____

Signature: ____

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OR

STATE OF KANSAS SS. ________________

COUNTY OF __________________________

This instrument was acknowledged before me on ______________ by ______________________________
Date Principal

Signature of notary public: ____________________________________

(Seal, if any)

My appointment expires: _________________________

Copies: ______________________________________

ANATOMICAL GIFTS

Optional

Upon my death:

_______ I wish to donate only the following organs or parts:

____
(specify the organs or parts)
____

____

_______ I wish to donate any needed organ or part.

_______ I wish to donate my body for anatomical study if needed.

_______ I refuse to make an anatomical gift. (If this revokes a prior commitment that I have made to make an anatomical gift to a designated donee, I will attempt to notify the donee to which or to whom I agreed to donate.)

Failure to check any of the lines immediately above creates no presumption about my desire to make or refusal to make an anatomical gift.

Signature: ____ Date: ____________________

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ADDENDUM TO THE KANSAS DURABLE POWER OF ATTORNEY FOR HEALTH CARE DECISIONS

MY HEALTH CARE STATEMENT OF BELIEFS

My philosophy regarding the health care decisions I would make, if I were able to participate in medical treatment decisions, is based on my belief in the inherent value of human life and that life is a gift from God. It is my desire that all reasonable efforts be made to sustain my life and health.

I believe that death is the normal end of earthly life, and that God takes life by his decision. Therefore, I reject any attempt to end my life when God would sustain it, regardless of any diminished state of quality to my life, even if I have a disability. Similarly, I reject any attempt to lengthen my life when it is clear God intends to take it.

I believe life begins at conception. Therefore, if I have been diagnosed as pregnant and my physician knows of this diagnosis, I request that every effort be made to save the life of my unborn child in full recognition that two lives are at stake, both equal in value and worthy of protection.

HEALTH CARE DIRECTIVES

1. I direct my health care agent to consent to the following health care:
   a. Health care that is intended to relieve pain or to make me comfortable.
   b. Health care to cure or improve any physical or mental condition which can be cured or improved. This includes health care that is intended to be used temporarily or because it is potentially effective.

2. My health care agent has no authority to consent to any act or omission intended to cause or hasten my death.

3. I instruct my health care agent to ensure that my attending physician and other health care providers provide my health care based on my health care philosophy and my health care directives as set forth in this document.

4. Should it become clear that God wishes to take my life, namely that I am diagnosed to have a terminal illness or injury where death is imminent, I direct that life–sustaining procedures be withheld or withdrawn, and that I be permitted to die in God's time. I do *not* give consent for the withholding or withdrawal of nutrition or hydration, even if I am diagnosed to have a terminal illness or injury, if doing so would cause my death by starvation or dehydration rather than from the terminal condition or injury.

5. If God allows the quality of my life to be diminished but gives me strength to continue living for an indeterminate amount of time, I request that reasonable care be administered to me to sustain my life and ease discomfort as much as possible.

EXCEPTIONS TO HEALTH CARE DIRECTIVES

1. My health care agent may refuse consent to health care that would not be effective in terms of my survival.

2. If I have an incurable terminal illness or injury where I am in the final stages of dying, and it is medically certain that my death will occur within hours or a few days, my health care agent may consent to the withholding or withdrawal of any health care that is not intended to relieve pain or make me comfortable.

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3. If I have an incurable terminal illness or injury, and it is medically certain that my death will occur within six (6) months, my health care agent may consent to the withholding or withdrawal of life–sustaining health care. However, I still desire health care for easily treatable acute and chronic conditions, and health care that is intended to relieve pain or make me comfortable.

4. If I have a total, chronic, and irreversible loss of consciousness, and this condition has been diagnosed with medical certainty by two physicians, one of whom is my attending physician and the other is an expert in diagnosing my condition, my health care agent may consent to the withholding or withdrawal of life–sustaining health care. However, I still desire health care for easily treatable acute and chronic conditions, and health care that is intended to relieve pain or make me comfortable.

DESIGNATION OF ALTERNATE HEALTH CARE AGENT(S)

If you wish to name alternate health care agents, insert the names and addresses of such alternates in the following paragraph:

If the agent named by me on page 2 of this Durable Power of Attorney for Health Care Decisions document shall die, become legally disabled, incapacitated, or incompetent, or resign, refuse to act, or be unavailable, I name the following (each to act successively in the order named) as alternates to such agent:

First alternate health care agent

______________________________ Phone: (____) ______________

Name of first successor agent

____

Address

Second alternate health care agent

______________________________ Phone: (____) ______________

Name of second successor agent

____

Address

ADMISSION TO NURSING HOMES

My health care agent may admit me to a nursing home for short–term stays for recuperative care or respite care.

If I have checked “Yes” to the following, my health care agent may admit me for a purpose other than recuperative care or respite care, but if I have checked “No” to the following, my health care agent may not so admit me:

A nursing home **Yes ❑** **No ❑**

If I have not checked either “Yes” or “No” immediately above, my health care agent may only admit me for short–term stays for recuperative care or respite care.

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PROVISION OF FEEDING TUBE

If I have checked "Yes" to the following, my health care agent may have a feeding tube withheld or withdrawn from me, unless my physician has advised that, in his or her professional judgment, this will cause me pain or will reduce my comfort. If I have checked "No" to the following, my health care agent may not have a feeding tube withheld or withdrawn from me.

My health care agent may not have orally ingested nutrition or hydration withheld or withdrawn from me unless provision of the nutrition or hydration is medically contraindicated.

Withhold or withdraw a feeding tube **Yes** ❑ **No** ❑

If I have not checked either "Yes" or "No" immediately above, my health care agent may not have a feeding tube withheld or withdrawn from me.

NUTRITION AND HYDRATION

Food and fluids

1. I believe that nutrition and hydration are basic human needs which should be provided to me even though providing them may require medical expertise and technology.

2. If I have checked "Yes" to the "Withhold or withdraw a feeding tube" option in the "PROVISION OF FEEDING TUBE" section of the Durable Power of Attorney for Health Care Decisions Document, then a feeding tube may only be withheld or withdrawn from me if:
   a. I have an incurable terminal illness or injury where I am in the final stage of dying, and it is medically certain that my death will occur within hours or a few days, and
   b. The withholding or withdrawal of the feeding tube would not result in my death from malnutrition or dehydration, or complications of malnutrition or dehydration, rather than from my underlying terminal illness or injury.

HEALTH CARE DECISIONS FOR PREGNANT WOMEN

If I have checked "Yes" to the following, my health care agent may make health care decisions for me even if my agent knows I am pregnant. If I have checked "No" to the following, my health care agent may not make health care decisions for me if my health care agent knows I am pregnant.

Health care decision if I am pregnant **Yes** ❑ **No** ❑

If I have not checked either "Yes" or "No" immediately above, my health care agent may not make health care decisions for me if he or she knows I am pregnant.

In no event is my health care agent authorized to make medical treatment decisions to withhold or withdraw treatment for me if I am pregnant that would result in my death.

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PREGNANT WOMEN

If I am pregnant, the following applies:

1. My health care agent is authorized to make health care decisions on behalf of my unborn child as an individual patient.

2. Health care necessary to sustain the life or health of my unborn child should be provided unless it is medically certain that my unborn child would not survive even if the health care were provided.

3. It is my desire that all reasonable efforts be made to sustain both my life and health and the life and health of my unborn child.

4. Even if I have an incurable illness or injury, or I am legally determined to be brain dead, it is my desire to receive all health care, to remain on any necessary life support systems, and to receive nutrition and hydration until my unborn child can sustain life apart from my body, unless it is medically certain that my unborn child would not survive even if I receive such health care.

5. No one is authorized to consent to an abortion for me unless it is directly and medically necessary to prevent my death.

INSPECTION AND DISCLOSURE OF INFORMATION RELATING TO MY PHYSICAL OR MENTAL HEALTH

Subject to any limitations in this document, my health care agent has the authority to do all of the following:

1. Request, review, and receive any information, verbal or written, regarding my physical or mental health, including medical and hospital records.

2. Execute on my behalf any documents that may be required in order to obtain this information.

3. Consent to the disclosure of this information.

HIPAA RELEASE STATEMENT

I intend for my health care agent to be treated as I would with respect to my rights regarding the use and disclosure of my individual protected health information or other medical records. I grant to my agent the right to receive, disclose, or release, without restriction, all of my protected health information. This release statement applies to any information that is governed by the Health Insurance Portability and Accountability Act (HIPAA) of 1996.

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The principal and the witnesses or notary public must sign this Addendum at the same time.

EXECUTION

Signature of Principal

Executed this ______________________________, at ____, Kansas.
Date City

Signature: ____ Date: ______________________________

(The signing of this document by the principal revokes all previous Durable Power of Attorney for Health Care Decisions documents.)

WITNESSES

This Addendum to the Durable Power of Attorney for Health Care Decisions 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 the principal's estate and not financially responsible for the principal's health care; **OR** (2) acknowledged by a notary public.

Witness #1

Print name: ____ Date: ______________________________

Address: ____

Signature: ____

Witness #2

Print name: ____ Date: ______________________________

Address: ____

Signature: ____

OR

STATE OF KANSAS

COUNTY OF ______________________________ } SS. __________________

This instrument was acknowledged before me on ______________________ by _________________________________
Date Principal

Signature of notary public: _____________________________________

(Seal, if any)

My appointment expires: ____________________________________

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STATEMENT OF HEALTH CARE AGENT

I understand that ______________________________ has designated me to be his or her health care agent
Name of Principal
if he or she is ever found to have incapacity and unable to participate in making health care decisions himself or herself.

______________________________ has discussed his or her desires regarding health care decisions with me.
Name of Principal

Agent's signature: ______________________________

STATEMENT OF ALTERNATE HEALTH CARE AGENT(S)

I understand that ______________________________ has designated me to be his or her alternate
Name of Principal
health care agent if he or she is ever found to have incapacity and unable to make health care decisions himself or herself and if the person designated as health care agent is unable or unwilling to make those decisions.

______________________________ has discussed his or her desires regarding health care decisions with me.
Name of Principal

First alternate agent's signature: ______________________________

Second alternate agent's signature: ______________________________

CLERGY
Optional

The principal has requested that the agent consult me, as the principal's clergy, regarding any health care decisions. I understand that this request has been made and am willing to work with the agent to help meet the directives as described in this Durable Power of Attorney for Health Care Decisions document and attached Addendum.

Clergy's signature: ______________________________ Phone: (_____) ______________________

Church address: ____

I have given copies of this Power of Attorney for Health Care – Christian Version to:

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