

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 professionals 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
Kentucky Residents*



*Statutory Compliant
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Health Care Choices*

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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 warranted 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 Kentucky 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 Kentucky state legislature has provided a combined living will and a surrogate appointment form for use by the public. Documents such as these are known as “advance directives.” As the content of this document was designed by your state government, it is in full compliance with all applicable statutes and laws.

There is an introduction that summarizes the scope and purpose of the document, as well as providing further directions for its completion. Read this carefully to ensure that your advance directive is 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 **Section I**, leaving just a statement of your values and wishes. Or you may complete only **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.

To complete each document, you should ***initial*** in the underlined spaces provided beside all the questions that are asked, and fill in any blank lines as directed. Feel free to write “No,” “None,” or “Does Not Apply” in areas that would otherwise be left blank.

Section I:
Living Will Directive

(Pursuant to KRS, Title 26: Ch.311: §311.621 to §311.643)

1. ***Be it Known that I:***

Full Legal Name: _____
Date of Birth: _____
Street Address: _____
City: _____ County: _____
State: _____ Zip Code: _____

~~ herein make known 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**.

2. My wishes have been indicated by checking and initialing the appropriate lines below. By checking and *initialing* the appropriate lines, I specifically:

_____ 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.

OR,

_____ I do NOT authorize that life-prolonging treatment be withheld or withdrawn.

(Regarding Artificial Nutrition and Hydration)

_____ I authorize the withholding or withdrawal of artificially provided food, water, or other artificially provided nourishment or fluids.

OR,

_____ I do NOT authorize the withholding or withdrawal of artificially provided food, water, or other artificially provided nourishment or fluids.

(Regarding a Surrogate and Nutrition and Hydration)

_____ I authorize my surrogate, if designated below, to withhold or withdraw artificially provided nourishment or fluids, or other treatment if the surrogate determines that withholding or withdrawing is in my best interest; but I do **not mandate** (or require) that withholding or withdrawing.

(Regarding Organ and Tissue Donation)

_____ I authorize the giving of all or any part of my body upon death for any purpose specified in *KRS §311.185*.

OR,

_____ I do NOT authorize the giving of all or any part of my body upon death.

Other Living Will Wishes

- 3. Other Living Will wishes and directions, if any: _____

Limitations and Legal Requirements

- 4. If I have been diagnosed as pregnant and that diagnosis is known to my attending physician, this directive shall have no force or effect during the course of my pregnancy.
- 5. Other Limitations, if any: _____

Statement of Intent

- 6. 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 accept or refuse medical or surgical treatment and I accept the consequences of my decisions.

Section II:
Designation of Health Care Surrogate
(Pursuant to KRS, Title 26: Ch.311: §311.621 to §311.643)

7. *Be it Known that I:*

Full Legal Name: _____

~~ Do hereby designate:

Name of Surrogate: _____

Address: _____

Telephone: Home: _____ Work: _____

Cell Phone or Pager: _____ E-mail: _____

~~ as my health care surrogate to make health care decisions for me in accordance with this directive when I no longer have decisional capacity. If the above named individual refuses or is not able to act for me, I then designate the following persons:

8. Name of Alternate #1: _____

Address: _____

Telephone: Home: _____ Work: _____

Cell Phone or Pager: _____ E-mail: _____

9. Name of Alternate #2: _____

Address: _____

Telephone: Home: _____ Work: _____

Cell Phone or Pager: _____ E-mail: _____

~~ to serve separately, in the order named, as my health care surrogate(s).
Any prior designation is revoked.

10. If I did not designate a surrogate, the following are my directions to my attending physician (*optional instructions, if any*): _____

11. If I have designated a surrogate, my surrogate shall comply with my wishes as indicated in my living will declaration, and above.

Validation and Signature

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

12. Signed this _____ day of _____, 20_____

Signature: _____ Date: _____

(Residence) _____

(City) _____ (State) _____ (Zip) _____

Statement of Witnesses

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

13. 1st Witness: _____
(Signature)

(Name Printed) (Date)

(Residence Address)

14. 2nd Witness: _____
(Signature)

(Name Printed) (Date)

(Residence Address)

**OR (optional):
Certificate of Notary Public**

15. 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 voluntarily dated and signed this writing or directed it to be signed and dated as above.

Done this _____ day of _____, 20_____

Signature of Notary Public or other officer.

Notary Seal:

Date commission expires: _____