KENTUCKY
Living Will Directive
Planning for Important Health Care Decisions

CaringInfo
1731 King St., Alexandria, VA 22314
www.caringinfo.org
800/658-8898

CaringInfo, a program of the National Hospice and Palliative Care Organization (NHPCO), is a national consumer engagement initiative to improve care at the end of life, supported by a grant from The Robert Wood Johnson Foundation.

It's About How You LIVE

It's About How You LIVE is a national community engagement campaign encouraging individuals to make informed decisions about end-of-life care and services. The campaign encourages people to:

Learn about options for end-of-life services and care
Implement plans to ensure wishes are honored
Voice decisions to family, friends and health care providers
Engage in personal or community efforts to improve end-of-life care

Note: The following is not a substitute for legal advice. While CaringInfo updates the following information and form to keep them up-to-date, changes in the underlying law can affect how the form will operate in the event you lose the ability to make decisions for yourself. If you have any questions about how the form will help ensure your wishes are carried out, or if your wishes do not seem to fit with the form, you may wish to talk to your health care provider or an attorney with experience in drafting living will directives.

USING THESE MATERIALS

BEFORE YOU BEGIN

Check to be sure that you have the materials for each state in which you may receive health care.

1. These materials include:
   - Instructions for preparing your living will directive.
   - Your state-specific living will directive forms, which are the pages with the gray instruction bar on the left side.

PREPARING TO COMPLETE YOUR LIVING WILL DIRECTIVE

2. Read all the instructions, as they will give you specific information about the requirements in your state.

ACTION STEPS

1. You may want to photocopy or print a second set of these forms before you start so you will have a clean copy if you need to start over.

2. When you begin to fill out the forms, refer to the gray instruction bars — they will guide you through the process.

3. Talk with your family, friends, and physicians about your living will directive. Be sure the person you appoint to make decisions on your behalf understands your wishes.

4. Once the form is completed and signed, photocopy the form and give it to the person you have appointed to make decisions on your behalf, your family, friends, health care providers, and/or faith leaders so that the form is available in the event of an emergency.

5. You may also want to save a copy of your form in an online personal health records application, program, or service that allows you to share your medical documents with your physicians, family, and others who you want to take an active role in your advance care planning.

INTRODUCTION TO YOUR LIVING WILL DIRECTIVE

This packet contains a Kentucky Living Will Directive (or "Advance Directive"), which protects your right to refuse medical treatment you do not want or to request treatment you do want in the event you lose the ability to make decisions yourself. You may complete Part I, Part II, or both, depending on your advance planning needs. You must complete Part III

Part I is an **Appointment of a Surrogate.** This part lets you name someone to make decisions about your health care, including decisions about life-sustaining procedures, if you can no longer speak for yourself. It goes into effect when your doctor determines that you cannot make your own health care decisions.

Part II allows you to provide **Instructions** regarding your wishes about health care. Part II also allows you to choose whether or not to donate your organs. These instructions become effective when your doctor determines that you cannot make your own health care decisions and that you are in a terminal condition or permanently unconscious.

Part III contains the witnessing and signature provisions to make your document effective.

This form does not expressly address mental illness. If you would like to make advance care plans regarding mental illness, you should talk to your physician and an attorney about a living will directive tailored to your needs.

Note: This document will be legally binding only if the person completing it is an individual of sound mind who is 18 years or older.

INSTRUCTIONS FOR
COMPLETING YOUR LIVING WILL DIRECTIVE

How do I make my living will directive legal?

In order to make your document effective, you must sign it in the presence of either:

1. Two witnesses, who must be at least 18 years of age. Your witnesses **cannot** be
   - A blood relative,
   - Entitled to any portion of your estate,
   - Your attending physician,
   - An employee of a health care facility in which you are a patient or resident, unless the employee serves as a notary public, or
   - Someone directly financially responsible for your medical care.

OR

2. A notary public. The notary public is subject to the same restrictions as your witnesses.

Can I add personal instructions to my living will directive?

One of the strongest reasons for naming a surrogate is to have someone who can respond flexibly as your health care situation changes and deal with situations that you did not foresee. If you add instructions to this document it may help your surrogate carry out your wishes, but be careful that you do not unintentionally restrict your surrogate's power to act in your best interest. In any event, be sure to talk with your surrogate about your future medical care and describe what you consider to be an acceptable "quality of life."

Whom should I appoint as my Surrogate?

Your surrogate is the person you appoint to make decisions about your health care if you become unable to make those decisions yourself. Your surrogate may be a family member or a close friend whom you trust to make serious decisions. The person you name as your surrogate should clearly understand your wishes and be willing to accept the responsibility of making health care decisions for you.

You can appoint a second person as your alternate surrogate. The alternate will step in if the first person you name as a surrogate is unable, unwilling, or unavailable to act for you.

You cannot appoint as your surrogate or alternate surrogate, an employee, owner, director, or officer of a health care facility in which you are a resident or patient, unless he or she is related to you by blood or marriage or is a member of the same religious order (for example, if you are both priests, monks, or nuns in the same order).

What if I change my mind?

You may revoke all or part of your living will directive, including the designation of your surrogate, at any time that you have the capacity to make your own decisions. You may revoke your living will directive at any time by:

(a) A signed and dated written revocation,
(b) An oral revocation made in the presence of two adults, one of whom must be a health care provider; or
(c) Destruction of the document by you or someone acting at your direction.

What other important facts should I know?

Despite any directions you or your surrogate gives, life-prolonging treatments and artificially provided nutrition and hydration will not be withheld while you are pregnant unless it is reasonably medically certain that such procedures will not allow the baby to be born, will be physically harmful to you, or will prolong severe pain that cannot be alleviated through medication.

PRINT YOUR NAME

PRINT YOUR SURROGATE'S NAME

PRINT YOUR ALTERNATE SURROGATE'S NAME

ADD OTHER INSTRUCTIONS, IF ANY, REGARDING YOUR ADVANCE CARE PLANS

THESE INSTRUCTIONS CAN FURTHER ADDRESS YOUR HEALTH CARE PLANS, SUCH AS YOUR WISHES REGARDING HOSPICE TREATMENT, BUT CAN ALSO ADDRESS OTHER ADVANCE PLANNING ISSUES, SUCH AS YOUR BURIAL WISHES

ATTACH ADDITIONAL PAGES IF NEEDED

NOTE: Execution of this document restricts withholding and withdrawing of some medical procedures. Consult Kentucky Revised Statutes or your attorney.

PART I. DESIGNATION OF HEALTH CARE SURROGATE

I,_____(print name),

designate _____
(name of surrogate) 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 person I name above refuses or is not able to act for me, I designate_____
(name of alternate surrogate)

as my health care surrogate.

When making health-care decisions for me, my surrogate should think about what action would be consistent with past conversations we have had, my treatment preferences as expressed in this or any other document where I have recorded my wishes, my religious and other beliefs and values, and how I have handled medical and other important issues in the past. If what I would decide is still unclear, then my surrogate should make decisions for me that my surrogate believes are in my best interest, considering the benefits, burdens, and risks of my current circumstances and treatment options.

I give the following instructions as further guidance to my surrogate:

_____

_____

_____

_____

_____

_____

Any prior designation is revoked.

PART II. HEALTH CARE INSTRUCTIONS

My wishes regarding healthcare, 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. If I do not designate a surrogate, or if my surrogate is not reasonably available, the following are my directions to my attending physician. If I have designated a surrogate, my surrogate shall comply with my wishes as indicated below:

INITIAL THIS DECISION IF YOU WANT YOUR SURROGATE TO MAKE DECISIONS REGARDING ARTIFICIAL NUTRITION AND HYDRATION AND OTHER LIFE-PROLONGING TREATMENTS. IF YOU INTIAL THE CHOICE IN PART A, DO NOT COMPLETE PARTS B OR C

A. Surrogate Decision-Maker

_____ I authorize my surrogate, designated above, to withhold or withdraw artificially provided nourishment or fluids, or other life-prolonging treatment, if the surrogate determines that withholding or withdrawing is in my best interest; but I do not mandate that withholding or withdrawing. **(Do not complete B or C, below, if you initial this choice).**

INITIAL ONLY ONE. DO NOT COMPLETE PART B IF YOU INITIALED THE CHOICE IN PART A

B. Life-Prolonging Treatment

_____ I direct that life-prolonging 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.

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

INITIAL ONLY ONE. DO NOT COMPLETE PART C IF YOU INITIALED THE CHOICE IN PART A

C. Artificially-Provided Nutrition and Hydration

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

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

INITIAL ONLY ONE

D. 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.

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

ADD OTHER INSTRUCTIONS, IF ANY, REGARDING YOUR ADVANCE CARE PLANS

THESE INSTRUCTIONS CAN FURTHER ADDRESS YOUR HEALTH CARE PLANS, SUCH AS YOUR WISHES REGARDING HOSPICE TREATMENT, BUT CAN ALSO ADDRESS OTHER ADVANCE PLANNING ISSUES, SUCH AS YOUR BURIAL WISHES

ATTACH ADDITIONAL PAGES IF NEEDED

Other directions:

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

(attach additional pages, if needed)

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, directions regarding life-prolonging treatments and artificially-provided nutrition and hydration in this directive shall have no force or effect during the course of my pregnancy.

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

SIGN AND DATE THE DOCUMENT AND PRINT YOUR NAME AND ADDRESS

TO BE VALID YOU MUST EITHER

HAVE YOUR WITNESSES AND SIGN AND DATE HERE AND PRINT THEIR ADDRESSES AND NAMES

OR

HAVE A NOTARY PUBLIC COMPLETE THIS SECTION

Part II. Execution

Signed this ____ day of _____, 20_____.
(date) (month) (year)

Signature of the grantor: _____

Printed Name: _____

Address of the grantor: _____

_____

WITNESSES

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

Signature of witness: _____

Date: _____

Address of witness: _____

Printed Name: _____

Signature of witness: _____

Date: _____

Address of witness: _____

Printed Name: _____

-OR-

NOTARY

STATE OF KENTUCKY)
) ss
County of_____)

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 dated and signed as above.

Done this _____ day of _____, 20_____.

_____
(signature of notary public or other person authorized to administer oaths)

Date commission expires: _____

Courtesy of CaringInfo
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You Have Filled Out Your Health Care Directive, Now What?

1. Your Kentucky Living Will Declaration is an important legal document. Keep the original signed document in a secure but accessible place. Do not put the original document in a safe deposit box or any other security box that would keep others from having access to it.

2. Give photocopies of the signed original to your surrogate and alternate surrogate, doctor(s), family, close friends, clergy, and anyone else who might become involved in your health care. If you enter a nursing home or hospital, have photocopies of your document placed in your medical records.

3. Be sure to talk to your surrogate(s), doctor(s), clergy, family, and friends about your wishes concerning medical treatment. Discuss your wishes with them often, particularly if your medical condition changes.

4. You may also want to save a copy of your form in an online personal health records application, program, or service that allows you to share your medical documents with your physicians, family, and others who you want to take an active role in your advance care planning.

5. If you want to make changes to your documents after they have been signed and witnessed, you must complete a new document.

6. Remember, you can always revoke your Kentucky document.

7. Be aware that your Kentucky document will not be effective in the event of a medical emergency. Ambulance and hospital emergency department personnel are required to provide cardiopulmonary resuscitation (CPR) unless they are given a separate directive that states otherwise. These directives called "prehospital medical care directives" or "do not resuscitate orders" are designed for people whose poor health gives them little chance of benefiting from CPR. These directives instruct ambulance and hospital emergency personnel not to attempt CPR if your heart or breathing should stop.

   Currently not all states have laws authorizing these orders. We suggest you speak to your physician if you are interested in obtaining one. **CaringInfo does not distribute these forms.**

Congratulations!

You've downloaded **your free, state specific advance directive.**

You are taking important steps to make sure your wishes are known. Help us keep this free.

Your generous support of the National Hospice Foundation and CaringInfo allows us to continue to provide these FREE resources, tools, and information to educate and empower individuals to access advance care planning, caregiving, hospice and grief services, and information.

I hope you will show your support for our mission and make a tax-deductible gift today.

Since 1992, the National Hospice Foundation has been dedicated to creating FREE resources for individuals and families facing a life-limiting illness, raising awareness for the need for hospice care, and providing ongoing professional education and skills development to hospice professionals across the nation.

Your gift strengthens the Foundation's ability to provide FREE caregiver and family resources.

Support your National Hospice Foundation by returning a **generous tax-deductible gift of $23, $47, $64,** or the most generous amount you can send.

You can help us provide resources like this advanced directive FREE by sending in your gift to help others.

Please help to make this possible with your contribution! Cut along the dotted line and use the coupon below to return a check contribution of the most generous amount you can send. Thank you.

YES! I want to support the important work of the National Hospice Foundation.

- ☐ $23 helps us provide free advanced directives
- ☐ $47 helps us maintain our free HelpLine
- ☐ $64 helps us provide webinars to hospice professionals

Return to:
National Hospice Foundation
PO Box 824401
Philadelphia, PA 19182-4401

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