~ Nebraska ~

Durable Power of Attorney for Health Care Christian Version

NOTICE TO PERSON MAKING THIS DOCUMENT

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.

Because your health care providers in some cases may not have had the opportunity to establish a long–term relationship with you, they are often unfamiliar with your beliefs and values and the details of your family relationships. This poses a problem if you become physically or mentally unable to make decisions about your health care.

In order to avoid this problem, you may sign this legal document to specify the person whom you wish to make health care decisions for you if you are unable to participate in medical treatment decisions and make those decisions personally. That person is known as your attorney in fact. You should take some time to discuss your thoughts and beliefs about medical treatment with the person or persons whom you have specified. You may state in this document any types of health care that you do or do not desire, and you may limit the authority of your attorney in fact. If your attorney in fact is unaware of your desires with respect to a particular health care decision, he or she is required to determine what would be in your best interests in making the decision.

This is an important legal document. It gives your attorney in fact broad powers to make health care decisions for you. It revokes any prior durable power of attorney for health care documents that you may have made. If you wish to change your Durable Power of Attorney for Health Care, you may revoke this document at any time by destroying it, by directing another person to destroy it in your presence, by signing a written and dated statement, or by stating that it is revoked in the presence of two witnesses. If you revoke, you should notify your attorney in fact, your health care provider(s), and any other person(s) to whom you have given a copy. If your attorney in fact is your spouse and your marriage is annulled or you are divorced after signing this document, the document is invalid.

Do not sign this document unless you clearly understand it. It is suggested that you keep the original of this document with your personal papers where it can be easily accessed by your attorney in fact, close family, or friends, if needed.

STATE OF NEBRASKA
DURABLE POWER OF ATTORNEY
FOR HEALTH CARE

Written in accordance with Nebraska Legislative Bill 696
(1992 Neb ALS 696, 1992 Neb Law 696, 1992 Neb LB 696) §30-3408 to 30-3432

The completed form may be acknowledged by a notary public who is not an appointed primary or secondary attorney in fact instead of two adult witnesses' signatures.

A principal may *not* name as an attorney in fact for health care:

- A person who is less than 19 years or age, unless he or she is married
- A witness to your durable power of attorney for health care
- His or her attending physician
- An employee of his or her physician or an owner, operator, or employee of a health care provider who is not related to the principal by blood, marriage, or adoption
- A person unrelated to the principal who is presently serving as an attorney in fact for ten or more principals

DESIGNATION OF ATTORNEY IN FACT AND SUCCESSOR ATTORNEY IN FACT

I appoint _____ whose address is _____,
Name of attorney in fact Street

_____, _____, _____, and whose telephone number is
City State Zip Code

(_____) _____as my attorney in fact for health care.
Phone

I appoint _____ whose address is _____,
Name of successor attorney in fact Street

_____, _____, _____, and whose telephone number is
City State Zip Code

(_____) _____ as my successor attorney in fact for health care.
Phone

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. I have read the warning which accompanies this document and understand the consequences of executing a durable power of attorney for health care.

- I direct that my attorney in fact comply with the following instructions or limitations:

_____

_____

_____

_____

❖ 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 instructions on artificially administered nutrition and hydration: (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 ATTORNEY IN FACT, 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.

_____ _____

Signature of person making designation Date

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 Durable 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.

Witnessed By:

_____	_____	_____
Signature of witness	Date	Printed name of witness
_____	_____	_____
Signature of witness	Date	Printed name of witness

OR

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

This _____ day of _____, _____, before me, _____,
Month Year Name of Notary Public

a notary public in and for _____ County, personally came _____,
Name of principal

personally to me known to be the identical person whose name is affixed to the above power of attorney for health care as principal, 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 by this power of attorney for health care.

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

_____
Signature of Notary Public

Seal

ADDENDUM TO THE STATE OF NEBRASKA DURABLE POWER OF ATTORNEY FOR HEALTH CARE

GENERAL STATEMENT OF AUTHORITY GRANTED

As the declarant of this document, I desire to have my health care decisions made in accordance with this Addendum to the Durable Power of Attorney for Health Care. The purposes of this Addendum are to provide a witness to my Christian belief that life is a gift from God, and to provide direction for my attorney in fact to make decisions that are consistent with my Christian faith.

Unless I have specified otherwise in this document, if I ever have incapacity I instruct my health care provider to obtain the health care decision of my attorney in fact, if I need treatment, for all of my health care and treatment. I have discussed my desires thoroughly with my attorney in fact and believe that he or she understands any philosophy regarding the health care decisions I would make if I were able. I desire that my wishes be carried out through the authority given to my attorney in fact under this document.

If I am unable, due to my incapacity, to participate in making a health care decision, my attorney in fact is instructed to make the health care decision for me, but my attorney in fact should try to discuss with me any specific proposed health care if I am able to communicate in any manner, including by blinking my eyes. If this communication cannot be made, my attorney in fact shall base his or her decision on any health care choices that I have expressed prior to the time of the decision. If I have not expressed a health care choice about the health care in question and communication cannot be made, my attorney in fact shall base his or her health care decision on what he or she believes to be in my best interest.

MY HEALTH CARE STATEMENT OF BELIEFS

My philosophy regarding the health care decisions I would make, if I were able to participate in medical treatment decisions, is based on my belief that life is a gift from God and in the inherent value of human life. It is my desire that all reasonable efforts be made to sustain my life and health.

I believe that death is the normal end of earthly life and that God takes life by his decision. Therefore, I reject any attempt to end my life when God would sustain it, regardless of any diminished state of quality to my life, even if I have a disability. Similarly, I reject any attempt to lengthen my life when it is clear God intends to take it.

I believe life begins at conception. Therefore, if I have been diagnosed as pregnant and my physician knows of this diagnosis, I request that every effort be made to save the life of my unborn child in full recognition that two lives are at stake, both equal in value and worthy of protection.

HEALTH CARE DIRECTIVES

1. I direct my attorney in fact to consent to the following health care:
   a. Health care that is intended to relieve pain or to make me comfortable.
   b. Health care to cure or improve any physical or mental condition which can be cured or improved. This includes health care that is intended to be used temporarily or because it is potentially effective.

2. My attorney in fact has no authority to consent to any act or omission intended to cause or hasten my death.

3. I instruct my attorney in fact to ensure that my attending physician and other health care providers provide my health care based on my health care philosophy and my health care directives as set forth in this document.

4. Should it become clear that God wishes to take my life, namely that I am diagnosed to have a terminal illness or injury where death is imminent, I direct that life–sustaining procedures be withheld or withdrawn, and that I be permitted to die in God's time. I do *not* give consent for the withholding or withdrawal of nutrition or hydration, even if I am diagnosed to have a terminal illness or injury, if doing so would cause my death by starvation or dehydration rather than from the terminal condition or injury.

5. If God allows the quality of my life to be diminished but gives me strength to continue living for an indeterminate amount of time, I request that reasonable care be administered to me to sustain my life and ease discomfort as much as possible.

EXCEPTIONS TO HEALTH CARE DIRECTIVES

1. My attorney in fact may refuse consent to health care that would not be effective in terms of my survival.

2. If I have an incurable terminal illness or injury where I am in the final stages of dying, and it is medically certain that my death will occur within hours or a few days, my attorney in fact may consent to the withholding or withdrawal of any health care that is not intended to relieve pain or make me comfortable.

3. If I have an incurable terminal illness or injury, and it is medically certain that my death will occur within six (6) months, my attorney in fact may consent to the withholding or withdrawal of life–sustaining health care. However, I still desire health care for easily treatable acute and chronic conditions, and health care that is intended to relieve pain or make me comfortable.

4. If I have a total, chronic, and irreversible loss of consciousness, this condition must be diagnosed with medical certainty by two physicians, one of whom is my attending physician and the other is an expert in diagnosing my condition. Upon such diagnosis, my attorney in fact may consent to the withholding or withdrawal of certain life–sustaining health care, remaining faithful to the directives found in the rest of this document. I still desire health care for easily treatable acute and chronic conditions and health care that is intended to relieve pain or make me comfortable.

NUTRITION AND HYDRATION

Food and fluids

1. I believe that nutrition and hydration are basic human needs which should be provided to me even though providing them may require medical expertise and technology.

2. If I check "Yes" to the "Withhold or withdraw a feeding tube" option in the next section, then a feeding tube may only be withheld or withdrawn from me if:
   a. I have an incurable terminal illness or injury where I am in the final stage of dying, and it is medically certain that my death will occur within hours or a few days, and
   b. The withholding or withdrawal of the feeding tube would not result in my death from malnutrition or dehydration, or complications of malnutrition or dehydration, rather than from my underlying terminal illness or injury.

PROVISION OF FEEDING TUBE

If I have checked "Yes" to the following, my attorney in fact may have a feeding tube withheld or withdrawn from me, unless my physician has advised that, in his or her professional judgment, this will cause me pain or will reduce my comfort. If I have checked "No" to the following, my attorney in fact may-1 not have a feeding tube withheld or withdrawn from me.

My attorney in fact may not have orally ingested nutrition or hydration withheld or withdrawn from me unless provision of the nutrition or hydration is medically contraindicated.

Withhold or withdraw a feeding tube **Yes ❑** **No ❑**

If I have not checked either "Yes" or "No" immediately above, my attorney in fact may not have a feeding tube withheld or withdrawn from me.

PREGNANT WOMEN

If I am pregnant, the following applies:

1. My attorney in fact is authorized to make health care decisions on behalf of my unborn child as an individual patient.

2. Health care necessary to sustain the life or health of my unborn child should be provided unless it is medically certain that my unborn child would not survive even if the health care were provided.

3. It is my desire that all reasonable efforts be made to sustain both my life and health and the life and health of my unborn child.

4. Even if I have an incurable illness or injury, or I am legally determined to be brain dead, it is my desire to receive all health care, to remain on any necessary life support systems, and to receive nutrition and hydration until my unborn child can sustain life apart from my body, unless it is medically certain that my unborn child would not survive even if I receive such health care.

5. No one is authorized to consent to an abortion for me unless it is directly and medically necessary to prevent my death.

PROVISION FOR PREGNANT WOMEN

If I have checked "Yes" to the following, my attorney in fact may make health care decisions for me if he/she knows I am pregnant. If I have checked "No" to the following, my attorney in fact may not make health care decisions for me if he/she knows I am pregnant.

Health care decision if I am pregnant **Yes ❑** **No ❑**

If I have not checked either "Yes" or "No" immediately above, my attorney in fact may not make health care decisions for me if he or she knows I am pregnant.

In no event is my attorney in fact authorized to make medical treatment decisions to withhold or withdraw treatment for me if I am pregnant that would result in my death.

LIMITATIONS ON MENTAL HEALTH TREATMENT

My attorney in fact may not admit or commit me on an inpatient basis to an institution for mental diseases, a state treatment facility, or a treatment facility. My attorney in fact may not consent to experimental mental health research or psycho surgery, electroconvulsive treatment, or drastic mental health treatment procedures for me.

INSPECTION AND DISCLOSURE OF INFORMATION RELATING TO MY PHYSICAL OR MENTAL HEALTH

Subject to any limitations in this document, my attorney in fact has the authority to do all of the following:

1. Request, review, and receive any information, verbal or written, regarding my physical or mental health, including medical and hospital records.

2. Execute on my behalf any documents that may be required in order to obtain this information.

3. Consent to the disclosure of this information.

HIPAA RELEASE STATEMENT

I intend for my attorney in fact to be treated as I would with respect to my rights regarding the use and disclosure of my individual protected health information or other medical records. I grant to my attorney in fact the right to receive, disclose, or release, without restriction, all of my protected health information. This release statement applies to any information that is governed by the Health Insurance Portability and Accountability Act (HIPAA) of 1996.

ADMISSION TO NURSING HOMES

My attorney in fact may admit me to a nursing home for short–term stays for recuperative care or respite care.

If I have checked "Yes" to the following, my attorney in fact may admit me for a purpose other than recuperative care or respite care, but if I have checked "No" to the following, my attorney in fact may not so admit me:

A nursing home **Yes** ❑ **No** ❑

If I have not checked either "Yes" or "No" immediately above, my attorney in fact may only admit me for short–term stays for recuperative care or respite care.

STATEMENT OF DESIRES, SPECIAL PROVISIONS, OR LIMITATIONS

The following are any specific desires, provisions, or limitations that I wish to state (add more items as appropriate):

1. I request that this attached Addendum (pages 5-11) be included as a valid part of this Durable Power of Attorney for Health Care document.

2. I request, but not as a requirement, that my attorney in fact consult my clergy regarding health care decisions.

3. _____

_____

_____

_____

_____

_____

_____

_____

[Attach additional pages, if necessary]

ANATOMICAL GIFTS
Optional

Upon my death:

_____ I wish to donate only the following organs or parts:

_____

_____

_____

_____

_____

_____ I wish to donate any needed organ or part.

_____ I wish to donate my body for anatomical study if needed.

_____ I refuse to make an anatomical gift. (If this revokes a prior commitment that I have made to make an anatomical gift to a designated donee, I will attempt to notify the donee to which or to whom I agreed to donate.)

Failure to check any of the lines immediately above creates no presumption about my desire to make or refusal to make an anatomical gift.

Signature: _____ Date: _____

I HAVE READ THIS ADDENDUM TO THE NEBRASKA DURABLE 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 ATTORNEY IN FACT, 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.

_____ _____

Signature of person making designation Date

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 Durable 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.

Witnessed By:

_____ _____ _____

Signature of witness Date Printed name of witness

_____ _____ _____

Signature of witness Date Printed name of witness

OR

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

This _____ day of _____, _____, before me, _____,
Month Year Name of Notary Public

a notary public in and for _____ County, personally came _____,
Name of principal

personally to me known to be the identical person whose name is affixed to the above power of attorney for health care as principal, 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 by this power of attorney for health care.

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

_____

Signature of Notary Public

Seal

STATEMENT OF ATTORNEY IN FACT

I understand that _____ has designated me to be his or her attorney in
Name of principal
fact if he or she is ever found to have incapacity and unable to participate in making health care decisions himself or herself. This designation shall not become effective unless the principal is unable to participate in medical treatment decisions.

_____ has discussed his or her desires regarding health care decisions
Name of principal
with me.

Signature of attorney in fact: _____ Phone (____) _____

Address _____

SUCCESSOR ATTORNEY IN FACT

The successor attorney in fact will assume the role of attorney in fact in the event your primary attorney in fact is not able or willing to carry out the duties as described.

Signature of successor attorney in fact: _____ Phone (____) _____

Address _____

CLERGY
Optional

The declarant has requested that the attorney in fact consult me, as the declarant's clergy, regarding any health care decisions. I understand that this request has been made and am willing to work with the attorney in fact to help meet the directives as described in this Power of Attorney for Health Care document and attached Addendum.

Signature of clergy: _____

Church name _____ Phone (____) _____

Church address _____

I have given copies of this Durable Power of Attorney for Health Care – Christian Version to:

_____ _____

_____ _____

_____ _____