Triage Cancer Estate Planning Toolkit: Kentucky

Part II: Understanding Estate Planning Documents in Your State

State Laws About Wills

A will is a legal document that provides instructions for what you would like to have happen to your property upon death. A will is also a place where parents can name a guardian for any minor children or adult children with developmental disabilities.

Kentucky probate courts accept written wills and holographic wills. To make a valid written will in Kentucky:

1. You need to be in the right state of mind to create a will. This means you need to be:
    - At least 18 years old
    - Of "sound mind" (meaning you know what you're doing)
2. You need to sign the will or authorize someone to do so for you, in front of two witnesses who are not included in your will.
3. Your will does not need to be notarized to be legal in Kentucky. However, you can make your will "self-proving," or accepted in probate court without the court needing to contact your witnesses. To do this, you and your witnesses must sign an affidavit affirming the will in front of a notary.

Due to the COVID-19 pandemic, Kentucky now allows you to execute your will remotely (e.g. sign an affidavit by teleconferencing with a notary). However, before you execute your will remotely, you should check your state's laws to make sure that this is still allowed at the time you are executing your will.

A holographic will is one that is handwritten by you. To make a valid holographic will in Kentucky:

1. You need to be in the right state of mind to create a will. This means you need to be:
    - At least 18 years old
    - Of "sound mind" (meaning you know what you're doing)
2. Your will must be written entirely in your handwriting and you must sign it.

If you make a holographic will, it does not need to be signed by witnesses. However, most estate planning experts do not recommend relying on holographic wills because it is more difficult to prove that they are valid in probate court.

State Laws About Financial Powers of Attorney

A power of attorney for financial affairs is a legal document where you (the principal) name a trusted adult (the agent) who is authorized to make financial decisions on your behalf.

Kentucky's statutory form for power of attorney allows you to appoint someone to manage your finances for you, including your property, taxes, and government benefits. You can also appoint a successor agent or co-agent in the "special instructions" section. This person can make all financial decisions for you, or you can limit their powers to specific areas, like filing taxes or banking. You can also use this document to nominate a conservator in advance, in

case a court decides one is necessary. Unless you indicate otherwise in the "special instructions" section, this document takes effect immediately after you sign it and will remain in effect until you die, unless you revoke your power of attorney.

Part III includes a sample form.

State Laws About Advance Directives for Health Care

An advance health care directive is a legal document you can use to provide written instructions, or state preferences, about your medical care in case you become unable to communicate. In Kentucky, this is called a living will directive.

This document includes three parts. You can complete part one and/or part two, but you must sign part three to make the document valid.

- **Appointment of Surrogate:** Here you can appoint someone to make any and all health care decisions for you, including decisions about life-prolonging care, if your doctor determines you can no longer make these decisions yourself for any reason. You can also choose an alternate person if the first person you appoint is not available.
- **Instructions:** You can use this document to express your preferences for life-sustaining care in case you become seriously ill or unconscious. This includes specific situations, including letting your surrogate make these decisions for you, administering or withholding life-prolonging procedures, artificially administered nutrition (food offered through surgically-placed tubes), and any other instructions you would like to include. You can also indicate your preferences for organ donation with this document.
- **Execution:** You must sign the document witnessed by a notary public, or by two adult witnesses. Your witnesses cannot be:
    - A blood relative
    - Included in your will
    - Your attending physician
    - An employee of your health care facility, unless they are a notary public
    - Someone directly financially responsible for your medical care.

If you are pregnant, directions in your living will directive for life-prolonging care will not be honored.

You can revoke all or part of your living will directive at any time that you have the capacity to make health care decisions for yourself, by:

- Signing a written revocation
- Making an oral revocation in front of two adults, if one is a health care provider
- Destroying the document

Part III of this toolkit includes a sample form.

State Laws About POLST/MOLST

A physician order for life-sustaining treatment (POLST) is a medical order completed by a seriously ill person and signed by a physician. In Kentucky, this form is called a medical order for scope of treatment (MOST). The MOST does not replace an advance directive. You can complete a MOST form with your doctor

This form lets you indicate your preferences for:

- Cardiopulmonary resuscitation orders (also known as a "Do not resuscitate," or DNR order)
- Medical Interventions, ranging from all medical and surgical treatments available to prolong your life, selective treatments to restore your health while avoiding burdensome procedures, or comfort-focused treatments to manage symptoms and allow natural death
- Use of antibiotics, whether to preserve life, for trial periods, or to relieve pain and discomfort

- Medically assisted nutrition, or food and hydration offered through surgically-placed tubes
- Additional orders or instructions for your care

This form will not expire, so it is important for you and your physician to review it regularly to make sure it still reflects your wishes.

You can find a sample form in Part III of this toolkit.

State Laws About Funeral Designation Forms

Funeral designation forms allow you to tell your loved ones what you would like to happen to your remains after you pass away. These forms can be used to choose someone to control what happens to your remains after your death, specify what you would like to have happen, and other wishes depending on your state.

Kentucky's Funeral Planning Declaration Form allows you to designate a trusted person to carry out your funeral plan, or create one for you, and/or provide instructions for the disposal of your remains. This includes whether you would like to be cremated, buried, entombed, or donated as an anatomical gift.

Part III of this toolkit includes a sample form.

State Laws About Death with Dignity

"Death with Dignity" laws, or physician-assisted dying/aid-in-dying laws, allow certain terminally ill people to voluntarily and legally request and receive a prescription medication from their physician to hasten their death in a peaceful, humane, and dignified way. By adding a voluntary option to the continuum of end-of-life care, these laws can give you dignity, control, and peace of mind during your final days with family and loved ones.

Kentucky does not have a death with dignity law. But, you can indicate other decisions related to end-of-life care through an advance health care directive.

Federal Law About HIPAA

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) is a federal law that protects the privacy of your health information. HIPAA does allow your protected health information to a be shared with your personal representative who has authority to make health care decisions for you (i.e., your health care agent or proxy).

To guarantee your agent's access to information, a HIPAA authorization form should be signed and dated by you. Also, it must identify the information to be disclosed, the purpose of the disclosure, the recipients of the information, and an expiration date. This means that any advance health care directives should be clear about the scope of your agent's authority to receive protected health care information.

You can revoke a HIPAA authorization form at any time by notifying your health care provider in writing.

Part III of this toolkit includes a sample HIPAA authorization form. For more information: www.cdc.gov/phlp/publications/topic/hipaa.html.

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Part III: Your State's Estate Planning Forms

- Power of Attorney for Financial Affairs
- Advanced Health Care Directive
- Medical Order for Scope of Treatment (MOST)
- Funeral Planning Declaration Form
- HIPAA Authorization Form

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Part III: Your State's Estate Planning Forms

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Power of Attorney for Financial Affairs

457.420 Statutory form power of attorney.

A document substantially in the following form may be used to create a statutory form power of attorney that has the meaning and effect prescribed by this chapter:

KENTUCKY

STATUTORY FORM POWER OF ATTORNEY

IMPORTANT INFORMATION

This power of attorney authorizes another person (your agent) to make decisions concerning your property for you (the principal). Your agent will be able to make decisions and act with respect to your property (including your money) whether or not you are able to act for yourself. The meaning of authority over subjects listed on this form is explained in the Uniform Power of Attorney Act in KRS Chapter 457.

This power of attorney does not authorize the agent to make health-care decisions for you.

You should select someone you trust to serve as your agent. Unless you specify otherwise, generally the agent's authority will continue until you die or revoke the power of attorney or the agent resigns or is unable to act for you.

Your agent is entitled to reasonable compensation unless you state otherwise in the Special Instructions.

This form provides for designation of one (1) agent. If you wish to name more than one (1) agent you may name a coagent in the Special Instructions. Coagents are not required to act together unless you include that requirement in the Special Instructions.

If your agent is unable or unwilling to act for you, your power of attorney will end unless you have named a successor agent. You may also name a second successor agent.

This power of attorney becomes effective immediately unless you state otherwise in the Special Instructions.

If you have questions about the power of attorney or the authority you are granting to your agent, you should seek legal advice before signing this form.

DESIGNATION OF AGENT

I, _____ _____, name the following person as my agent:

(Name of Principal)

Name of Agent:
Agent's Address:
Agent's Telephone Number

DESIGNATION OF SUCCESSOR AGENT(S) (OPTIONAL)

If my agent is unable or unwilling to act for me, I name as my successor agent:

Name of Successor Agent:
Successor Agent's Address:
Successor Agent's Telephone Number:

If my successor agent is unwilling or unable to act for me, I name as my second successor agent:

Name of Second Successor Agent:

Second Successor Agent's Address:
Second Successor Agent's Telephone Number:

GRANT OF GENERAL AUTHORITY

I grant my agent and any successor agent general authority to act for me with respect to the following subjects as defined in the Uniform Power of Attorney Act in KRS Chapter 457:

(INITIAL each subject you want to include in the agent's general authority. If you wish to grant general authority over all of the subjects you may initial "All Preceding Subjects" instead of initialing each subject.)

(___) Real Property
(___) Tangible Personal Property
(___) Stocks and Bonds
(___) Commodities and Options
(___) Banks and Other Financial Institutions
(___) Operation of Entity or Business
(___) Insurance and Annuities
(___) Estates, Trusts, and Other Beneficial Interests
(___) Claims and Litigation
(___) Personal and Family Maintenance
(___) Benefits from Governmental Programs or Civil or Military Service
(___) Retirement Plans
(___) Taxes
(___) All Preceding Subjects

GRANT OF SPECIFIC AUTHORITY (OPTIONAL)

My agent MAY NOT do any of the following specific acts for me UNLESS I have INITIALED the specific authority listed below:

(CAUTION: Granting any of the following will give your agent the authority to take actions that could significantly reduce your property or change how your property is distributed at your death. INITIAL ONLY the specific authority you WANT to give your agent.)

(___) Create, amend, revoke, or terminate an inter vivos trust
(___) Make a gift, subject to the limitations of the Uniform Power of Attorney Act in KRS 457.400 and any special instructions in this power of attorney
(___) Create or change rights of survivorship
(___) Create or change a beneficiary designation
(___) Authorize another person to exercise the authority granted under this power of attorney
(___) Waive the principal's right to be a beneficiary of a joint and survivor annuity, including a survivor benefit under a retirement plan
(___) Exercise fiduciary powers that the principal has authority to delegate

(___) Access the content of electronic communications

LIMITATION ON AGENT'S AUTHORITY

An agent that is not my ancestor, spouse, or descendant MAY NOT use my property to benefit the agent or a person to whom the agent owes an obligation of support unless I have included that authority in the Special Instructions.

SPECIAL INSTRUCTIONS (OPTIONAL)

You may give special instructions on the following lines:

_____
_____
_____
_____
_____
_____
_____

_____

EFFECTIVE DATE

This power of attorney is effective immediately unless I have stated otherwise in the Special Instructions.

NOMINATION OF CONSERVATOR OR GUARDIAN (OPTIONAL)

If it becomes necessary for a court to appoint a conservator of my estate or guardian of my person, I nominate the following person(s) for appointment:

Name of Nominee for conservator of my estate:
Nominee's Address:
Nominee's Telephone Number:
Name of Nominee for guardian of my person:
Nominee's Address:
Nominee's Telephone Number:

RELIANCE ON THIS POWER OF ATTORNEY

Any person, including my agent, may rely upon the validity of this power of attorney or a copy of it unless that person knows it has terminated or is invalid.

SIGNATURE AND ACKNOWLEDGMENT

Your Signature Date
Your Name Printed
Your Address
Your Telephone Number
State of _____
County of _____
This document was acknowledged before me on
(Date)
by_____.
(Name of Principal)
_____ (Seal, if any)
Signature of Notary

My commission expires: _____
This document prepared by:

_____

_____

IMPORTANT INFORMATION FOR AGENT

Agent's Duties

When you accept the authority granted under this power of attorney, a special legal relationship is created between you and the principal. This relationship imposes upon you legal duties that continue until you resign or the power of attorney is terminated or revoked. You must:

(1) Do what you know the principal reasonably expects you to do with the principal's property or, if you do not know the principal's expectations, act in the principal's best interest;

(2) Act in good faith;

(3) Do nothing beyond the authority granted in this power of attorney; and

(4) Disclose your identity as an agent whenever you act for the principal by writing or printing the name of the principal and signing your own name as "agent" in the following manner:

(Principal's Name) by (Your Signature) as Agent

Unless the Special Instructions in this power of attorney state otherwise, you must also:

(1) Act loyally for the principal's benefit;

(2) Avoid conflicts that would impair your ability to act in the principal's best interest;

(3) Act with care, competence, and diligence;

(4) Keep a record of all receipts, disbursements, and transactions made on behalf of the principal;

(5) Cooperate with any person that has authority to make health-care decisions for the principal to do what you know the principal reasonably expects or, if you do not know the principal's expectations, to act in the principal's best interest; and

(6) Attempt to preserve the principal's estate plan if you know the plan and preserving the plan is consistent with the principal's best interest.

TERMINATION OF AGENT'S AUTHORITY

You must stop acting on behalf of the principal if you learn of any event that terminates this power of attorney or your authority under this power of attorney. Events that terminate a power of attorney or your authority to act under a power of attorney include:

(1) Death of the principal;

(2) The principal's revocation of the power of attorney or your authority;

(3) The occurrence of a termination event stated in the power of attorney;

(4) The purpose of the power of attorney is fully accomplished; or

(5) If you are married to the principal, a legal action is filed with a court to end your marriage, or for your legal separation, unless the Special Instructions in this power

of attorney state that such an action will not terminate your authority.

LIABILITY OF AGENT

The meaning of the authority granted to you is defined in the Uniform Power of Attorney Act in KRS Chapter 457. If you violate the Uniform Power of Attorney Act under KRS Chapter 457 or act outside the authority granted, you may be liable for any damages caused by your violation.

Effective: July 15, 2020

History: Created 2020 Ky. Acts ch. 41, sec. 61, effective July 15, 2020.

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Part III: Your State's Estate Planning Forms

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Advance Health Care Directive

KENTUCKY
LIVING WILL PACKET

OFFICE OF THE ATTORNEY GENERAL
COMMONWEALTH OF KENTUCKY
UNITED WE STAND
DIVIDED WE FALL

Living Wills in Kentucky

A Living Will gives you a voice in decisions about your medical care when you are unconscious or too ill to communicate. As long as you are able to express your own decisions, your Living Will will not be used and you can accept or refuse any medical treatment. But if you become seriously ill, you may lose the ability to participate in decisions about your own treatment.

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.

The Kentucky Living Will Directive Act of 1994 was passed to ensure that citizens have the right to make decisions regarding their own medical care, including the right to accept or refuse treatment. This right to decide — to say yes or no to proposed treatment — applies to treatments that extend life, like a breathing machine or a feeding tube.

In Kentucky a Living Will allows you to leave instructions in four critical areas. You can:

- Designate a Health Care Surrogate
- Refuse or request life prolonging treatment
- Refuse or request artificial feeding or hydration (tube feeding)
- Express your wishes regarding organ donation

Everyone age 18 or older can have a Living Will. The effectiveness of a Living Will is suspended during pregnancy.

It is not necessary that you have an attorney draw up your Living Will. Kentucky law (**KRS 311.625**) actually specifies the form you should fill out. You probably should see an attorney if you make changes to the Living Will form. The law also prohibits relatives, heirs, health care providers or guardians from witnessing the Will. You may wish to use a Notary Public in lieu of witnesses.

The Living Will form includes two sections. The first section is the Health Care Surrogate section which allows you to designate one or more persons, such as a family member or close friend, to make health care decisions for you if you lose the ability to decide for yourself. The second section is the Living Will section in which you may make your wishes known regarding life-prolonging treatment so your Health Care Surrogate or Doctor will know what you want them to do. You can also decide whether to donate any of your organs in the event of your death.

When choosing a surrogate, remember that the person you name will have the power to make important treatment decisions, even if other people close to you might urge a different decision. 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. Your wishes should be laid out specifically in the Living Will.

If you decide to make a Living Will, be sure to talk about it with your family and your doctor. The conversation is just as important as the document.

A copy of any Living Will should be put in your medical records. Each time you are admitted for an overnight stay in a hospital or nursing home, you will be asked whether you have a Living Will. You are responsible for telling your hospital or nursing home that you have a Living Will.

If there is anything you do not understand regarding the form, you might want to discuss it with an attorney. You can also ask your doctor to explain the medical issues. When completing the form, you may complete all of the form, or only the parts you want to use. You are not required by law to use these forms. Different forms, written the way you want, may also be used. You should consult with an attorney for advice on drafting your own forms.

You are not required to make a Living Will to receive healthcare or for any other reason. The decision to make a Living Will must be your own personal decision and should only be made after serious consideration.

For additional copies of this packet, you may download it from the Attorney General's website at **https://ag.ky.gov/consumer-protection/livingwills** or make photocopies of this packet.

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

_____
(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.

LIVING WILL DIRECTIVE — CONTINUED

☐ _____ (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____

_____

(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.

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Part III: Your State's Estate Planning Forms

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Physician Orders for Life Sustaining Treatment (POLST)

HIPAA PERMITS DISCLOSURE OF MOST TO OTHER HEALTH CARE PROFESSIONALS AS NECESSARY

MOST
Medical Orders for Scope of Treatment

This document is based on this person's medical condition and wishes. Any section not completed indicates a preference for full treatment for that section.

Patient's Last Name:	Effective Date of Form: _____ Form must be reviewed at least annually.
Patient's First Name, Middle Initial:	Patient's Date of Birth:

Section A *Check One Box Only*

CARDIOPULMONARY RESUSCITATION (CPR): PERSON HAS NO PULSE AND IS NOT BREATHING.

❑ Attempt Resuscitation (CPR) ❑ Do Not Attempt Resuscitation

When not in cardiopulmonary arrest, follow orders in B, C, and D.

Section B *Check One Box Only*

MEDICAL INTERVENTIONS: PERSON HAS PULSE OR IS BREATHING.

❑ Full Scope of Treatment: Use intubation, advanced airway interventions, mechanical ventilation, defibrillation or cardioversion as indicated, medical treatment, IV fluids, and provide comfort measures. Transfer to a hospital if indicated. Includes intensive care. Treatment Plan: Full treatment including life support measures.

❑ Limited Additional Intervention: Use medical treatment, oral and IV medications, IV fluids, cardiac monitoring as indicated, non-invasive bi-level positive airway pressure, a bag valve mask, and comfort measures. Do not use intubation or mechanical ventilation. Transfer to hospital if indicated. Avoid intensive care. Treatment Plan: Provide basic medical treatments.

❑ Comfort Measures: Keep clean, warm and dry. Use medication by any route. Positioning, wound care and other measures to relieve pain and suffering. Use oxygen, suction and manual treatment of airway obstruction as needed for comfort. Do not transfer to hospital unless comfort needs cannot be met in the patient's current location (e.g. hip fracture).

Other Instructions _____

Section C *Check One Box Only*

ANTIBIOTICS

❑ Antibiotics if indicated for the purpose of maintaining life

❑ Determine use or limitation of antibiotics when infection occurs.

❑ Use of antibiotics to relieve pain and discomfort.

❑ No Antibiotics (use other measures to relieve symptoms).

Other instructions: _____

Section D *Check One Box Only in Each Column*

MEDICALLY ADMINISTERED FLUIDS AND NUTRITION: the provision of nutrition and fluids, even if medically administered, is a basic human right and authorization to deny or withdraw shall be limited to the patient, the surrogate in accordance with KRS 311.629, or the responsible party in accordance with KRS 311.631.

❑ Long term IV fluids if indicated

❑ IV fluids for a defined trial period. Goal: _____

❑ No IV fluids (provide other measures to ensure comfort)

❑ Long term feeding tube if indicated

❑ Feeding tube for a defined trial period. Goal: _____

❑ No feeding tube

Special instructions _____

Section E *Check The Appropriate Box*

Directions were given:
❑ *Orally*
❑ Written

Patient Preferences as a Basis for This MOST Form:

Basis for order must be documented in medical record.

❑ Adult Patient with decisional capacity
❑ Parent/guardian of minor patient
❑ Surrogate per advance directive
❑ Judicially appointed guardian/durable power of attorney with power to make health care decisions
❑ Spouse
❑ Majority of patient's reasonably available adult children
❑ Parent
❑ Majority of patient's reasonably available nearest living relatives of same relation

❑ Patient does not have an advance medical directive such as a living will or health care power of attorney.

❑ Patient has an advance medical directive such as a living will or health care power of attorney in place. I certify this form is in accordance with the decisions in the current advance medical directive.

Name: Printed: _____ Position: _____ Signature: _____

I agree that adequate information has been provided and significant thought has been given to decisions outlined in this form. Treatment preferences have been expressed to the physician (MD/DO). This document reflects those treatment preferences and indicates informed consent. *If signed by a patient, surrogate or responsible party, preferences expressed must reflect patient's wishes as best understood by that surrogate or responsible party.* You are not required to sign this form to receive treatment.

Patient, Surrogate or Responsible Party:	Signature:	Relationship: Contact #:	
Health Care Professional Preparing Form: Print Name	Health Care Professional Preparing Form: Signature	Preferred Phone #:	Date Prepared:
Physician Signature	Physician (Print Name)	Physician Contact Number	

SEND FORM WITH PATIENT/RESIDENT WHEN TRANSFERRED OR DISCHARGED

INFORMATION FOR PATIENT, SURROGATE OR RESPONSIBLE PARTY OF PATIENT NAMED ON THIS FORM

- The MOST form is always voluntary and is usually for persons with advanced illness. MOST records your wishes for medical treatment in your current state of health. The provision of nutrition and fluids, even if medically administered, is a basic human right and authorization to deny or withdraw shall be limited to the patient, the surrogate in accordance with KRS 311.629, or the responsible party in accordance with KRS 311.631. Once initial medical treatment is begun and the risks and benefits of further therapy are clear, your treatment wishes may change. Your medical care and this form can be changed to reflect your new wishes at any time. However, no form can address all the medical treatment decisions that may need to be made. An advance directive, such as the Kentucky Health Care Power of Attorney, is recommended for all capable adults, regardless of their health status. An advance directive allows you to document in detail your future health care instructions or name a surrogate to speak for you if you are unable to speak for yourself, or both. If there are conflicting directions between an enforceable living will and a MOST form, the provisions of the living will shall prevail.

DIRECTIONS FOR COMPLETING AND IMPLEMENTING FORM

COMPLETING MOST

- MOST must be reviewed, prepared and signed by the patient's physician in personal communication with the patient, the patient's surrogate or responsible party.
- MOST must be reviewed and contain the original signature of the patient's physician to be valid. Be sure to document the basis in the progress notes of the medical record. Mode of communication (e.g., in person, by telephone, etc.) should also be documented.
- The signature of the patient, surrogate or a responsible party is required; however, if the patient's surrogate or a responsible party is not reasonably available to sign the original form, a copy of the completed form with the signature of the patient's surrogate or a responsible party must be signed by the patient's physician and placed in the medical record.
- Use of original form is required. Be sure to send the original form with the patient.
- There is no requirement that a patient have a MOST.

IMPLEMENTING MOST

- If a health care provider or facility cannot comply with the orders due to policy or personal ethics, the provider or facility must arrange for transfer of the patient to another provider or facility.

REVIEWING MOST

This MOST must be reviewed at least annually or earlier if:

- The patient is admitted and/or discharged from a health care facility;
- There is a substantial change in the patient's health status; or
- The patient's treatment preferences change.
- If MOST is revised or becomes invalid, draw a line through sections A – E and write "VOID" in large letters.

REVOCATION OF MOST

This MOST may be revoked by the patient, the surrogate or the responsible party.

Review of MOST

Review Date	Reviewer and Location of Review	MD/DO Signature (Required)	Signature of Patient, Surrogate or Responsible Party (Required)	Outcome of Review, describing the outcome in each row by selecting one of the following:
				❑ No Change ❑ FORM VOIDED, new form completed ❑ FORM VOIDED, no new form
				❑ No Change ❑ FORM VOIDED, new form completed ❑ FORM VOIDED, no new form

SEND FORM WITH PATIENT/RESIDENT WHEN TRANSFERRED OR DISCHARGED

Triage Cancer Estate Planning Toolkit

⌘

Part III: Your State's Estate Planning Forms

⌘

Funeral Designation Form

COMMONWEALTH OF KENTUCKY
OFFICE OF THE ATTORNEY GENERAL

FUNERAL PLANNING DECLARATION
FORM FPD-1, 04-17

Declaration made this ____ day of _____ (month, year). I, _____ (print name, also referred to as "Declarant" in this Declaration), being at least eighteen (18) years of age and of sound mind, willfully and voluntarily make known my instructions concerning funeral services, funeral and cemetery merchandise, ceremonies, and the disposition of my remains after my death. By executing this Declaration, I revoke any Declaration previously made.

Designee

1. A Designee is an individual designated and directed by the terms of this Declaration to carry out the Declarant's funeral plan or make arrangements concerning disposition of the Declarant's remains, funeral services, cemetery merchandise, funeral merchandise, or ceremonies;
2. If the Declarant does not designate a Designee in this Declaration, the Declarant shall provide instructions concerning funeral services, ceremonies, and disposition of the Declarant's remains;
3. A person is not considered to be entitled to any part of the Declarant's estate solely by virtue of being designated in this Declaration to serve as the Designee;
4. The Designee shall not be a provider of funeral or cemetery services, or employed by any entity responsible for providing funeral or cemetery services or disposing of the Declarant's remains, unless the Designee is related to the Declarant by birth, marriage or adoption;
5. A Designee shall not be a witness to this Declaration;
6. If the Designee or alternate Designee fail to assume an obligation set forth in this Declaration, within five (5) days of notification of the Declarant's death, the authority to make arrangements shall devolve pursuant to the terms of this Declaration or KRS 367.93117.

_____ I hereby declare and direct that after my death _____ (name of Designee) shall, as my Designee, carry out the instructions that are set forth in this Declaration. If my Designee is unwilling or unable to act, I declare _____ (name of alternate Designee) as an alternate Designee.

_____ I hereby elect not to select a Designee, and direct that the instructions listed herein for funeral services, ceremonies, and the disposition of my remains after my death be followed.

Instructions Concerning Funeral Services, Funeral and Cemetery Merchandise, Ceremonies, and the Disposition of My Remains After My Death

I hereby declare and direct that after my death the following actions be taken (indicate your choice by initialing or making your mark before signing this declaration:

(1) My body shall be (select one):

(A) ____ Buried. I direct that my body be buried at _____.

(B) ____ Cremated. I direct that my cremated remains be disposed of as follows, or if no method of disposition is selected then I leave the decision to my Designee:
____ Placing them in a grave, crypt, or niche at _____, or if left blank then at a location to be selected by my Designee;
____ Scattering them in a scattering area; or
____ On private property with the consent of the owner.

(C) ____ Entombed. I direct that my body be entombed at _____.

(D) ____ Donated. I direct that my body be donated as an anatomical gift pursuant to KRS 311.1911, et. seq. (Do not select if donation has been selected by another method).

(E) ____ I intentionally make no decision concerning the disposition of my body, leaving the decision to my Designee.

(2) My arrangements shall be made as follows:

(A) ____ I direct that funeral services be obtained from (if left blank then my Designee will decide): _____

(B) ____ I direct that the following funeral services and ceremonial arrangements be made:
_____
_____

(C) ____ I direct the selection of a grave memorial, monument or marker, as follows:
_____

(D) ____ I direct that the following funeral and cemetery merchandise and other property be selected for the disposition of my remains, my funeral or other ceremonial arrangements:
_____
_____

(E) ____ I direct my Designee make all arrangements concerning ceremonies and other funeral or burial services.

(3) ____ In addition to the instructions listed above, I request the following:

_____

_____

(4) I direct my Designee to make alternate arrangements to the best of the Designee's ability if it is impossible to make an arrangement specified herein because:

(A) A funeral home or other service or merchandise provider is out of business, impossible to locate, or otherwise unable to provide the specified service; or

(B) The specified arrangement is impossible, illegal, or exceeds the funds available or is inconsistent with the terms of the pre-arranged funeral or cemetery contract.

It is my intention that this Declaration be honored by my family and others as the final expression of my intentions concerning my funeral and the disposition of my body after my death. I understand the full import of this Declaration.

Signatures **The following signatures and notary signature all need to be obtained:**

Declarant, or another person in the Declarant's presence and at the Declarant's direction

Signed: _____ Date: _____

Declarant's City, County, and State of Residence: _____

Print name of person who signed at Declarant's direction (if applicable): _____

Witnesses

I believe the Declarant to be of sound mind and willfully and voluntarily executed the Declaration. I did not sign the Declaration on behalf of and at the direction of the Declarant. I am not a Designee of the Declarant. The Declarant, or the person signing at the direction of the Declarant, signed the Declaration in my presence. I am competent and at least eighteen (18) years of age.

Witness _____ Witness _____

Printed Name _____ Printed Name _____

Date _____ Date _____

Notary Public or other person authorized to administer oaths

State of Kentucky

_____County

Before me, the undersigned authority, came the Declarant and acknowledged that he or she voluntarily dated and signed this writing, or directed it to be signed and dated as above in his or her presence, on this the _____ day of _____, 20____.

_____ My Commission Expires: _____

Notary Public or other person authorized to administer oaths

Title: _____

Triage Cancer Estate Planning Toolkit

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Part III: Your State's Estate Planning Forms

⌘

HIPAA Authorization Form

Sample HIPAA Right of Access Form for Family Member/Friend

I, _____, direct my health care and medical services providers and payers to disclose and release my protected health information described below to:

Name: *Relationship:*

_____ _____

Contact information: _____

_____

Health Information to be disclosed upon the request of the person named above -- (Check either A or B):

- ☐ A. **Disclose** my complete health record (including but not limited to diagnoses, lab tests, prognosis, treatment, and billing, for all conditions) **OR**
- ☐ B. **Disclose** my health record, as above, **BUT do not disclose** the following (check as appropriate):
  - ☐ Mental health records
  - ☐ Communicable diseases (including HIV and AIDS)
  - ☐ Alcohol/drug abuse treatment
  - ☐ Other (please specify):

    _____
    _____

Form of Disclosure (unless another format is mutually agreed upon between my provider and designee):

- ☐ An electronic record or access through an online portal
- ☐ Hard copy

This authorization shall be effective until (Check one):

- ☐ All past, present, and future periods, OR
- ☐ Date or event:_____

unless I revoke it. (NOTE: You may revoke this authorization in writing at any time by notifying your health care providers, preferably in writing.)

_____ _____
Name of the Individual Giving this Authorization Date of birth

_____ _____
Signature of the Individual Giving this Authorization Date

Note: HIPAA Authority for Right of Access: 45 C.F.R. § 164.524