The Rest Of Your Life www.theroyl.com

Advance Directive and Durable Power of Attorney

Living Will Directive and Health Care Surrogate Designation

State of Kentucky

The Rest of Your Life recommends that you review completed documents with an attorney, especially if there are mitigating circumstances surrounding your Advance Directive or Durable Power of Attorney.

Advance Directives Electronic Forms

The ROYL is a leader in offering electronic Advance Directive documents for digital signatures. Electronic Advance Directive Forms are secure and accessible anytime from any device that allows for Internet access.

Why do an Advance Directive?

Anyone 18 years of age or older should have an Advance Directive. This document allows for the care you have designated to be respected and followed through in the event you cannot speak for yourself. It allows for you to name someone to speak on your behalf, but most importantly it removes the stress, anxiety and guilt from decisions that your loved ones would otherwise have to make on your behalf.

An Advance Directive is not just for aging people. The cases of Teri Shivo and Karen Ann Quinlan serve as examples of how any adult, regardless of age, can benefit from having one. Both young adults, Shivo and Quinlan were kept alive by machines for years because they did not tell or write down what they wanted in the event of a tragic accident. The court battles that ensued took not only an emotional toll, but required government involvement because of disagreements between spouses and family members.

Description:

An Advance Directive, sometimes referred to as a Living Will or an Advance Health Care Directive, allows you to make your wishes known if you are unable to speak for yourself. An Advance Directive provides you and your loved ones with peace of mind that your care is compatible with your wishes. This is truly a gift to those you love as it helps them clearly know what to do in this stressful situation.

Advance Directive requirements vary from state to state. You can download the appropriate state form here at no cost prior to completing the form online so that you have the required information prepared in advance.

Security:

Your documents are processed using DocuSign, the leader in global electronic signature and document security.

When you complete your Advance Directive with The ROYL, you can download it as a PDF file to your computer's hard drive. DocuSign will email a final copy to the designees in your Advance Directive. We recommend you print a hard copy and send it via email or mail to others you want to have copies.

Contact us if you have questions in preparing the forms selected.

NOTICE: You must have the required information available prior to initiating the document (designees, contact information, wishes for care).

Instructions for Completing the Kentucky Living Will Form

The Living Will form should be used to let your physician and your family know what kind of life-sustaining treatments you want to receive if you become terminally ill or permanently unconscious and are unable to make your own decisions. This form should also be used if you would like to designate someone to make those healthcare decisions for you should you become unable to express your wishes.

NOTE: You may fill out all or part of the form according to your wishes. Keep in mind that filling out this form is not required for any type of healthcare or any other reason. Filling out this form should solely be a personal decision.

1. Read over all information carefully before filling out any part of the form.
2. At the top of the form in the designated area, print your full name and birth date.
3. The first section of the form on page one relates to designating a "Health Care Surrogate." Fill this section out if you would like to choose someone to make your healthcare decisions for you should you become unable to do so yourself. When choosing a surrogate, remember that the person you name will have the power to make important treatment decisions. Choose the person best qualified to be your health care surrogate. Also, consider picking a back-up person, in case your first choice isn't available when needed. Be sure to tell the person that you have named them a surrogate and make sure that the person understands what's most important to you. **Do not complete this section if you do not wish to name a surrogate.**
4. The next section of the form is the "Living Will Directive." Fill out this section to identify what kinds of life-sustaining treatments you want to receive should you become terminally ill or permanently unconscious.

Life Prolonging Treatment
Under this bolded section on page one, you may designate whether or not you wish to receive treatment (such as a life support machine), and be permitted to die naturally, with only the administration of medication or treatment deemed necessary to alleviate pain. If you do not want treatment, except for pain, and would like to die naturally, check and initial the first line. If you want life-sustaining treatment, check and initial the second line. Check and initial only one line.

Nourishment and/or Fluids
Under this bolded section on page two, you may designate whether or not you wish to receive artificially provided food, water, or other artificially provided nourishment or fluids (such as a feeding tube). If you do not want to receive artificial nourishment or fluids, check and initial the first line. If you want to receive nourishment and/or fluids, check and initial the second line. Check and initial only one line.

Surrogate Determination of Best Interest
Important: This section cannot be completed if you have completed the two previous bolded sections. Under this bolded section on page two, IF you have designated a person as your surrogate in the first section, you may allow that person to make decisions for you regarding life-sustaining treatments and/or nourishment. Check and initial this line ONLY if you wish to allow your surrogate to make decisions for you and if you do not want to detail your specific life-sustaining wishes on this form.

Organ/Tissue Donation
Under this bolded section on page two, you may designate whether or not to donate your all or any part of your body upon your death. If you wish to donate all or part of your body, check and initial the first line. If you do not want to donate all or part of your body, check and initial the second line. Check and initial only one line.

5. On page three, you will sign and date the form. Sign and date the form **in the presence of two witnesses over the age of 18 OR in the presence of a Notary Public.**

   The following people CANNOT be a witness to or serve as a notary public:
   a) A blood relative of yours;
   b) A person who is going to inherit your property under Kentucky law;
   c) An employee of a health care facility in which you are a patient (unless the employee serves as a notary public);
   d) Your attending physician; or
   e) Any person directly financially responsible for your health care.

6. Once you have filled out the Living Will and either signed it in the presence of witnesses or in the presence of a notary public, give a copy to your personal physician and any contacts you have listed in the Living Will. A copy of any Living Will should be put in your medical records. Remember, you are responsible for telling your hospital or nursing home that you have a Living Will. Do not send your Living Will to the Office of the Attorney General.

Kentucky Living Will Directive and Health Care Surrogate Designation of

EXAMPLE
_____
(PRINTED NAME)

_____
(DATE OF BIRTH)

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.

Health Care Surrogate Designation

By checking and initialing the line below, I specifically:

☐ _____ (check box and initial line, if you desire to name a surrogate)

Designate _____ as my health care surrogate(s) to make 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 for me, I designate _____ as my health care surrogate(s).

Any prior designation is revoked.

Living Will Directive

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 below. By checking and initialing the lines below, I specifically:

Life Prolonging Treatment (check and initial only one)

☐ _____ (check box and initial line, if you desire the option below)
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.

☐ _____ (check box and initial line, if you desire the option below)
DO NOT authorize that life-prolonging treatment be withheld or withdrawn.

Nourishment and/or Fluids (check and initial only one)

☐ _____ (check box and initial line, if you desire the option below)
Authorize the withholding or withdrawal of artificially provided food, water, or other artificially provided nourishment or fluids.

☐ _____ (check box and initial line, if you desire the option below)
DO NOT authorize the withholding or withdrawal of artificially provided food, water, or other artificially provided nourishment or fluids.

Surrogate Determination of Best Interest

NOTE: If you desire this option, DO NOT choose any of the preceding options regarding Life Prolonging Treatment and Nourishment and/or Fluids

☐ _____ (check box and initial line, if you desire the option below)
Authorize my surrogate, as designated on the previous page, 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 that withholding or withdrawing.

Organ/Tissue/Eye Donation

I certify that I am eighteen (18) years of age or older and of sound mind, and that upon my death, I hereby give:

Check appropriate boxes and initial the line beside that box:

☐ _____ Any needed organs, tissues, and eye/corneas

OR

The following organs or tissues only (check and initial all that apply):

☐ _____ All needed organs

☐ _____ All needed tissues

☐ _____ Corneas

☐ _____ Eyes

☐ _____ Other

OR

☐ _____ Only the specified organs/tissues as listed:

_____

_____

_____

Organs that can be donated: heart, lungs, liver, pancreas, kidneys, and small bowel.

Tissues that can currently be donated: skin (outermost layer from lower trunk and abdomen), bone, heart valves, leg veins, pericardium, vertebral bodies.

Eye donation can be the corneas (outer most layer), the sclera (shell), or the entire eye.

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, this directive shall have no force or effect during the course of my pregnancy.

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

Signed this _____ day of _____, 20____

EXAMPLE

_____

(signature and address of the grantor)

Have two adults witness your signature OR have signature notarized.*

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.

_____

(signature and address of witness)

_____

(signature and address of witness)

OR

COMMONWEALTH 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/she 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 Date commission expires

** None of the following shall be a witness to or serve as a notary public or other person authorized to administer oaths in regard to any advance directive made under this section:*

a) A blood relative of the grantor;
b) A beneficiary of the grantor under descent and distribution statutes of the Commonwealth;
c) An employee of a health care facility in which the grantor is a patient, unless the employee serves as a notary public;
d) An attending physician of the grantor; or
e) Any person directly financially responsible for the grantor's health care.

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

A person designated as a surrogate pursuant to an advance directive may resign at any time by giving written notice to the grantor; to the immediate successor surrogate, if any; to the attending physician; and to any health care facility which is then waiting for the surrogate to make a health care decision.

A letter to my loved ones...

Dear Loved Ones,

I want the best quality of life possible during my last days. Therefore, I hereby request as follows...

☐	(a) I ask that medical treatment to alleviate pain, to provide comfort, and to mitigate suffering be provided so that I may be as free of pain and suffering as possible. Please consult with my doctor in this regard.
☐	(b) If my temperature is above normal, I want a cool moist cloth put on my head.
☐	(c) I want my mouth and lips kept moist.
☐	(d) I need to be kept fresh and clean at all times. I wish to have warm baths often or warm showers, if I am stable enough for a shower.
☐	(e) I desire to be massaged with or without warm oils as often as you think will help maintain my skin integrity and provide for my comfort.
☐	(f) I want my personal care such as nail clipping, hair combing, teeth brushing and shaving as long as they do not cause me pain.

I hope my family and friends would consider that...

- [ ] (a) I enjoy your company and want you with me when possible. I desire that one of you stay with me when it seems that my death may be imminent.
- [ ] (b) Please continue to talk to me about daily happenings and events, even if you think I don't understand, because I might be able to understand.
- [ ] (c) Please don't be afraid to hold my hand or hug me.
- [ ] (d) Please tell the members of my church or synagogue I am sick and ask them to pray for me and visit me.
- [ ] (e) Please maintain a cheerful atmosphere around me.
- [ ] (f) Please place pictures of my loved ones in my room, near my bed, or near the place I sit during the day.
- [ ] (g) My clothes and bed linens are to be kept clean, and they are to be changed as soon as possible, if they have been soiled.
- [ ] (h) If at all possible, allow me to die in my home.
- [ ] (i) Please arrange for me to watch television or listen to my favorite sports events.
- [ ] (j) Let me enjoy the outdoors as often as possible by letting me spend time in my yard, garden and other appropriate outdoor places, even if it causes slight discomfort to either you or me.
- [ ] (k) I want to have my favorite types of music played when possible.
- [ ] (l) I want to have religious readings read to me when I am near death.
- [ ] (m) I want to have my favorite poems read to me from time to time.

I want you to know the following about my thoughts and concerns, if I am disabled and cannot convey these thoughts to you verbally...

(1) I want you to know that I love you.	☐
(2) I would like to be forgiven for the times I have hurt you.	☐
(3) I forgive you for what you may have done to me in my life.	☐
(4) I want you to know that I do not fear death itself.	☐
(5) I want all of my family members to recommit their love for one another.	☐
(6) Please remember me the way I was before I had a terminal illness.	☐
(7) Please help me maintain meaning to my life during this process of dying by realizing that this is an opportunity for personal growth for all.	☐
(8) Don't be afraid to seek counseling, if you have trouble with my death.	☐

If friends want to know how I want to be remembered, tell them the following...

_____

_____

_____

_____

The following person(s) know my funeral plans...

_____

_____

_____

At any memorial service for me, I want to include the following music, songs, readings or other plans for such a service...

_____

_____

_____

_____

I also have the following requests...

_____

_____

_____

_____

These are requests of my family members, loved ones, and friends, and are not to be considered legal directives to my attorney-in-fact for health care, if any.

(If you wish to change your answer, you may do so by drawing an "X" through the answer you do not want, and circling the answer you prefer.)

Dated this ____ day of _____, 20_____.

Signature EXAMPLE _____

Print Name _____

Additional Pages:

Additional Pages: