Advance Directives

Thank you for your interest in completing an Advance Directive.

Writing an Advance Directive is an opportunity to *direct* your future health needs in *advance* of an illness or crisis.

Sometimes when an unexpected illness or crisis occurs, family members or close friends are not sure what decisions to make. An Advance Directive will guide your loved ones and your health care providers and help them know what medical choices you would make for yourself.

In this packet, you will find:

- A comprehensive question/answer sheet: *Advance Directives, What you Should Know*
- Helpful directions for completing these documents (outlined on sample forms)
- Advance Directive forms:
    - Power of Attorney for Health Care (designates someone to make medical decisions)
    - Living Will (provides instructions about medical care desired/not desired)
- A reference sheet with resources and contact information

Please feel free to make an appointment with your Methodist Health System health care provider or health coach who will assist you with the Advance Directive documents. Your provider will discuss your options and help you with your decisions, as well as provide you with information on the types of medical interventions that may be necessary in an illness or crisis situation.

Methodist Hospital chaplains also are available to answer questions and assist you in completing these documents. Or, you may complete the documents at home by yourself, with your family, or with your attorney. However, as legal documents, they will need to be signed in the presence of a notary or two witnesses. Attorney participation is not required.

It is our hope that this packet contains all of the tools you need to understand what an Advance Directive is, why you may want one, the steps to completing an Advance Directive, and a list of resources if you have additional questions.

By completing these documents you are giving a gift to yourself and to your loved ones by choosing to have your voice heard when you cannot speak for yourself.

Thank you!
Methodist Health System

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The meaning of care.®

ADVANCE DIRECTIVES: WHAT YOU SHOULD KNOW

Advance care planning is the process of deciding one's future medical care. It helps ensure that, if you can't speak for yourself, your wishes will still be carried out. This information sheet is designed to help you understand the terminology and the process of creating Advance Directives – legal documents that state your health care wishes. It is important to discuss your preferences with your health care providers, family, close friends, clergy, and whomever you will rely on to speak for you when you cannot.

What are Advance Directives?

Advance Directives are legal documents in which you identify your choices for health care and medical treatment or name someone to make such choices for you if you become unable to communicate your wishes. They are for anyone of any age or health status.

What is a Power of Attorney for Health Care and when does it become effective?

A Power of Attorney for Health Care is one type of Advance Directive. It allows you to name another person to act as your agent and make medical decisions for you if you are unable to make them for yourself. Your agent's duty is to see that your wishes are followed.

What is a Living Will and when does it become effective?

A Living Will is another type of Advance Directive and is a written statement that describes the medical care you want or do not want. It becomes effective only when you are unable to make or communicate your own health care choices.

What is the difference between a Power of Attorney for Health Care and a Living Will?

A Power of Attorney for Health Care designates an agent to make health care decisions for you. A Living Will provides specific instructions about treatments desired or not desired. Both documents come into effect at any point in your health care when you are unable to make or communicate your own decisions.

Is it important to complete both a Power of Attorney for Health Care and a Living Will?

Completing one or both Advance Directives is your decision. If you only complete one document, generally, we suggest the Power of Attorney for Health Care. Then your Power of Attorney agent can represent you regarding your choices, including decisions that would have been stated in your Living Will. The most important thing is to have conversations with your agent and loved ones so they are aware of your wishes.

(over)

What is a DNR and when does it become effective?

A DNR (Do Not Resuscitate) or "No Code" is a medical order that must be written at the patient's or agent's request at every admission to a medical facility, regardless of the condition of the patient. A Living Will or a Power of Attorney for Health Care is not the same as a DNR.

May I use other legal documents as Advance Directives?

No. Other legal documents are important, but are not specific to health care decisions. A Last Will and Testament is not the same as a Living Will. A Power of Attorney for financial decisions is not the same as a Power of Attorney for Health Care. Therefore, it is important to write documents specific to your health care choices.

Do Advance Directives have to be witnessed?

Yes. The signing of these documents must be witnessed by a notary public or two persons who are not relatives or health care providers.

What should I do with these documents?

It is your responsibility to provide copies of your Advance Directive documents to your physician, local hospital, other regular health care providers, and your agent (the person you have chosen to make medical decisions if you have executed a Power of Attorney for Health Care). You should also give copies to close relatives and friends and discuss your choices with them and your agent. Put your original in a safe, but accessible, place.

Can I change my mind after I write an Advance Directive?

Yes. You may change or revoke an Advance Directive at any time through verbal or written communication. It is important to notify family members, health care providers, hospital, or home health agencies if you change or revoke your Advance Directives and provide these individuals with copies of the new documents.

Will an Advance Directive from one state be honored in a different state?

Most states will honor valid Advance Directives from other states, but you should check if you plan to spend time in another state since there are some exceptions and documents vary by state.

Must a health care provider follow an Advance Directive?

Yes. Your health care provider will follow your Advance Directives within the limits of the law and hospital policy.

Must I have an Advance Directive?

No. It is entirely up to you. If you do not have an Advance Directive and become unable to make or communicate your own health care decisions, your Next of Kin will make such decisions for you in consultation with your health care provider. Advance Directives, however, give you greater assurance that your wishes will be honored.

Who at Methodist Health System can answer my questions or help write a Power of Attorney for Health Care or Living Will?

If you are a patient at Methodist Hospital or Methodist Women's Hospital, please ask your nurse and s/he will contact a chaplain or administrative coordinator to answer your questions, provide the necessary forms for you, and notarize your document(s).

Or you may call the Methodist Pastoral Services Department (402) 354-4016 with any questions or to make an appointment. One of our chaplains will be happy to assist you with the forms and notarization.

Please also feel free to make an appointment to discuss and complete your Advance Directives with your health coach or health care provider at your Methodist Physicians Clinic.

This material is for informational purposes only. For specific legal or medical advice, contact your attorney or health care provider.

SAMPLE FORM

Nebraska Power of Attorney for Health Care

I, ____[Your name]_____, appoint _[Your primary decision maker's name], whose address is ___[Primary decision maker's home address]_____, and whose telephone number is [Primary decision maker's phone number]_, as my **attorney-in-fact** for Health Care.

I appoint __[Your alternate decision maker's name]_____, whose address is _[Alternate decision maker's home address]_____, and whose telephone number is _[Alternate decision maker's phone number]_, 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. I understand the consequences of executing a Power of Attorney for health care.

I direct that my attorney-in-fact comply with the following instructions or limitations:
_[Your additional instructions. Examples: additional decision makers to consult, preferred location of health _____

_services (i.e. the hospital, home, hospice house, etc), or write "none" so the line is not blank.]_____

I direct that my attorney-in-fact comply with the following instructions on life-sustaining treatment: ___[Your directions for a ventilator, CPR, etc. or write "none" so the line is not blank.]_____

_____

I direct that my attorney-in-fact comply with the following instructions on artificially administered nutrition and hydration:
___[Your directions for a feeding tube, IV hydration and nutrition, etc. or write "none" so the line is not blank.]_____

_____

I request that a second physician confirm my incapacity. _____ YES _____ NO [Initial on correct line]

I have read this Power of Attorney for Health Care and have discussed/ will discuss my wishes with my Power of Attorney. 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.

STOP HERE – YOU MUST HAVE YOUR SIGNATURE WITNESSED BY A NOTARY OR TWO WITNESSES

Signature _____ Address _____

Printed Name_____ _____

Date _____

SAMPLE FORM

Nebraska Power of Attorney for Health Care (Cont'd)

Declaration of Witnesses

THIS DOCUMENT MUST BE SIGNED BY TWO WITNESSES OR A NOTARY PUBLIC

We declare that the principal is personally known to us, that the principal signed or acknowledged his or her signature on this Living Will Declaration in our presence, and 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.

Witnesses fill out this portion – OR –

Witness Signature_____
Print Name _____
Address _____
_____
Date _____

Witness Signature_____
Print Name _____
Address _____
_____
Date _____

OR

A notary fills out this portion

State of Nebraska)
)SS.
County of _____)

On this _____ day of _____ 20___, before me, _____,
a notary public in and for _____ County, _____
voluntarily signed this document in my presence.

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

Notary Signature_____ Seal →

Nebraska Power of Attorney for Health Care

I, _____, appoint _____, whose address is _____, and whose telephone number is _____, as my **attorney-in-fact** for Health Care.

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. I understand the consequences of executing a 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: _____

_____

I direct that my attorney-in-fact comply with the following instructions on artificially administered nutrition and hydration:

_____

_____

I request that a second physician confirm my incapacity. _____ YES _____ NO

I have read this Power of Attorney for Health Care and have discussed/ will discuss my wishes with my Power of Attorney. 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.

Signature _____ Address _____

Printed Name_____ _____

Date _____

Updated 12/2014

Nebraska Power of Attorney for Health Care (Cont'd)

Declaration of Witnesses

THIS DOCUMENT MUST BE SIGNED BY TWO WITNESSES OR A NOTARY PUBLIC

We declare that the principal is personally known to us, that the principal signed or acknowledged his or her signature on this Living Will Declaration in our presence, and 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.

Witness Signature_____
Print Name _____
Address _____
_____
Date _____

Witness Signature_____
Print Name _____
Address _____
_____
Date _____

OR

State of Nebraska)
)SS.
County of _____)

On this _____ day of _____ 20____, before me, _____,
a notary public in and for _____ County, _____
voluntarily signed this document in my presence.

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

Notary Signature_____ Seal →

SAMPLE FORM

Nebraska Living Will Declaration

If I, _____[Your name]_____, 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 withhold or withdraw life-sustaining treatment that is not necessary for my comfort or to alleviate pain.

You may list specific life-sustaining treatments you do not want such as cardiac resuscitation, mechanical respiration (i.e breathing machine) and artificial feeding/ fluids by tube. Otherwise, your general statement, above, will stand for your wishes.

I especially **do not want:**
__[List what you do not want: chest compressions, feeding tube, breathing tube, to die at hospital, etc]_____

You may want to add instructions or care you **do want** such as pain medication, preference to die at home, if possible. __[List what you do want: family surrounding you, have pet on bed, etc],_____
_____

STOP HERE – YOU MUST HAVE YOUR SIGNATURE WITNESSED BY A NOTARY OR TWO WITNESSES

Signature_____ Date _____

Address, City, State, Zip Code_____

Declaration of Witnesses

THIS DOCUMENT MUST BE SIGNED BY TWO WITNESSES OR A NOTARY PUBLIC

We declare that the principal is personally known to us, that the principal signed or acknowledged his or her signature on this Living Will Declaration in our presence, and 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.

Witnesses fill out this portion – OR –

Witness Signature_____
Print Name _____
Address _____
_____
Date _____

Witness Signature_____
Print Name _____
Address _____
_____
Date _____

OR

A notary fills out this portion

State of Nebraska)
)SS.
County of _____)

On this _____ day of _____ 20____, before me, _____,
a notary public in and for _____ County, _____ voluntarily signed this document in my presence.

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

Notary Signature_____ Seal→

Updated 12/2014

Nebraska Living Will Declaration

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 withhold or withdraw life-sustaining treatment that is not necessary for my comfort or to alleviate pain.

You may list specific life-sustaining treatments you do not want such as cardiac resuscitation, mechanical respiration (i.e breathing machine) and artificial feeding/ fluids by tube. Otherwise, your general statement, above, will stand for your wishes.

I especially **do not want:**

_____

You may want to add instructions or care you **do want** such as pain medication, preference to die at home, if possible. _____

_____

Signature_____ Date _____

Address, City, State, Zip Code_____

Declaration of Witnesses

THIS DOCUMENT MUST BE SIGNED BY TWO WITNESSES OR A NOTARY PUBLIC

We declare that the principal is personally known to us, that the principal signed or acknowledged his or her signature on this Living Will Declaration in our presence, and 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.

Witness Signature_____
Print Name _____
Address _____
_____
Date _____

Witness Signature_____
Print Name _____
Address _____
_____
Date _____

OR

State of Nebraska)
)SS.
County of _____)

On this _____ day of _____ 20____, before me, _____,
a notary public in and for _____ County, _____ voluntarily signed this document in my presence.

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

Notary Signature_____ Seal→

Updated 12/2014

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ADVANCE DIRECTIVES

Resource List for Beginning the Conversation

For More Information

Methodist Pastoral Services
at Methodist Hospital

402-354-4016
8303 Dodge St.
Omaha, NE 68114

Or please contact your Health Coach or Health Care Provider at your Methodist Physician's Clinic.

Helpful Websites

Methodist Health System
www.bestcare.org/AdvanceDirectives

The Methodist Health System website is intended to give you additional tools to help you understand your choices when writing Advance Directives. On our website you will find:

- A link to watch a video on Powers of Attorney for Health Care and Living Wills
- A PDF document of this entire packet
- Power of Attorney for Health Care and Living Will forms
- Helpful phone numbers to call for additional information

American Hospital Association (Put It In Writing)
www.aha.org/advocacy-issues/initiatives/piiw

National Hospice and Palliative Care Organization (Planning Ahead)
www.caringinfo.org

Workbooks

The following booklets assist in guiding you and your loved ones with your health care choices.

5 Wishes: *www.agingwithdignity.org*

Caring Conversations: *www.practicalbioethics.org/resources/caring-conversations*

The Conversation Project: *www.theconversationproject.org/starter-kit/intro*

Books

Planning for Uncertainty: Living Wills and Other Advance Directives for You and Your Family
by David John Doukas and William Reichel (2007)

My Voice, My Choice: A Practical Guide to Writing a Meaningful Healthcare Directive
by Anne Elizabeth Denny (2012)

Advance Directives, Durable Power of Attorney, Wills, and Other Legal Consideration (Alzheimer's Roadmap Book #3, Amazon Kindle e-book)
by Laura Town and Karen Kassel (2014)