~ Kentucky ~
Advance Directive
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 SURROGATE. 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 SURROGATE. IF YOUR SURROGATE 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 SURROGATE BROAD POWERS TO MAKE HEALTH CARE DECISIONS FOR YOU. IT REVOKES ANY PRIOR ADVANCE DIRECTIVE THAT YOU MAY HAVE MADE. IF YOU WISH TO CHANGE YOUR ADVANCE DIRECTIVE, 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 SURROGATE, YOUR HEALTH CARE PROVIDER(S), AND ANY OTHER PERSON(S) TO WHOM YOU HAVE GIVEN A COPY. IF YOUR SURROGATE IS YOUR SPOUSE AND YOUR MARRIAGE IS ANNULLED OR YOU ARE DIVORCED AFTER SIGNING THIS DOCUMENT, THE DOCUMENT IS INVALID.

YOU MAY ALSO USE THIS DOCUMENT TO MAKE OR REFUSE TO MAKE AN ANATOMICAL GIFT UPON YOUR DEATH. IF YOU USE THIS DOCUMENT TO MAKE OR REFUSE TO MAKE AN ANATOMICAL GIFT, THIS DOCUMENT REVOKES ANY PRIOR DOCUMENT OF GIFT THAT YOU MAY HAVE MADE.

DO NOT SIGN THIS DOCUMENT UNLESS YOU CLEARLY UNDERSTAND IT. IT IS SUGESTED THAT YOUR KEEP THE ORIGINAL OF THIS DOCUMENT WITH YOUR PERSONAL PAPERS WHERE IT CAN BE EASILY ACCESSED BY YOUR HEALTH CARE SURROGATE, CLOSE FAMILY, OR FRIENDS, IF NEEDED.

STATE OF KENTUCKY
ADVANCE DIRECTIVE

Written in accordance with Kentucky Revised Statutes § 311.625 to 311.643

CREATION OF ADVANCE DIRECTIVE

I, ________________________, ____,
Print full legal name Address

______/_____/_____, being of sound mind, intend by this document to create an advance directive.
Date of birth

My executing this advance directive is voluntary. Despite the creation of this advance directive, I expect to be fully informed about and allowed to participate in any health care decision for me, to the extent that I am able. For the purposes of this document, "health care decision" means an informed decision to accept, maintain, discontinue, or refuse any care, treatment, service, or procedure to maintain, diagnose, or treat my physical or mental condition.

In addition, I may, by this document, specify my wishes with respect to making an anatomical gift upon my death.

LIVING WILL DIRECTIVE

My wishes regarding life-prolonging treatment and artificially provided nutrition and hydration to be provided to me if I no longer have decisional capacity, have a terminal condition, or become permanently unconscious have been indicated by checking and initialing the appropriate lines below. By checking and initialing the appropriate lines, I specifically:

______ Designate ____, (____) __________________,
Surrogate Phone

____,
Address

as my surrogate to make any health care decisions for me in accordance with this directive when I no longer have

decisional capacity. If ____ refuses or is not able to act
Surrogate

for me, I designate ____, (____) __________________,
Alternate surrogate Phone

____,
Address

as my alternate surrogate.

Any prior designation is revoked.

If I do not designate a surrogate, the following are my directions to my attending physician. If I have designated a surrogate, my surrogate shall comply with my wishes as indicated by checking and initialing the appropriate lines that follow:

______ 1. Direct that treatment be withheld or withdrawn, and that I be permitted to die naturally with only the administration of medication or the performance of any medical treatment deemed necessary to alleviate pain.

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_______ 2. DO NOT authorize that life-prolonging treatment be withheld or withdrawn.

_______ 3. Authorize the withholding or withdrawal or artificially provided food, water, or other artificially provided nourishment or fluids.

_______ 4. DO NOT authorize the withholding or withdrawal or artificially provided food, water, or other artificially provided nourishment or fluids.

_______ 5. Authorize my surrogate, designated on page 2 of this document, to withhold or withdraw artificially provided nourishment or fluids, or other treatment if my surrogate determines that withholding or withdrawing is in my best interest; but I do not mandate that withholding or withdrawing.

_______ 6. Authorize the giving of all or any of my body upon death for any purpose specified in KRS 311.1929.

_______ 7. DO NOT authorize the giving of all or any part of my body upon death.

In the absence of my ability to give directions regarding the use of life-prolonging treatment and artificially provided nutrition and hydration, it is my intention that this directive shall be honored by my attending physician, my family, and any surrogate designated pursuant to this directive as the final expression of my legal right to refuse medical or surgical treatment and I accept the consequences of the refusal.

If I have been diagnosed as pregnant and that diagnosis is known to my attending physician, the above directives shall have no force or effect during the course of my pregnancy.

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

STATEMENT OF GRANTOR

(Person creating this Advance Directive)

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

Signed this ___________ day of ____________________________, _____________
Month Year

Signature: ____

Address: ____

____

STATEMENT OF WITNESSES

None of the following should be a witness to any advance directive made under this section:

(1) A blood relative of the grantor;
(2) A beneficiary of the grantor under descent and distribution statutes of the State;
(3) An employee of a health care facility in which the grantor is a patient, unless the employee serves as a notary public;
(4) An attending physician of the grantor; or
(5) Any person directly financially responsible for the grantor's health care.

In our joint presence, ____________________________________, who is of sound mind and eighteen (18)
Grantor
years of age, or older, voluntarily dated and signed this writing or directed it to be dated and signed for the grantor.

Witness #1

Name: ____

Address: ____

Signature: ____

Witness #2

Name: ____

Address: ____

Signature: ____

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OR

STATE OF KENTUCKY

____ County

Before me, the undersigned authority, came the grantor who is of sound mind and eighteen (18) years of age, or older, and acknowledged that he or she voluntarily dated and signed this writing or directed it to be signed and dated as above.

Done this ____________ day of _____________________________, _____________
Month Year

Signature of notary public or other officer: ____

Date commission expires: ______/______/______

Execution of this document may restrict withholding and withdrawal of some medical procedures. Consult Kentucky Revised Statutes or your attorney.

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ADDENDUM TO THE STATE OF KENTUCKY ADVANCE DIRECTIVE

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 that life is a gift from God and in the inherent value of human life. 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 surrogate 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 surrogate has no authority to consent to any act or omission intended to cause or hasten my death.

3. I instruct my surrogate 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 surrogate 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 with occur within hours or a few days, my surrogate 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 surrogate 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 surrogate 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.

GENERAL STATEMENT OF AUTHORITY GRANTED

Unless I have specified otherwise in this document, if I ever have incapacity I instruct my health care provider to obtain the health care decision of my surrogate, if I need treatment, for all of my health care and treatment. I have discussed my desires thoroughly with my surrogate and believe that he or she understands any philosophy regarding the health care decisions I would make if I were able. I desire that my wishes be carried out through the authority given to my surrogate under this document.

If I am unable, due to my incapacity, to participate in making a health care decision, my surrogate is instructed to make the health care decision for me, but my surrogate should try to discuss with me any specific proposed health care if I am able to communicate in any manner, including by blinking my eyes. If this communication cannot be made, my surrogate shall base his or her decision on any health care choices that I have expressed prior to the time of the decision. If I have not expressed a health care choice about the health care in question and communication cannot be made, my surrogate shall base his or her health care decision on what he or she believes to be in my best interest.

LIMITATIONS ON MENTAL HEALTH TREATMENT

My surrogate may not admit or commit me on an inpatient basis to an institution for mental diseases, a state treatment facility, or a treatment facility. My surrogate may not consent to experimental mental health research or psychosurgery, electroconvulsive treatment, or drastic mental health treatment procedures for me.

ADMISSION TO NURSING HOMES

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

A nursing home **Yes ❑** **No ❑**

If I have not checked either “Yes” or “No” immediately above, my surrogate 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 surrogate 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 surrogate may not have a feeding tube withheld or withdrawn from me.

My surrogate 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 surrogate 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 Advance Directive 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 surrogate may make health care decisions for me even if my surrogate knows I am pregnant. If I have checked "No" to the following, my surrogate may not make health care decisions for me if my surrogate 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 surrogate may not make health care decisions for me if he or she knows I am pregnant.

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

PREGNANT WOMEN

If I am pregnant, the following applies:

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

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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.

STATEMENT OF DESIRES, SPECIAL PROVISIONS, OR LIMITATIONS

In exercising authority under this document, my surrogate 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 this Addendum (pages 6-12) be included as a valid part of this Advance Directive document.

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

3. ____

____

____

____

[Attach additional pages, if needed]

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

Subject to any limitations in this document, my surrogate 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 surrogate 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 surrogate 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 grantor and the witnesses or notary public must sign the document at the same time.

STATEMENT OF GRANTOR

(Person creating this Advance Directive)

I have read this addendum to the Kentucky Advance Directive - Christian Version. I understand that it allows another person to make life and death decisions for me if I am incapable of making such decisions. I also understand that I can revoke this Advance Directive at any time by notifying my patient advocate, my physician, or the facility in which I am a patient or resident. I also understand that I can require in this Advance Directive that the fact of my incapacity in the future be confirmed by a second physician.

Signed this ____________ day of ________________________, ______________
Month Year

Signature: ____

Address: ____

____

STATEMENT OF WITNESSES

None of the following should be a witness to any advance directive made under this section:

(1) A blood relative of the grantor;
(2) A beneficiary of the grantor under descent and distribution statutes of the State;
(3) An employee of a health care facility in which the grantor is a patient, unless the employee serves as a notary public;
(4) An attending physician of the grantor; or
(5) Any person directly financially responsible for the grantor's health care.

In our joint presence, ________________________________, who is of sound mind and eighteen (18)
Grantor
years of age, or older, voluntarily dated and signed this writing or directed it to be dated and signed for the grantor.

Witness #1

Name: ____

Address: ____

Signature: ____

Witness #2

Name: ____

Address: ____

Signature: ____

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STATE OF KENTUCKY

________________________________ County

Before me, the undersigned authority, came the grantor who is of sound mind and eighteen (18) years of age, or older, and acknowledged that he or she voluntarily dated and signed this writing or directed it to be signed and dated as above.

Done this ___________ day of ____________________, ____________
Month Year

Signature of notary public or other officer: ____

Date commission expires: _____/_____/ _____

STATEMENT OF SURROGATE

I understand that ____ has designated me to be his or her
Name of grantor
surrogate 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 grantor

Surrogate's signature: ____

Address: ____

____

STATEMENT OF ALTERNATE SURROGATE

I understand that ______________________________________ has designated me to be his or her alternate
Name of grantor
surrogate 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 surrogate is unable or unwilling to make those decisions.

________________________________ has discussed his or her desires regarding health care decisions with me.
Name of grantor

Alternate surrogate's signature: ____

Address: ____

____

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CLERGY

Optional

The grantor has requested that the surrogate consult me, as the grantor's clergy, regarding any health care decisions. I understand that this request has been made and am willing to work with the surrogate to help meet the directives as described in this Advance Directive Document and Addendum.

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

Church address: ____

I have given copies of this Advance Directive – Christian Version to:

____

____

____

____

____

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