NEBRASKA
Advance Directive
Planning for Important Health Care Decisions

CaringInfo
1731 King St., Suite 100, Alexandria, VA 22314
www.caringinfo.org
800/658-8898

CaringInfo, a program of the National Hospice and Palliative Care Organization (NHPCO), is a national consumer engagement initiative to improve care at the end of life.

It's About How You LIVE

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

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

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

Using these Materials

BEFORE YOU BEGIN

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

2. These materials include:
    - Instructions for preparing your advance directive, please read all the instructions.
    - Your state-specific advance directive forms, which are the pages with the gray instruction bar on the left side.

ACTION STEPS

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

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

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

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

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

Introduction to Your Nebraska Advance Directive

This packet contains a legal document, a **Nebraska Advance Directive**, that protects your right to refuse medical treatment you do not want, or to request treatment you do want, in the event you lose the ability to make decisions yourself. You may fill out Part I, Part II, or both, depending on your advance planning needs. You must complete Part III.

Part I is the **Nebraska Power of Attorney for Health Care.** This part lets you name an adult, called your attorney in fact, to make decisions about your health care—including decisions about life-sustaining treatments—if you can no longer speak for yourself. The Power of Attorney for Health Care is especially useful because it appoints someone to speak for you any time you are unable to make your own health care decisions, not only at the end of life.

Part I goes into effect when your doctor determines that you are no longer able to understand and appreciate the nature and consequences of health care decisions or that you are unable to communicate in any manner an informed health care decision.

Part II is a **Nebraska Declaration**, which is your state's living will. Part II lets you state your wishes about medical care in the event that you can no longer make your own health care decisions and you are either terminally ill or in a persistent vegetative state.

The declaration in Part II becomes effective once your attending physician (1) determines that you are incapable of making decisions about the use of life-sustaining treatment, (2) determines that you are either in a persistent vegetative state or in a terminal condition, and (3) has notified a reasonably available member of your immediate family or your guardian, if you have one, of his or her intent to invoke your Declaration.

Part III contains the signature and witnessing provisions so that your document will be effective.

Following the advance directive is an **Organ Donation Form**.

The *Nebraska Advance Directive* does not expressly address mental illness. If you would like to make advance care plans regarding mental illness, you should talk to your physician and an attorney about a durable power of attorney tailored to your needs.

Note: These documents will be legally binding only if the person completing them, the person named as attorney in fact, and the two witnesses are all competent adult who are:

- *at least 19 years old, OR*
- *married, OR*
- *have been married.*

Instructions for Completing Your Advance Directive

How do I make my Nebraska Advance Directive legal?

The law requires that you have your *Nebraska Advance Directive* witnessed. You can do this in either of two ways:

1. Have your signature witnessed by a notary public you have not named as your attorney in fact or alternate attorney in fact,

   OR

2. Sign your document in the presence of two adult witnesses. Only one witness may be an administrator or employee of a health care provider who is providing treatment. Neither witness may be an employee of your health or life insurer. If you have filled out Part I, the power of attorney for health care, your witnesses may not be your spouse, parent, child, grandchild, sibling, your presumptive heir, any known devisee (someone who you have named in your will to inherit from your estate), your attending physician, or your attorney in fact or his/her alternate.

Whom should I appoint as my attorney in fact?

Your attorney in fact is the person you appoint to make decisions about your health care if you become unable to make those decisions yourself. Your attorney in fact does not have to be a lawyer and may be a family member or a close friend whom you trust to make serious decisions. The person you name as your attorney in fact should clearly understand your wishes and be willing to accept the responsibility of making health care decisions for you.

The person you appoint as your attorney in fact cannot be:

- your attending physician,
- an employee of your attending physician who is not related to you by blood, marriage, or adoption,
- an owner, operator or employee of your treating health care provider who is not related to you by blood, marriage, or adoption, or
- a person unrelated to you by blood, marriage, or adoption who is currently serving as an attorney in fact for ten or more people.

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

Should I add personal instructions to my Nebraska Advance Directive?

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

What if I change my mind?

You may revoke your *Nebraska Advance Directive* at any time and in any manner that reflects your intent to revoke, provided that you are competent. Your revocation is effective once you notify your health care provider, attending physician, or attorney in fact.

Unless you provide otherwise, making a new valid power of attorney for health care (Part I) will revoke any previously executed power of attorney for health care.

If you appoint your spouse as your attorney in fact, a decree of divorce or legal separation will automatically revoke that appointment, unless the decree specifically provides otherwise.

What other important facts should I know?

A direction to withhold or withdraw life-sustaining treatment from a pregnant patient will not be honored if it is probable that the fetus will develop to the point of live birth with continued life-sustaining treatment.

How do I make my Nebraska Organ Donation form legal?

You must sign your organ donation form in the presence of two witnesses. At least one of your witnesses must be disinterested, which means that he or she has no interest or claim on your estate or any anatomical gift you plan to make.

Part I: Power of Attorney for Health Care

PRINT YOUR NAME

I, _____,

PRINT THE NAME, ADDRESS, AND TELEPHONE NUMBER OF YOUR ATTORNEY IN FACT

appoint _____,

whose address is _____,

and whose telephone number is _____,
as my attorney in fact for health care.

If my first choice is unable, unwilling, or not reasonably available to act

PRINT THE NAME, ADDRESS AND TELEPHONE NUMBER OF YOUR ALTERNATE ATTORNEY IN FACT

as my attorney in fact I appoint _____,

whose address is _____,

and whose telephone number is _____,
as my successor attorney in fact for health care

I authorize my attorney in fact appointed by this document to make health care decisions for me when I am determined to be incapable of making my own health care decisions, including decisions to withhold or withdraw life-sustaining treatment and artificially administered nutrition and hydration. I have read the warning which accompanies this document and understand the consequences of executing a power of attorney for health care.

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

STATE YOUR DIRECTIONS FOR THE USE OF LIFE-SUSTAINING TREATMENT, IF ANY

STATE YOUR DIRECTIONS FOR THE USE OF ARTIFICIAL NUTRITION AND HYDRATION, IF ANY

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

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

ATTACH ADDITIONAL PAGES IF NEEDED

Further Instructions. Attach additional pages as needed.

I direct that my attorney in fact comply with the following instructions on life-sustaining treatment: (optional)

_____
_____
_____

I direct that my attorney in fact comply with the following on artificially administered nutrition and hydration: (optional)

_____
_____
_____
_____

I direct that my power of attorney comply with the following instructions or limitations: (optional)

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

I HAVE READ THIS POWER OF ATTORNEY FOR HEALTH CARE. I UNDERSTAND THAT IT ALLOWS ANOTHER PERSON TO MAKE LIFE AND DEATH DECISIONS FOR ME IF I AM INCAPABLE OF MAKING SUCH DECISIONS. I ALSO UNDERSTAND THAT I CAN REVOKE THIS POWER OF ATTORNEY FOR HEALTH CARE AT ANY TIME BY NOTIFYING MY POWER OF ATTORNEY, MY PHYSICIAN, OR THE FACILITY IN WHICH I AM A PATIENT OR RESIDENT. I ALSO UNDERSTAND THAT I CAN REQUIRE IN THIS POWER OF ATTORNEY FOR HEALTH CARE THAT THE FACT OF MY INCAPACITY IN THE FUTURE BE CONFIRMED BY A SECOND PHYSICIAN.

Part II: Declaration Relating to the Use of Life-Sustaining Treatment

If I should lapse into a persistent vegetative state or have an incurable and irreversible condition that, without the administration of life-sustaining treatment, will, in the opinion of my attending physician, cause my death within a relatively short time and I am no longer able to make decisions regarding my medical treatment, I direct my attending physician, pursuant to the Rights of the Terminally Ill Act, to:

INITIAL YOUR PREFERENCE IN THE EVENT YOU ARE IN A TERMINAL CONDITION

INITIAL ONLY ONE PREFERENCE

_____ 1. Keep me comfortable and allow natural death to occur. I do not want any life-sustaining treatment or other medical interventions used to try to extend my life. I do not want to receive nutrition and fluids by tube or other medical means.

((or))

_____ 2. Keep me comfortable and allow natural death to occur. I do not want any life-sustaining treatment or other medical interventions used to try to extend my life. If I am unable to take enough nourishment by mouth, however, I want to receive nutrition and fluids by tube or other medical means.

((or))

_____ 3. Try to extend my life for as long as possible, using all available life-sustaining treatment or other medical interventions that in reasonable medical judgment would prevent or delay my death. If I am unable to take enough nourishment by mouth, I want to receive nutrition and fluids by tube or other medical means.

Any questions regarding how to interpret or apply my declaration shall be resolved by my attorney in fact appointed under a durable power of attorney for health care (Part I), if I have appointed one.

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

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

ATTACH ADDITIONAL PAGES IF NEEDED

I further direct that:

Attach additional pages if needed.

PART III: EXECUTION

This Health Care Directive will not be valid unless it is EITHER:

IF YOU CHOOSE TO SIGN WITH WITNESSES, USE ALTERNATIVE 1, BELOW

(A) Signed by two (2) adult witnesses who are present when you sign or acknowledge your signature.

Only one witness may be an administrator or employee of a health care provider who is providing treatment. Neither witness may be an employee of your health or life insurer.

If you have filled out Part I, the power of attorney for health care, your witnesses may not be your spouse, parent, child, grandchild, sibling, your presumptive heir, any known devisee (someone who you have named in your will to inherit from your estate), your attending physician, or your attorney in fact or his/her alternate. (Use Alternative 1, below (page), if you decide to have your signature witnessed.)

OR

IF YOU CHOOSE TO HAVE YOUR SIGNATURE NOTARIZED, USE ALTERNATIVE 2, BELOW

(B) Witnessed by a notary.

If you have filled out Part I, the power of attorney for health care, your document may not be notarized by your attorney in fact or his/her alternate. (Use Alternative 2, below (page), if you decide to have your signature notarized.)

Alternative No. 1: Sign Before Witnesses

SIGN AND DATE YOUR ADVANCE DIRECTIVE

_____ _____
(signature) (date)

PRINT YOUR NAME

_____
(printed name)

DECLARATION OF WITNESSES

We declare that the principal is personally known to us, that the principal signed or acknowledged his or her signature on this power of attorney for health care in our presence, that the principal appears to be of sound mind and not under duress or undue influence, and that neither of us nor the principal's attending physician is the person appointed as attorney in fact by this document.

Witness No. 1

YOUR WITNESSES MUST SIGN, DATE, AND PRINT THEIR NAMES HERE

_____ _____
(signature of witness) (date)

_____
(printed name of witness)

Witness No. 2

_____ _____
(signature of witness) (date)

_____
(printed name of witness)

Alternative No. 2: Sign Before a Notary Public

SIGN AND DATE YOUR ADVANCE DIRECTIVE

_____ _____
(signature) (date)

PRINT YOUR NAME

_____
(printed name)

A NOTARY PUBLIC SHOULD COMPLETE THIS SECTION OF YOUR DOCUMENT

State of Nebraska,)
) ss.
County of _____)

On this _____ day of _____ 20_____, before me,

_____, a notary public in

_____ County, personally

came_____,
personally to known to be the identical person whose name is affixed to the above advance directive as principal of power of attorney for health care, if Part I is filled out, and/or as declarant of declaration relating to the use of life-sustaining treatment, if Part II is filled out, and I declare that he or she appears in sound mind and not under duress or undue influence, that he or she acknowledges the execution of the same to be his or her voluntary act and deed, and that I am not the attorney in fact or successor attorney in fact designated in Part I, if it has been completed.

Witness my hand and notarial seal at _____
in such county the day and year last above written.

SEAL

_____
signature of notary public

Courtesy of CaringInfo
1731 King St., Suite 100, Alexandria, VA 22314
www.caringinfo.org, 800/658-8898

ORGAN DONATION (OPTIONAL)

INITIAL THE OPTION THAT REFLECTS YOUR WISHES

ADD NAME OR INSTITUTION (IF ANY)

PRINT YOUR NAME, SIGN, AND DATE THE DOCUMENT

YOUR WITNESSES MUST SIGN AND PRINT THEIR ADDRESSES

AT LEAST ONE WITNESS MUST BE A DISINTERESTED PARTY

NEBRASKA ORGAN DONATION FORM – PAGE 1 OF 1

Initial the line next to the statement below that best reflects your wishes. You do not have to initial any of the statements. If you do not initial any of the statements, your attorney for health care, proxy, or other agent, or your family, may have the authority to make a gift of all or part of your body under Nebraska law.

_____ I do not want to make an organ or tissue donation and I do not want my attorney for health care, proxy, or other agent or family to do so.

_____ I have already signed a written agreement or donor card regarding organ and tissue donation with the following individual or institution:

Name of individual/institution:_____

_____ Pursuant to Nebraska law, I hereby give, effective on my death:

_____ Any needed organ or parts.
_____ The following part or organs listed below:

For (initial one):

_____ Any legally authorized purpose.
_____ Transplant or therapeutic purposes only.

Declarant name: _____

Declarant signature: _____, Date: _____

The declarant voluntarily signed or directed another person to sign this writing in my presence.

Witness _____Date_____

Address _____
_____

I am a disinterested party with regard to the declarant and his or her donation and estate. The declarant voluntarily signed or directed another person to sign this writing in my presence.

Witness _____Date_____

Address _____
_____

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

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

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

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

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

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

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

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

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

Congratulations!

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

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

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

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

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

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

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

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

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

- -

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

$23	helps us provide free advance directives
$47	helps us maintain our free InfoLine
$64	helps us provide webinars to hospice

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

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OR donate online today: www.caringinfo.org/donate