Triage Health Estate Planning Toolkit: Kansas

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.

Kansas probate courts accept written and oral wills. To make a valid written will in Kansas:

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, unless you are an emancipated minor, or are 16 and emancipated upon marriage.
    - Of "sound mind" (meaning you know what you're doing)
2. You need to sign the will, in front of two competent, disinterested witnesses who are not included in your will. If you are not physically able, you may direct someone to sign on your behalf in front of those same two witnesses. The will must be printed. Kansas does not allow digital wills.
3. Your will does not need to be notarized to be legal in Kansas. 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.

Kansas allows you to execute your will remotely (e.g. witness the signing of a will by teleconferencing). This change was made permanent through Senate Bill 106. 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.

Oral wills are only valid in Kansas if made by someone with a terminal illness. This will cannot be used to pass down "real property," which is land or buildings on land. You can distribute "personal property," or personal belongings like clothing or photographs, with an oral will. To make a valid oral will, you must declare your will in front of two disinterested witnesses, meaning they will not benefit from your will. Both witnesses need to write down the will within 30 days of your death.

While oral wills are useful for extreme circumstances, experts recommend creating a written will if you can.

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.

Kansas's durable power of attorney form allows you to appoint someone to manage your finances, including assets like your property, taxes, and government benefits. You can also appoint an alternate agent in case the first person cannot act. This person can make all financial decisions for you, or you can limit their powers to specific areas, like filing taxes or banking. Unless you indicate otherwise in the "special instructions" section, this document takes effect

immediately after you sign it, and will remain in effect if you become incapacitated. This document will remain in effect until you die or revoke your power of attorney.

Part III of this toolkit includes a sample form.

State Laws About Advance Directives for Health Care

An advance health care directive (AHCD) 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 Kansas, this document contains two parts.

1. **Kansas Durable Power of Attorney for Health Care Decisions:** This document lets you choose someone (your "agent") to make health care decisions for you, including decisions about life-sustaining care, any time your doctor determines that you cannot communicate these decisions. You can also appoint an alternate person to make these decisions if the first person you chose isn't available. The form also allows for you to have your agent be in charge of the final disposition of your remains. You can indicate that you have attached information about treatment choices you want to be honored, as well as if you want to be an organ and tissue donor.
2. **Kansas Declaration:** Also known as a "living will," this document lets you express your preferences for having life-sustaining procedures withheld or withdrawn if you develop a terminal condition and can no longer make your own health care decisions. This document goes into effect if your doctor determines you have reached this state. This form allows you to:
    - Indicate that you would like life-sustaining procedures withdrawn, if there is no reason to believe they would lead to your recovery and they do not alleviate pain
    - Describe specific directions, if any, for your life-sustaining care

To make your advance health care directive legal, you must sign and date it in front of a witness. You can have your AHCD witnessed in two ways:

1. Sign your directive in front of a notary public
2. Sign your directive in front of two witnesses. They must be over eighteen, and cannot be:
    - The person signing the form for you, if you cannot sign yourself
    - Your agent
    - Related to you by blood, marriage, or adoption
    - Entitled to any portion of your estate
    - Directly financially responsible for your health care

You can revoke your agent's authority by telling, or writing to, your agent. This becomes effective once you tell your physician.

You can revoke your declaration by:

- Destroying the document
- Signing and dating a written revocation
- Orally expressing your desire to revoke your declaration in front of a witness at least 18 years old, who will sign and date a written statement. The revocation goes into effect after your doctor receives a copy of the document.

Part III of this toolkit includes a sample advance health care directive.

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 Kansas, this form is called a Kansas transportable physician order for patient preferences, or TPOPP. The TPOPP does not replace an advance directive. You can complete a TPOPP 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 this 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.

Kansas does not have a funeral designation form, but you can appoint someone to handle the disposal of your remains in an advance health care directive.

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.

Kansas 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 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
- Kansas Transportable Physician Order for Patient Preferences (TPOPP)
- 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

General Durable Power of Attorney

[Your Name]

[Address]

[City, State Zip Code]

Pursuant to the Kansas Power of Attorney Act, K.S.A. 58-650 to K.S.A. 58-665, I appoint the following person as my attorney-in-fact:

[Primary Attorney-in-Fact Name]

[Primary Attorney-in-Fact Address]

[Primary Attorney-in-Fact City, State Zip Code]

If the above person should be unable to perform in this capacity due to death, disability, disqualification, or incapacity, then I appoint the following person as my attorney-in-fact:

[Alternate Attorney-in-Fact Name]

[Alternate Attorney-in-Fact Address]

[Alternate Attorney-in-Fact City, State Zip Code]

This is a durable power of attorney, and the authority of my attorney-in-fact shall not terminate if I become disabled or in the event of later uncertainty regarding whether I am alive or dead. This durable power of attorney shall become effective immediately. My attorney-in-fact shall not be obligated to furnish bond or other security as a condition to this instrument. No compensation shall be paid for services as attorney-in-fact, but reasonable expenses accrued therewith shall be compensated.

I. General Grant of Authority. The attorney-in-fact shall have general powers regarding all lawful subjects and purposes, including every action or power that an able adult may perform through an agent, except as specifically provided in Section II of this document. The following specific powers are listed for illustration and clarification purposes and not to limit this authority.

1. Collect Funds. To demand, receive, and collect all money or property now or hereafter due or owing to me; to receipt and make releases or other discharges therefore; and to settle, adjust, or compromise any and all claims, accounts, or debts owing to me, including to file any proof of debt and take any proceedings under the Bankruptcy Code or similar statutes.

2. Deposit and Withdraw Funds. To receive, endorse, deposit, withdraw, and transfer all funds of any type into and from any checking, savings, or other account. This authority shall include taxes, Social Security, Medicare, Medicaid, Veteran's Benefits, and any other public or private assistance program. I nominate my attorney-in-fact to serve as my representative payee with respect to the receipt, deposit, and use of Social Security benefits, and I release the Social Security Administration from any claims that my attorney-in-fact misused Social Security payments.

3. Safe Deposit Box. To enter any safe deposit box on which I am the tenant or a co-tenant; to open new safe deposit boxes; to add to and remove any of the contents of any such safe deposit box; and to close out any safe deposit box.

4. Property. To maintain, repair, improve, manage, insure, rent, lease, sell, convey, mortgage, or otherwise dispose of, deal with, or encumber any interest in property, whether real, personal, tangible, intangible, jointly owned, presently owned, or later acquired; to execute any instrument; and to transfer property to a revocable or living trust made by me and that benefits me while alive.

5. Homestead. To give consent on my behalf to the sale, gift, transfer, mortgage or other alienation of my homestead or any interest in my homestead. The street address of the homestead is _____ _____ , and the legal description is _____ . Nothing in this document shall be construed as a limitation or abridgement of the right of my spouse to consent or withhold consent to the alienation of the spouse's homestead or any rights therein under Article 15, Section 9 of the Kansas Constitution.

6. Transact Business. To transact any and all lawful business of any kind on my behalf, including to open accounts with financial institutions, and to buy, sell, endorse, transfer, hypothecate, and borrow against any stocks, bonds, or other securities, and to vote as my proxy regarding the shares. This also includes authority to pay any and all expenses incurred on my behalf.

7. Prosecute, Defend, and Settle Claims. To institute, prosecute, defend, settle, compromise, or otherwise dispose of any claim on my behalf, including appearance on my behalf in any proceedings before any court, agency, or other venue, and the retaining of counsel.

8. Power of Attorney Documents. To execute a power of attorney required by any agency or entity on my behalf authorizing my attorney-in-fact to transact with such group or legal entity.

9. Gifts. To make or revoke a gift of my property, whether in trust or otherwise, and to disclaim a gift or devise of property to or for my benefit.

10. Tax. To make, sign, and file Federal and state tax returns of any type or forms, documents, or agreements with the Internal Revenue Service (IRS) or any state taxing agency, to receive and pay any amounts with regard to tax matters, and to represent me before the IRS as my attorney-in-fact (including signing Form 2848 authorizing my attorney-in-fact to act on my behalf). This shall include consenting that any gift made by my spouse was made one-half by me for gift tax purposes. It is not, however, my intention to grant a general power of appointment to my attorney-in-fact for purposes of any federal or state gift, estate, or generation skipping tax law.

11. Public Assistance. To apply for Medicaid, Social Security, Veteran's Benefits, Medicaid, or any other public or private assistance program, and to execute any documents or actions that are required to receive benefits, optional, or advisable for the optimal preservation of assets.

12. Insurance. To purchase, pledge, liquidate, borrow against or make claim against any insurance policy of any type. However, my attorney shall have no power arising to an incidence of ownership over any policy on my attorney-in-fact's life, including, without limitation, the power to surrender the policy, borrow on it, pledge it, or distribute it to any person, except that my attorney-in-fact may pay, out of my assets, any premium on such policies.

13. Nomination of Guardian and/or Conservator. If protective proceedings are commenced pursuant to my disability or incapacity, I nominate my attorney-in-fact to be my guardian and/or conservator and authorize my attorney-in-fact to name a guardian and/or conservator for my benefit.

14. Medical Care. My attorney-in-fact shall have the authority to, on my behalf:

A. Consent, refuse consent, or withdraw consent to any care, treatment, service, or procedure to maintain, diagnose, or treat a physical or mental condition, and to make decisions about organ donation, autopsy, and disposition of the body, including payment of the expenses of my funeral and the burial, cremation, or other disposition of the body.

B. make any and all arrangements at any hospital, psychiatric hospital, or psychiatric treatment facility, hospice, nursing home, or similar institution in Kansas or any other state or country; make arrangements for my release and removal from any institution; employ or discharge health care personnel to include physicians, psychiatrists, psychologists, dentists, nurses, therapists, or any other person who is licensed, certified, authorized, or permitted by law to administer health care, as the agent shall deem necessary for my physical, mental, and emotional well being;

C. request, receive, and review any verbal or written information regarding my personal affairs or physical or mental health, including medical and hospital records, to execute any releases that may be required to obtain this information, and to consent to the disclosure of this information.

D. I waive my patient-physician privileges relating to this General Durable Power of Attorney.

15. HIPAA Release. I intend for my agent to be treated as I would be with respect to my rights regarding the use and disclosure of my individually-identifiable health information or other medical records. This release authority applies to any information governed by the Health Insurance Portability and Accountability Act of 1996 (HIPAA), 42 U.S.C. 1320(d) and 45 C.F.R. 160-164. I authorize any physician, health care professional, dentist, health plan, hospital, clinic, laboratory, pharmacy, or other covered health care provider, any insurance company, and the Medical Information Bureau Inc. or other health care clearinghouse that has provided treatment or services to me or that has paid for

or is seeking payment from me for such services, to give, disclose, and release to my agent, without restriction, all of my individually-identifiable health information and medical records regarding any past, present, or future medical or mental health condition, including all information relating to the diagnosis and treatment of any transmitted diseases, mental illness, and drug or alcohol abuse. The authority given my agent shall supersede any prior agreement that I may have made with my healthcare providers to restrict access to or disclosure of my individually identifiable health information. The authority given my agent has no expiration date and shall expire only in the event that I revoke the authority in writing and deliver it to my health care provider. The authority granted my agent under this paragraph shall be effective immediately.

16. All Other Acts. To do anything necessary or proper in handling and managing my affairs.

II. Powers Prohibited. Pursuant to K.S.A. 58-654(g), the attorney-in-fact shall not have authority:

1. To make, publish, declare, amend, or revoke any will.
2. To make, execute, modify, or revoke a living will, "do not resuscitate" order, a general durable power of attorney, or a durable power of attorney for health care decisions.
3. To require me, against my will, to take or refrain from taking any action.
4. To carry out any action that I have specifically forbidden while not disabled or incapacitated.

III. Accounting Waived. I waive the necessity of my attorney-in-fact to provide an accounting to me or any other person during my lifetime or upon my death.

IV. Disability or Incapacity Defined. Disability or incapacity means the person's ability to receive and evaluate information effectively or communicate decisions is impaired to the extent that the person lacks the capacity to manage personal financial resources or exercise a reasonable level of care with regard to the duties of an attorney-in-fact, as determined by the certification of one licensed physician, and shall apply if the person cannot take any effective actions due to involuntary detention or disappearance, as determined by affidavit of one party with such knowledge.

V. Revocation. I hereby revoke all of my previous powers of attorney, except any separate Durable Power of Attorney for Health Care Decisions, any separate power of attorney executed on Form 2848 appointing an agent to represent me before the IRS, and any separate Power of Attorney for Homestead Property. I retain the right to revoke or amend this document in whole or in part.

VI. Attorney-Client Privilege. I hereby authorize my attorney to provide my attorney-in-fact with any information that is necessary for my attorney-in-fact to adequately exercise the authority granted herein. I waive any attorney-client privilege for this limited purpose.

VII. Execution and Construction. This instrument is executed pursuant to the Kansas Power of Attorney Act and amendments thereto, and any questions surrounding this document shall be addressed pursuant to those statutes. Any question concerning the power or authority of my attorney-in-fact shall be construed in favor of the attorney-in-fact having such power or authority.

Signed: _____ Dated: _____

State of Kansas

County of _____

This instrument was acknowledged before me on _____ , _____ , by _____ .

_____

Notarial Officer

_____

Title

My Appointment Expires:

CONSENT OF SPOUSE

_____, spouse of _____, consents to this General Durable Power of Attorney, which provides that the attorney-in-fact may consent to the sale, gift, transfer, mortgage, or other alienation of the homestead or an interest therein. I understand that the attorney-in-fact may alienate the interest described therein, and I agree that the consent of the attorney-in-fact will constitute the consent required by Article 15, Section 9, of the Kansas Constitution.

Signed: _____ Dated: _____

State of Kansas

County of _____

This instrument was acknowledged before me on _____ , _____ , by _____ .

_____
Notarial Officer

_____
Title

(SEAL)

My Appointment Expires:

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Advance Health Care Directive

DURABLE POWER OF ATTORNEY FOR HEALTHCARE DECISIONS

DECISION TO NAME SOMEONE TO SPEAK FOR ME

I, (your name) _____ (date of birth) _____ , appoint the following person(s) to make healthcare decisions for me when I am unable to make or communicate my own wishes:

Agent may not be the treating healthcare provider, an employee of the treating healthcare provider, or an employee, owner, director or officer of a facility, unless that person is a relative or is bound to you by common vows to a religious life.

PLEASE PRINT:

Name of Agent:_____ _____ Telephone _____ Telephone

Agent's address: _____City_____State/Zip _____

Name of First Alternate Agent: _____ _____ Telephone _____ Telephone

Agent's address: _____City_____State/Zip _____

Name of Second Alternate Agent: _____ _____ Telephone _____ Telephone

Agent's address: _____City_____State/Zip _____

This power of attorney for healthcare decisions shall become effective when I am unable to make decisions or unable to communicate my wishes regarding healthcare. This power of attorney for healthcare decisions shall not be affected by my subsequent disability or incapacity. Any durable power of attorney for healthcare decisions I have previously made is hereby revoked.

AUTHORITY GRANTED

My healthcare agent may:

1. Consent, refuse consent, or withdraw consent to any care, treatment, service or procedure to maintain, diagnose or treat a physical or mental condition;
2. Make all arrangements for me at any hospital, treatment facility, hospice, nursing home or similar institution;
3. Employ or discharge healthcare personnel including physicians, psychiatrists, dentists, nurses, therapists or other persons who provide treatment for me;
4. Request, receive and review any information, spoken or written, regarding my personal affairs or physical or mental health including medical and hospital records, and execute any releases or other documents that may be required in order to obtain such information; and
5. Make decisions about organ and tissue donations, autopsy and the disposition of my body.

My agent shall authorize consent for the following special instructions:

☐ I wish to be a donor for organs and tissues.

☐ I have attached information about treatment choices I wish to have honored by my agent. ___ page(s) attached.

LIMITATIONS ON AUTHORITY GRANTED

My healthcare agent may not:

1. Exceed the powers set out in writing in this document; *or*
2. Revoke any existing Living Will Declaration I may have.

X _____
signature date

Notary Public: Notary Seal:

STATE OF _____COUNTY OF _____

This instrument was acknowledged before me this _____ day of _____ (month, year)

Signature of Notary_____

or

Witnesses: (witnesses may not be the agent or a relative, or beneficiary of the principal)

X _____ Date: _____
(Signature)

X _____ Date: _____
(Signature)

This document is based on Kansas Statutes Annotated, (58-625 through 632)
Additional forms and information are available through

Wichita Medical Research & Education Foundation
3306 E. Central, Wichita, KS 67208
316-686-7172
www.wichitamedicalresearch.org

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LIVING WILL DECLARATION

Kansas Natural Death Act

I, _____, being of sound mind, willfully and voluntarily making known my desire that my dying shall not be artificially prolonged under the circumstances set forth below, do hereby declare:

If at any time I should have an incurable injury, disease, or illness certified to be a terminal condition by two physicians who have personally examined me, one of whom shall be my attending physician, and the physicians have determined that my death will occur whether or not life-sustaining procedures are utilized and where the application of life-sustaining procedures would serve only to artificially prolong the dying process, I direct that such procedures be withheld or withdrawn and that I be permitted to die naturally with only the administration of medication or the performance of any medical procedure deemed necessary to provide me with comfort care.

In the absence of my ability to give directions regarding the use of such life-sustaining procedures, it is my intention that this declaration shall be honored by my family and physician(s) as the final expression of my legal right to refuse medical or surgical treatment and accept the consequences from such refusal.

I understand the full import of this declaration and I am emotionally and mentally competent to make this decision. Any Living Will declaration I have previously made is hereby revoked.

Declarations made this _____ (day) of _____ (month, year)

Signature:

X _____ Date of Birth _____

Address: _____
street **city** **state** **zip**

This document must be witnessed by two individuals *or* acknowledged by a notary public.

Notary Public: Notary Seal:

STATE OF _____ COUNTY OF _____

This instrument was acknowledged before me this _____ day of _____ (month, year)

Signature of Notary _____

or

Witnesses:

The declarant has been personally known to me and I believe the declarant to be of sound mind. I did not sign the declarant's signature above for or at the direction of the declarant. I am not related to the declarant by blood or marriage, entitled to any portion of the estate of the declarant according to the laws of intestate succession or under any will of declarant or codicil thereto, or directly responsible for declarant's medical care.

Name: _____ Name: _____

Address: _____ Address: _____

City, State, Zip: _____ City, State, Zip: _____

This document is based on Kansas Statute 65-28,101 et seq. as amended
Additional forms and information are available through

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Physician Orders for Life Sustaining Treatment (POLST)

FORM SHALL ACCOMPANY PERSON WHEN TRANSFERRED OR DISCHARGED

Kansas Transportable Physician Orders for Patient Preferences (TPOPP)

This Physician Order set is based on the patient's current medical condition and wishes and is to be reviewed for potential replacement in the case of a substantial change in either, as well as in other cases listed under F. Any section not completed indicates full treatment for that section. Photocopy or fax copy of this form is legal and valid.

Patient's Last Name/First Name/Middle Initial

Date of Birth

Effective Date of this Form:
Form must be reviewed at least annually.

A. **Check One**

CARDIOPULMONARY RESUSCITATION (CPR): Person has no pulse and is not breathing.
□Attempt Resuscitation (CPR) □Do Not Attempt Resuscitation (DNR/no CPR)
When not in cardiopulmonary arrest, follow orders in **B, C** and **D** below.

B. **Check One**

MEDICAL INTERVENTIONS: Person has pulse and/or is breathing.
□**Full Treatment** Includes the use of intubation, advanced airway interventions, mechanical ventilation, defibrillation or cardio version as indicated, medical treatment, intravenous fluids, and cardiac monitor as indicated. Transfer to hospital if indicated. Include intensive care. Includes treatment listed under "Limited Interventions" and "Comfort Measures."
Treatment Goal: Attempt to preserve life by all medically effective means.
□**Limited Interventions** Includes the use of medical treatment, oral and intravenous medications, intravenous fluids, cardiac monitoring as indicated, noninvasive bi-level positive airway pressure, a bag valve mask, or other advanced airway interventions. Includes treatment listed under "Comfort Measures." Do not use intubation or mechanical ventilation. Transfer to hospital if indicated. Avoid intensive care. **Treatment Goal: Attempt to preserve life by basic medical treatments.**
□**Comfort Measures only** Includes keeping the patient clean, warm, and dry; use of 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. Transfer from current location to intermediate facility only if needed and adequate to meet comfort needs and to hospital only if comfort needs cannot otherwise be met (e.g., hip fracture; if intravenous route of comfort measures is required).
Additional Orders: _____

C. **Check One**

ANTIBIOTICS
□**Use Antibiotics to preserve life.**
□**Trial period of antibiotics if and when infection occurs.** **Include goals below in E.*
□**Initially, use antibiotics only to relieve pain and discomfort.** *+Contact patient or patient's representative for further direction.*
Additional Orders: _____

D. **Check One In Each** Column

ASSISTED NUTRITION AND HYDRATION
Administer oral fluids and nutrition, if necessary by spoon feeding, if physically possible.

TPN (Total Parenteral Nutrition-provision of nutrition into blood vessels)	Tube Feeding	Intravenous (IV) Fluids for Hydration
□**TPN long-term** if needed	□**Long-term feeding tube** if needed	□**Long-term IV fluids** if needed
□**TPN for a trial period***	□**Feeding tube for a trial period***	□**IV fluids for a trial period***
□**Initially, no TPN+**	□**Initially, no tube feeding+**	□ **Initially, no IV fluids+**

Additional Orders: _____ **Include goals below in E. +Contact patient or patient's representative for further direction.*

E. **Check all that apply**

PATIENT PREFERENCES AS A BASIS FOR THIS TPOPP FORM

Patient Goals/Medical Condition:

□The patient has a durable power of attorney for health care decisions in accordance with K.S.A. 58-628 or 58-630, and amendments thereto.
□The patient has a declaration in accordance with K.S.A. 65-28,103, and amendments thereto.
Date of execution_____
If TPOPP not being executed by patient: we certify that this TPOPP is in accordance with the patient's advance directive

_____
Name and Position (print) Signature Signature of Physician

Directions given by:
□Patient □Parent of Minor □Guardian of Minor □Health Care Agent □Other: _____
Basis of Authority_____

	Printed Name	Signature	Date
Attending physician			
Patient or other individual checked above (patient's representative)			
Health care professional preparing form (besides doctor)			

HIPPA PERMITS DISCLOSURE TO HEALTH CARE PROFESSIONALS AND PROXY DECISION MAKERS AS NECESSARY FOR TREATMENT

F.

INFORMATION FOR PATIENT OR REPRESENTATIVE OF PATIENT NAMED ON THIS FORM

The TPOPP form is **always voluntary** and is usually for persons with advanced illness. TPOPP records your wishes for medical treatment in your current state of health. 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 health-care directive is recommended, regardless of your health status. An advance directive allows you to document in detail your future health care instructions and/or name a health-care agent to speak for you if you are unable to speak for yourself.

The State of Kansas affirms that the lives of all are of equal dignity regardless of age or disability and emphasizes that no one should ever feel pressured to agree to forego life-preserving medical treatment because of age, disability, or fear of being regarded as a "burden."

If this form is for a minor for whom you are authorized to make health-care decisions, you may not direct denial of medical treatment in a manner that would violate the child abuse and neglect laws of Kansas. In particular, you may not direct the withholding of medically indicated treatment from a disabled infant with life-threatening conditions, as those terms are defined in 42 U.S.C. § 5106g or regulations implementing it and 42 U.S.C. § 5106a.

G.

DIRECTIONS FOR COMPLETING AND IMPLEMENTING FORM

COMPLETING TPOPP

TPOPP must be reviewed and prepared in consultation with the patient or the patient's representative. TPOPP must be reviewed and signed by a physician to be valid. Be sure to document the basis for concluding the patient had or lacked capacity at the time of execution of the form in the patient's medical record. If the patient lacks capacity, any current advance directive form must be reviewed and the patient's representative and physician must both certify that TPOPP complies with it. The signature of the patient or the patient's representative is required; however, if the patient's representative is not reasonably available to sign the original form, a copy of the completed form with the signature of the patient's representative must be placed in the medical record as soon as practicable and "on file" must be written on the appropriate signature line on this form.

IMPLEMENTING TPOPP

If a physician, or health facility as defined by subsection (c) of K.S.A. 40-2, 116, and amendments thereto, is unwilling to comply with the orders due to policy or personal objections, the provider or facility must not impede transfer of the patient to another provider or facility willing to implement the orders and must provide at least requested care in the meantime unless, in reasonable medical judgment, denial of requested care would not result in or hasten the patient's death. If a minor protests a directive to deny the minor life-preserving medical treatment, the denial of treatment may not be implemented pending issuance of a judicial order resolving the conflict. A direction to "preserve" life means the relevant treatment is to be provided whenever, in reasonable medical judgment, its withholding or withdrawal would result in or hasten the patient's death.

REVIEWING TPOPP

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

- The patient is admitted to or discharged from a medical care facility;
- There is a substantial change in the patient's health status; or
- The treatment preferences of the patient or patient's representative change

The same requirements for participation of the patient or the patient's representative, and signature by both a physician and the patient or the patient's representative, that are described under COMPLETING TPOPP" also apply when TPOPP is reviewed, and must be documented in Section I.

H.

REVOCATION OF TPOPP

If TPOPP is revised or becomes invalid, write the word "**VOID**" in large letters on the front of the form. After voiding the form a new form may be completed. A patient with capacity or the individual or individuals authorized to sign on behalf of the patient in Section E of this form may void this form. If no new form is completed, full treatment and resuscitation is to be provided.

I.

REVIEW SECTION: Periodic review confirms current form or may require completion of new form

Date of Review	Location of Review	Patient or Representative Signature	Physician Signature	Outcome of Review
				□FORM CONFIRMED - No Change □FORM VOIDED, see updated form □FORM VOIDED, no new form
				□FORM CONFIRMED - No Change □FORM VOIDED, see updated form □FORM VOIDED, no new form
				□FORM CONFIRMED - No Change □FORM VOIDED, see updated form □FORM VOIDED, no new form
				□FORM CONFIRMED - No Change □FORM VOIDED, see updated form □FORM VOIDED, no new form
				□FORM CONFIRMED - No Change □FORM VOIDED, see updated form □FORM VOIDED, no new form

CONTACT INFORMATION:

Patient/Representative	Relationship	Phone Number	Email Address
Health Care Professional Preparing Form	Relationship	Phone Number	Email Address

Triage Health Estate Planning Toolkit

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Part III: Your State's Estate Planning Forms

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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