

NEBRASKA

Advance Directive

Planning for Important Healthcare Decisions

Courtesy of CaringInfo

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 and the experience of caregiving during serious illness and at the end of life. As part of that effort, CaringInfo provides detailed guidance for completing advance directive forms in all 50 states, the District of Columbia, and Puerto Rico.

This package includes:

- 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.

BEFORE YOU BEGIN

Check to be sure that you have the materials for each state in which you may receive healthcare. Because documents are state-specific, having a state-specific document for each state where you may spend significant time can be beneficial. A new advance directive is not necessary for ordinary travel into other states. The advance directives in this package will be legally binding only if the person completing them is a competent adult who is 19 years of age or older, or an emancipated minor.

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, scan, or take a photo of the form and give it to the person you have appointed to make decisions on your behalf, your family, friends, healthcare 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 your electronic healthcare record, or 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 HEALTH CARE 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.

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 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.

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

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

You may fill out Part I, Part II, or both, depending on your advance planning needs. **You must complete Part III.**

How do I make my Nebraska Advance Health Care Directive legal?

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

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

OR

Option 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.

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.

Whom should I appoint as my attorney in fact?

Your attorney in fact is the person you appoint to make decisions about your healthcare if you become unable to make those decisions yourself. Your attorney in fact may be a family member or a close friend whom you trust to make serious decisions. The person you name as your agent should clearly understand your wishes and be willing to accept the responsibility of making healthcare 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 advance directive?

Yes! One of the most important reasons to execute an advance directive is to have your voice heard. When you name an attorney in fact and clearly communicate to them what you want and don't want, they are in the strongest position to advocate for you. Because the future is unpredictable, be careful that you do not unintentionally restrict your attorney in fact's power to act in your best interest. Be especially careful with the words "always" and "never." In any event, be sure to talk with your agent and others about your future healthcare and describe what you consider to be an acceptable "quality of life."

When does my attorney in fact's authority become effective?

Part I, **Nebraska Power of Attorney for Health Care**, goes into effect when your doctor determines that you are no longer able to understand and appreciate the nature and consequences of healthcare decisions or that you are unable to communicate in any manner an informed healthcare decision.

Part II, **Declaration**, 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.

Attorney in Fact Limitations

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 and your attorney in fact will be bound by the current laws of Nebraska as they regard pregnancy and termination of pregnancies.

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 healthcare 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.

Mental Health Issues

These forms do not *expressly* address mental illness, although you can state your wishes and grant authority to your agent regarding mental health issues. The National Resource Center on Psychiatric Advance Directives maintains a website (<https://nrc-pad.org/>) with links to each state's psychiatric advance directive forms. If you would like to make more detailed advance care plans regarding mental illness, you could talk to your physician and an attorney about a durable power of attorney tailored to your needs.

What other important facts should I know?

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 adults who are (1) at least 19 years old, OR married, OR have been married.

Be aware that your advance directive will not be effective in the event of a medical emergency, except to identify your attorney in fact. Ambulance and hospital emergency department personnel are required to provide cardiopulmonary resuscitation (CPR) unless you have a separate physician's order, which are typically called "prehospital medical care directives" or "do not resuscitate orders." DNR forms may be obtained from your state health department or department of aging (<https://www.hhs.gov/aging/state-resources/index.html>). Another form of orders regarding CPR and other treatments are state-specific POLST (portable orders for life sustaining treatment) (<https://polst.org/form-patients/>). Both a POLST and a DNR form MUST be signed by a healthcare provider and MUST be presented to the emergency responders when they arrive. These directives instruct ambulance and hospital emergency personnel not to attempt CPR (or to stop it if it has begun) if your heart or breathing should stop.

NEBRASKA ADVANCE DIRECTIVE – PAGE 1 OF 7

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.

NEBRASKA ADVANCE DIRECTIVE – PAGE 2 OF 7

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

Further Instructions. Attach additional pages as needed.

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

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

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

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

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

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 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:

___ 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.

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

INITIAL ONLY ONE
PREFERENCE

I further direct that:

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

Attach additional pages if needed.

PART III: EXECUTION

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

(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

(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.)

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

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

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)

NEBRASKA ADVANCE DIRECTIVE – PAGE 7 OF 7

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,)
County of _____) ss.

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

NEBRASKA ORGAN DONATION FORM – PAGE 1 OF 1

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

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Hospice and
Palliative Care
Organization 2023
Revised.

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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